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TROUBLED AGING: AN ETHNOGRAPHIC ANALYSIS

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ABSTRACT

TROUBLED AGING: AN ETHNOGRAPHIC ANALYSIS

By

Sister Mary Christine Cremin, R.S.M.

Despite efforts to change it, the stereotype persists in our society that old age is primarily a time of enduring irreversible losses in physical health, social relationships, and autonomy. The endurance of the stereotype is due, at least in part, to the lack of information about the experience of growing old from the point of view of those most immediately involved in the process. Using an ethnographic approach, this study explored the experiences of aging constructed by five older people, their adult children and a team of health professionals involved in evaluating their health status. The study found that the older participants made a clear distinction between <u>being old</u> and <u>feeling old</u>, whereas their children did not. None of the five older people, who ranged in age from 69 to 86, identified themselves as old although each of them identified specific and transient episodes of feeling old. Their children, on the other hand, identified the older people as <u>being old</u> when they perceived them as having lost a characteristic which had been a central factor in the children's experiences of them <u>as parents</u>. Contrary to the older people's construction of feeling old as a temporary phenomenon, the children's identification of their parents as old included the understanding that their parents were in a process of inevitable and irreversible decline for which something needed to be done. In an effort to help, the children referred their parents to a geriatric assessment clinic to identify the cause

of their problems and to recommend solutions for resolving them. The involvement of the assessment clinic generated yet another construction of the older peoples' problems. The dissertation explores the impact which these conflicting constructions of old age had in unwittingly precipitating an additional burden of trouble for both older people and children. Conversely, the study also demonstrates the ability of participants' definitions of themselves and their situations to withstand the weight of conflicting constructions. Finally, the phenomenon of troubled aging is seen as a feature of the children's experience of their parents' aging rather than as a central aspect of the older people's experience.

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I am particularly indebted to the families and the clinic staff who participated so generously in this research. They gave me an opportunity to share in the richness and complexity of their experiences of aging and its implications and I have learned much from them.

I am grateful to Dr. Roy Gerard and the Department of Family Practice at Michigan State University who have provided both time and technology to ensure the completion of the dissertation. Father Roger Prokop saw the value of this project when it was in its earliest phases and has given thoughtful and insightful advice during the course of its development. Father James Murray provided consistent encouragement as well as the benefit of his years of pastoral experience with older people. Susan Irwin has been a good friend who provided both a knowledgeable critique of various segments of the dissertation as well as invaluable logistical assistance. Meg Rademacher edited multiple drafts with an eye for mistakes coupled with unfailing tact and humor. Theresa Braccio gave generously of her time and talent to support the completion of this work.

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CHAPTER 1

INTRODUCTION

A curious set of dichotomies about growing old exists in our society. We can see these contradictory notions of aging in the way the elderly are considered in political circles, the media, the health industry, and in the literature of social science. On the one hand they are portrayed as a dependent and resource-draining segment of our population. On the other they are seen as comprising a powerful voter constituency and a wealthy consumer market. The elderly are singled out as a primary target for health promotion activities and sought out as needy recipients of assessment technology which will evaluate their level of impairment. They are dramatized in the media as feeble and passive participants in life and as wise and energetic forces to be reckoned with. In the literature of the social sciences they are seen as prime candidates for depression because they are enduring an inevitable series of losses and as vibrant, incisively wise people who have reached a peak point of integration in life.

It is true that these dichotomies characterize two ends of a very long spectrum of what older people are like. It is also true that there has been a concerted effort to debunk the stereotype that all old people are alike. Nevertheless, the dichotomies point to the ambivalence with which we look upon aging in this country. Part of the reason for our

ambivalence is that both ends of the spectrum contain elements of truth. For example, we do know that older people are living longer and healthier lives than they ever have in the past. We also know that adult illnesses occur with greater frequency and often with more serious consequences in the older population (Cassel, 1986). We know that in 1986 the proportion of people 65 and older who had incomes below the poverty level was higher (12.4%) than those between the ages of 18 and 64 (10.8%) (AARP, 1987). [1] Figures from the same year, however, show that the median net worth of households headed by an individual 65 or older was almost double the U.S. average ($60,300 vs. $32,700) (AARP, 1987).

In addition to these external dichotomies affecting the way we think about older people, another and perhaps more salient cause of our ambivalence may be that we lack understanding of the "insider's" experience of growing older. Although I certainly include as "insider" here the older person, I also include family members and others intimately involved with him or her in the aging process. Older people, like any other people, fashion the meaning of their experience in relationship with those who participate in it with them. This is no less true for their experience of aging. If we want to gain an understanding of what it is like to grow older, it is important at some stage to consider older peoples' experiences of aging in relationship to the perspectives of those participating in the experience with them.

This study examines the views which five older people had of their own

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[1] The poverty level in 1986 was defined as $6,630 for an older couple household or $5,255 for an older individual living alone.

aging and compares them with the perspectives of at least one of their adult children. The older people had been identified by their children as having difficulty associated with their aging and the children had referred them to a geriatric assessment clinic for evaluation. [2] The purpose of the clinic was to examine people over the age of 65 who were thought to need additional help because they had a combination of complex medical problems or problems with memory loss or confusion.

Because the clinic's purpose was explicitly geriatric assessment, it directly confronted the perceptions about age and trouble which patients and their families held. Because their perceptions were being called into question by the very fact of their involvement with the clinic, the families who participated in this study were particularly apt to offer insights about what it was like to grow old or to witness a parent growing old.

The title of this dissertation is based on my original belief that the older participants in this study actually perceived themselves as experiencing "troubled aging." What I discovered, rather, was a much more complex relationship between the concepts of trouble and old age. Older participants did not think of themselves as old. [3] They were people who were actively engaged in fashioning the meaning of their

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[2] Geriatric assessment units began developing in this country approximately fifteen years ago and their numbers have increased rapidly since 1980. Based on the concept developed in Great Britain of special geriatric wards, the function of these units is to assess the physical, emotional, mental, and social needs of patients over 65 who are considered frail elderly.

[3] Participants were emphatic in not wanting to be described as "old" in this research. "Older people" was an acceptable alternative.

experiences as they grew older, presumably as they had done throughout their lives and, in the process, they continued to fashion their sense of self. As they aged, troubles of particular kinds came to have special significance for them. In confronting, enduring, or bypassing situations which they defined as troublesome, the older participants came face to face with a sense of feeling old which, as we shall see, was essentially different from any sense of identifying themselves as being old.

The findings of this study hinge on understanding the meaning of the terms "construction" and "self-identity" as I use them in this dissertation. My use of the term "construction" implies an understanding that individuals are continuously engaged in a process of selecting aspects of reality to which they attend or which they ignore. What is attended to becomes incorporated into one's experience of the world and of oneself in the world. This approach of selective attention and inattention is a life long process of mutual interaction between the self and the world outside oneself. Over time one develops a pattern of noting and interpreting aspects of experience in ways that are congruent with one's sense of self. At the same time one's sense of self is being formed and re-formed by the act of interpreting the meaning of each experience. The act of interpretation is one of construction, of putting the pieces of experience together in ways that are unique for each individual.

The concept of self-identity as I use it flows logically from an understanding of the active nature of the construction of experience. The beliefs one has about who one is are formed over time in relation to

the experiences one has in the world. Once established, these beliefs have a tremendous power to resist external pressures. Alverson has noted this phenomenon in his work with the Tswana and I use the term self-identity in this study as he has described it.

> Self-identity consists of those authentic beliefs a person holds about the **who-and-what**-he-is which resist variations in the outside forces that impel his various social actions....The words **who** and **what** tell us that the beliefs have as their object some essential core of features, attributes, propositions, feelings, and so forth, which are not accidental or variable but **necessary to the experience of the self**....The word **resist** implies something more than a mere "common denominator" of the experience of self or of behavior. It suggests, rather, an active striving against forces which, were it not for this striving, might alter those beliefs about the self....The phrasing of the definition implies that the person himself is conscious of what he believes. While not everything one is lies within consciousness, much of it does. This conscious component consists in particular of the beliefs one holds about the essential **what-I-am**. Finally, this definition concedes that while an individual's social behavior may be impelled (by habit, sanction, and so forth), what a person believes himself essentially to be is **not** merely the sum of his accumulated behaviors or actions. Rather, it is a construction, an object of belief which resists the shaping and molding of social forces. (1978: 3-4)

The importance of self-identity and the active nature of construction are evident throughout this study in the participants' reflections on their experiences of age and trouble. I have organized the chapters of the dissertation to highlight the ways in which participants' unique understandings of themselves resulted in equally unique experiences of aging. Following this introductory chapter, Chapter 2 reviews the literature pertinent to the issues raised in the study. Chapter 3 presents brief life histories of the participants, describes the clinic setting and staff, and discusses the methods used in the study.

Chapter 4 discusses the ways in which older participants and their children constructed the meaning of age. Older participants did not identify themselves as old and resisted societal images of old people as passive, lethargic, and non-productive. When they were faced with changes in their physical or mental capacities because of illnesses as they grew older, they dealt with these as they had dealt with other difficulties throughout their lives. Their approaches to the limitations they faced as they grew older were consistent with the styles they had developed over a lifetime of experience. What was important to them depended on their sense of who they were and they actively worked to respond to the difficulties they encountered in a way that kept their self-identity intact. On the contrary, with the exception of one family, all of the children of older participants thought of their parents as old. Paradoxically, while it was the strength of their self-identity which caused the older people to resist thinking of themselves as old, it was that same identity - as their children perceived it - that caused them to consider their parents as old. Precisely because these adult children had such definitive ideas of who their parents were, they responded to limitations which impinged on these ideas with the perception that now their parent was old.

In Chapter 5, I discuss the ways in which participants constructed the meaning of trouble. The concept of trouble was a central focus in the perceptions which all participants had of old age and is a key concept in analyzing one of the major findings of this research, namely, the distinction which the older people made between <u>feeling</u> old and <u>being</u> old. Their distinction hinged on the occurrence of trouble of specific kinds which made them occasionally <u>feel</u> old. For older participants the

kind of trouble that made them feel old was related directly to wh
they perceived as a threat to values which were of critical import
to them. Feeling old was a temporary and sporadic condition and d
imply that these older people identified themselves in any signifi
or permanent sense as old.

In contrast to this view, the children of the older participants, w
the exception of one family, identified their parents as <u>being</u> old
children's perception also centered on specific kinds of trouble t
parents were having. Children identified their parents as being o
when they experienced them having trouble which resulted in the lo
a prime characteristic by which they had always known their parent
Contrary to the older peoples' view of feeling old as a temporary
phenomenon, however, their identification, once it was made, was
permanent and implied that their parents had entered an irreversib
and deteriorating state.

Chapter 6 analyzes the clinic's interventions with each participan
discusses the ritual power of the clinic and its role in the formu
of troubled aging. Because the older peoples' constructions of
themselves and of old age were based on a lifetime of interacting w
their world, their conversations revealed definitive patterns or t
which reflected the values which were important to them. These th
served as a framework for organizing the unique ways in which each
these older people experienced themselves becoming older without e
becoming old, without ever losing their sense of self which had be
continuous throughout a lifetime.

Since the older peoples' and children's formulations of age and of trouble were consistent with values and parent-child relationships built over a lifetime, they were relatively impervious to the pressures of conflicting interpretations of their experience. This was especially evident in their interpretation of their experience with the assessment clinic. The clinic's role with the older people and their children was a conflicted one. This was inevitable in most cases because older people and children had opposing views of the older person's situation. In most cases, therefore, the clinic's recommendations appeared to agree with one "side" or the other and the side not in agreement found the clinic ineffective.

Despite the degree of family agreement or disagreement with clinic diagnoses and treatment recommendations however, all participants retained their original constructions of age and trouble. All of the older people who were evaluated as mentally competent by the clinic staff rejected or significantly modified clinic recommendations. For the two older participants who experienced memory loss or confusion, their children followed the clinic recommendations which, in any case, were in agreement with their views of what was going on with their parents.

Chapter 7 concludes with a discussion of the implications of the research findings and suggestions for further research. The finding that participants were actively involved in constructing unique experiences of age is considered in the light of the trend in cognitive anthropology to view beliefs about oneself and the world as fixed and rigid. Similarly, the creative efforts of participants in

this study to make sense out of their experiences of aging is examined in the light of the division in the gerontological literature between an understanding of the aging process as a series of losses more or less passively endured by older people and aging as a continuity of the self forging meaning out of the experiences of life. Suggestions are made for viewing the process of geriatric assessment as an occasion for empowering older people in their efforts to make their experiences of aging meaningful and creative.

CHAPTER 2

REVIEW OF LITERATURE

The literature which relates to this study is embedded in three major areas of research: 1) cognitive anthropology; 2) sociocultural gerontology and; 3) medical anthropology. This chapter will review the pertinent literature in each of these areas, summarizing the major findings related to this study and highlighting issues left unanswered in the literature which this study addresses.

Cognitive Anthropology

From its beginnings, the literature in the field of cognitive anthropology, variously called ethnoscience or ethnosemantics, has been concerned with discovering how it is that people understand the world. Focusing largely on the mentalistic component of culture, ethnoscientists looked to language as the key to understanding the cultural code of a people. Although many of the early subjects ethnoscientists chose to study might be considered obscure or irrelevant, their stress on rigorous elicitation techniques which minimized the ethnocentric biases of the ethnographer made the field promising enough to be named "the new ethnography" (Colby, 1966, 1975).

It is not within the scope of this review to consider the vast literature in the area of cognitive anthropology or the lengthy

controversy which it has sparked within the field of anthropology. (Useful reviews of the goals, methods, and limitations of cognitiv anthropology can be found in Colby, 1966 and 1975; D'Andrade, 198 Fisher and Werner, 1978; Frake, 1962). I will focus rather on the aspect of cognitive anthropology which relates most directly to th study, namely, the development of methods for the elicitation of native, or emic, perspective and the separation of this view from of the ethnographer.

In one of the earliest writings in the field of cognitive anthropo Frake addressed the dilemma of how the anthropologist should go ab discovering the category systems of a culture. His solution is at heart of what this research has attempted to do: rather than attem find the names people call things, "redefine the task as one of fi the 'things' that go with the words." (1962: 192) Old age and tro are words commonly used in our society, particularly by older peop their families, and health professionals. This common usage has resulted in the faulty assumption that the three groups mean the s thing by the same words. Following Frake's dictum in this study h allowed me to discover significant differences in the "things" tha of my informants attached to the words "old age" and "trouble."

Through elaborate techniques of elicitation and coding of response Goodenough (1956), Lounsbury (1964), Frake (1962), Spradley (1972) others have refined the concept of "discovering what things go wit words" into the concept of semantic domain or category. The proce categorization allows an individual to respond to unfamiliar exper by treating them as being, in some essential aspects, equivalent t

something already familiar (Spradley, 1972). Without using formal ethnosemantic methods of elicitation and coding, this study relied heavily on the concept of category. How informants thought of age and trouble was dependent upon categories they had established throughout life - categories which, in some instances were radically different from those of their own family members or the medical personnel who were caring for them. This study departs, however, from any understanding of category as a static construct. By analyzing participants' constructions of self-identity as the basis for understanding their formulations of age and trouble, the study highlights the dynamic processes by which categories are formed. The participants in this study were actively involved in shaping their experiences and understandings by relating aspects of their past experiences to their present situations and making choices about them. Participants' categories were constantly being formed and reformed at the same time that they were using them to shape the meaning of their experiences.

The primacy of the ethnosemantic approach as a "necessary prerequisite" in any ethnographic investigation has been developed by Werner and Schoepfle.

> Assuming the primacy of the insider's point of view of culture - based on careful attention to issues of epistemology and human cognition - the ethnoscience approach is a necessary prerequisite to any subsequent (perhaps conceptually or theoretically more complex) investigation. In other words, we assert that all specialized forms of social science research require that the investigator first know something about the internal view - that is, the interpretation of things and events as seen by the actors themselves. It is precisely ethnoscience,...that provides the most appropriate primary tool. (1987, (1): 21)

Werner and Schoepfle base their approach to ethnoscience upon an explicit theory of lexical/semantic fields and upon an epistemology which exploits anomaly. The methods I used in this study relied heavily upon this latter epistemology which Werner and Schoepfle have developed into the principle of "epistemological windows". These are defined as "any situation during the ethnographic process that potentially enhances the discovery of new insights into the cultural knowledge of the people under study." (1987, (1): 57).

Werner and Schoepfle describe seven "windows" which can potentially facilitate the ethnographer's understanding of a culture:

1) the "ethnological window", formed through the ethnographer's immersion into the language and literature of the target culture;
2) the "classical stereo vision window" which is formed by the clear separation of the ethnographer's views from the natives' views;
3) the "second stereo window", formed from the discrepancies which exist between informants;
4) the "negotiated questions window" which occurs in the process of matching the ethnographer's questions with the natives' cultural knowledge;
5) the "diachronic window", formed by comparing first impressions of the field and early interviews with informants with data collected at a later time;
6) the "systematic distortion hypothesis window" which exploits the discrepancy between the observations made of an event at the time of its occurrence and later

recall of the event and;

7) the "qualitative/quantitative window" formed by combining qualitative and quantitative approaches to the culture under study.

The approach of exploiting anomaly was a primary consideration in this study both because I was investigating the degree of congruence and discrepancy in understanding which existed among three groups of participants and because, having been a member of one of the three groups, I participated in the ethnocentric bias of that group. Utilizing a modified form of Werner and Schoepfle's formation of epistemological windows provided me with a systematic way of guarding against this bias.

Sociocultural Gerontology

A small but growing segment of the gerontological literature has begun to emphasize the need for exploring the meaning of aging to those who know most about it, the elderly themselves (Kaufman, 1986; Cole and Gadow, 1986; Fry and Keith, 1986). Through a project sponsored by the Institute for the Medical Humanities in 1983, scholars from the social sciences, humanities, medicine and law engaged in cross- disciplinary reflection on the relationship of aging and meaning (Cole and Gadow, 1986). A persistent theme that pervades their reflection is the awareness that societal values responsible for the negative status attributed to old people have been incorporated into much gerontological research and practice. To counteract this trend, they highlight the need for research into the experience which old people

themselves have of the aging process.

A consistent theme in the gerontological literature has been the central place of the family in relationship to older adults (Streib, 1965; Shanas, 1979; Riley, 1983). A number of researchers have been concerned with the phenomenon of intergenerational relationships as these are affected by the aging process (Brody, 1981; Brody, Johnson, Fulcomer and Lang, 1983; Goldfarb, 1965; Lang and Brody, 1983; Rosow, 1965; Shanas, 1979; Troll, 1971). Brody notes that the combination of increasing numbers of individuals over 65 in the U.S. population plus the increased longevity of this group has meant that individuals and families having a dependent elderly parent has now become a "normative experience" (Brody, 1985: 20). She cites the following statistics to illustrate her point:

> Between 1900 and 1976, the number of people who experienced the death of a parent before the age of 15 dropped from 1 in 4 to 1 in 20, while the number of middle aged couples with two or more living parents increased from 10% to 47% (Uhlenberg, 1980)....By 1980, 40% of people in their late 50s had a surviving parent as did 20% of those in their early 60s, 10% of those in their late 60s and 3% of those in their 70s (NRTA-AARP, 1981). Ten percent of all people 65 years or older had a child over the age of 65! (1985: 20).

Much of the research that has been done in the area of intergenerational relationships involving older adults has focused on the experience of caregiving from the adult child's perspective (Cantor, 1983; Zarit et al., 1980; Kleban et al., 1984) and the stresses which the experience frequently involves have been widely documented. While the adult children who participated in this study indicated that they experienced the care of their parents as a highly stressful situation, the study

also found that, from their parents' perspectives, the concerns of the children were often misplaced.

Although it is a fairly recent development, anthropological research in gerontology has begun to make a major contribution toward a meaning centered approach to aging. Much of the anthropological literature has focused on cross-cultural experiences of aging, the effect of cultural change on the elderly, and the social organization of age differences (Strange and Teitelbaum, 1987; Myerhoff and Simic, 1978). Fry, Keith et. al. are using ethnosemantic methods to investigate the meaning of aging across cultures (Fry, 1986). Fry points out the usefulness of the explicit elicitation procedures inherent in the ethnosemantic approach both for enhancing cross-cultural comparability in gerontological research and for developing instruments which can be used to elicit data from large samples of a population (1986).

Myerhoff and Simic, among others, have explored the ways in which old people in different cultures view themselves (Myerhoff and Simic, 1978). Their focus on understanding aging from the point of view of elderly individuals led them to the formulation of the concept of aging as a career rather than as a series of losses. This concept lends strong support to a major finding of this study - the significance of life themes in expressing the essential continuity of older participants' understanding of themselves and their experiences as they grew older. A similar emphasis on continuity of experience can be found in Myerhoff's classic study of elderly Jewish participants in a California senior center (Myerhoff, 1978). Relying heavily on verbatim transcripts of interviews, Myerhoff shows how the meanings which elderly

participants constructed from their personal and cultural histories served as the backdrop against which they fashioned meaning from the experiences of their daily lives. While both of these works emphasize the organizing force of continuity in growing older, neither addresses directly the significance of themes as an expression of continuity.

The explicit study of themes in the lives of older people is the focus of Kaufman's work, The Ageless Self. As the title implies, age was not an identifying characteristic for the participants in her research. Rather, the continuity of themes throughout life is the key element by which this population of older people identified themselves. Many of the findings in Kaufman's work are similar to those in this study, most significantly the lack of significance to participants of chronological age. However, this study differs from Kaufman's by comparing older participants' constructions of growing older with those of their adult children.

Medical Anthropology

Research into the construction of meaning within clinical encounters between patients and physicians has not dealt extensively with relationships involving elderly patients. The need for understanding the meaning of the doctor-patient encounter and its significance in constructing the experience of illness has been highlighted by numerous authors (Fisher, 1983; Cicourel,1983; Kleinman, Eisenberg and Good, 1978; Kleinman, 1980). Kleinman's development of the theoretical framework of explanatory models (1980) is based on the concept of the social construction of reality developed by Berger and Luckmann (1966)

and draws upon the semantic network analysis developed by Good (1977). In the development of explanatory models, Kleinman proposes an interpretive framework through which physicians can discover the particular ways in which patients construct the meaning of their illness. Awareness of these constructions of illness juxtaposed with the physicians' construction of disease is the foundation for development of physician-patient encounters based upon the negotiation of these meaning systems.

Kleinman, Eisenberg and Good (1978: 254) observe that "patient-doctor interactions are transactions between explanatory models, transactions often involving major discrepancies in cognitive content as well as therapeutic values, expectations, and goals." The present study confirms this observation but also extends its implications to interactions between the older individual and his or her family. Additionally, it departs from the notion of explanatory models as a static concept and emphasizes the dynamic nature of the way participants constructed the meaning of their experiences of age and trouble. By comparing the meanings of troubled aging constructed by old people, family caregivers and health professionals, the present study also provides insights into discrepancies in perspective which contribute to such phenomena as caregiver burden, problems of compliance with health care recommendations and quality of life issues.

CHAPTER 3

STUDY PARTICIPANTS AND METHODS

The participants in this study were drawn from a geriatric assessment clinic in a Midwestern city. The clinic was located in the outpatient wing of a mid-size hospital and was staffed by a multi-disciplinary team of health care professionals. The purpose of the clinic was to evaluate the physical and mental status of people over 65 who were referred because of difficulty with memory loss or for complex physical problems.

Members of the clinic staff who participated in the study included two family practice physicians, one of whom was participating in a geriatric fellowship program sponsored by a neighboring University medical school, an internist, a psychiatrist, the clinical nurse specialist and the social worker. The assessment clinic was not the setting for this study in the strict sense since only some aspects of the research (staff interviews and review of medical records) took place there. However, since the clinic's role in the lives of the study participants is a major focus of this research, it is described in detail in the first section of this chapter.

Five older people who were seen in the clinic and one or more of their adult children formed the study groups who participated in the research. Because many of the issues discussed in the following chapters hinge on

understanding the background and family relationships of these older people and their children, the second section of the chapter contains brief biographical sketches and kinship diagrams for each family group. This section concludes with a discussion of my relationships with the study participants and a consideration of special problems encountered in the study.

The remainder of the chapter deals with the methods used in this study including a discussion of criteria for selecting participants, interviewing methods and methods of analysis.

THE ASSESSMENT CLINIC AND THE CLINIC STAFF

The geriatric assessment clinic accepted only patients who were over 65 and who were referred for evaluation of their physical or mental functioning. Although older people could request a clinic appointment themselves, such a request was extremely rare and most patients were referred by family members. The reason for most referrals to the clinic was a concern that the older person was experiencing memory loss or that their physical condition was deteriorating. The clinic provided assessment, referral, and limited follow-up (i.e., visits at three and six months following the patient's initial assessment). Primary care and emergency services were not provided.

The clinic was the only geriatric assessment unit in the city and was a joint effort sponsored by the hospital and by the medical school of a large state university. At the time this study was done, the clinic was operating two half days a week and was reimbursed by a combination of

third party payments and fees charged to patients. A complete description of the clinic's assessment procedure is contained in Appendix A. A brief description of its operation is provided here.

The assessment process was complex and took approximately six to eigh weeks to complete. After patients were accepted by the clinic, they were visited at home by the nurse who talked with them and with at le one member of their family. She asked questions about their health, occupational history, interests, family relationships, and the extent their current activity. She also administered a mental status exam. Following the home visit the patient and family were seen in the clin where the patient had a complete physical examination including a num of diagnostic x-rays and laboratory studies. In addition, the patien and family were interviewed separately by the clinic social worker. second visit was scheduled for the patient to be evaluated by an occupational or physical therapist. At this visit the patient's abil to perform activities ranging from getting in and out of a chair to doing simple arithmetic was assessed.

After the clinic staff had completed their individual evaluations the met to discuss their assessments and to develop a series of recommendations for the patient's continuing treatment. A family conference was then scheduled which was attended by the patient and family and at least two of the clinic staff. The purpose of this meeting was to explain the results of the clinic evaluation to the patient and family, review the clinic's recommendation for further treatment, and answer questions.

The members of the assessment team ranged in age from mid-thirties to late fifties. Each had particular expertise in geriatric medicine and gerontology. The family practice physician and the internist were on the faculty at the University medical school and had previously taken year long sabbaticals to study geriatric medicine. The clinical nurse specialist had taught gerontology in a masters degree program for nursing students. Besides his responsibilities in the clinic, the psychiatrist directed an inpatient geriatric psychiatry unit. The social worker had extensive experience in mental health programs for older adults before joining the clinic staff. Because the occupational and physical therapists were members of a separate department and, as such, both spatially and functionally separate from the day to day operations of the clinic staff, they were not included in this study.

STUDY GROUPS

Mr. Brown And His Family

John Brown was an 81 year old man who had been a widower for three years when I first met him. He had one child, a daughter Joan who, with her husband, also participated in the study. A kinship diagram of Mr. Brown's family is presented in Figure 1.

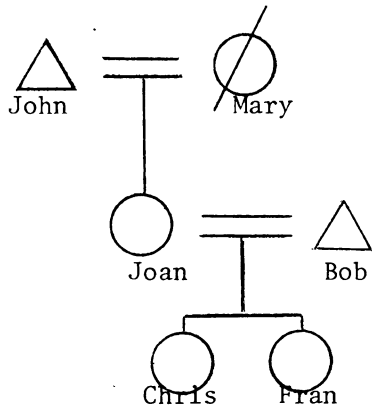

FIGURE 1

KINSHIP DIAGRAM OF MR. BROWN'S FAMILY

Mr. Brown had been born in the Northeast United States and grew up on a farm. When he was in his early twenties he moved to the Midwest to pursue studies in an automotive technical institute. Mr. Brown advanced steadily in the automotive industry and attained a mid-level management position from which he retired when he was 65. When he was in his fifties, he was diagnosed as having Parkinson's disease and, although he had some difficulty with a tremor in his arm and some unsteadiness in walking, he maintained an active professional and social life until his wife became seriously ill. Mr. Brown cared for his wife at home for five years before she died. Following her death, he resumed many of his former activities, particularly travel, joining his daughter and son-in-law and their family on trips to different parts of the country. During the years after his wife's death, Mr. Brown fell fairly often because of problems with his balance resulting from Parkinson's disease. Approximately six months before I met him, Mr. Brown had fallen in his home and fractured his hip. After surgery to repair the fracture, he was discharged to a nursing home for a period of convalescence. At the time I met him, he had regained his ability to

care for himself and walked with the aid of a walker. He was still living in the nursing home.

Mr. Brown's daughter, Joan, and her husband, Bob, lived approximately 80 miles from Mr. Brown. They maintained frequent telephone contact saw him several times a month. Bob was in his sixties and had retire from the automobile industry two years before I met him. Joan was a high school counselor who had retired a few weeks before our first interview. Their relationship with Mr. Brown appeared close, strengthened by the memory of many years of shared enjoyment in trave and in visits with Joan and Bob's children and grandchildren. Durin the time Mr. Brown was hospitalized and after he moved to the nursing home, Joan and Bob assumed responsibility for monitoring his care and for managing his financial affairs. Their relationship at this time was marked by their desire to have Mr. Brown regain as much independe as possible. They worked closely with him to try to understand his wishes about the management of his finances and about where he wanted live as his condition improved. They expected that Mr. Brown would m his own decisions and saw themselves responsible for supporting him i the decisions he made.

Mr. Hauser And His Daughters

Frank Hauser was an 82 year old man who had been widowed for many yea His wife had been an invalid for most of their married life and was diagnosed as having Multiple Sclerosis approximately ten years after their marriage. Mr. Hauser and his wife had three children, two daughters, Frances and Betty, who lived close to him and a son who li

in a distant city. A kinship diagram of Mr. Hauser's family is presented in Figure 2.

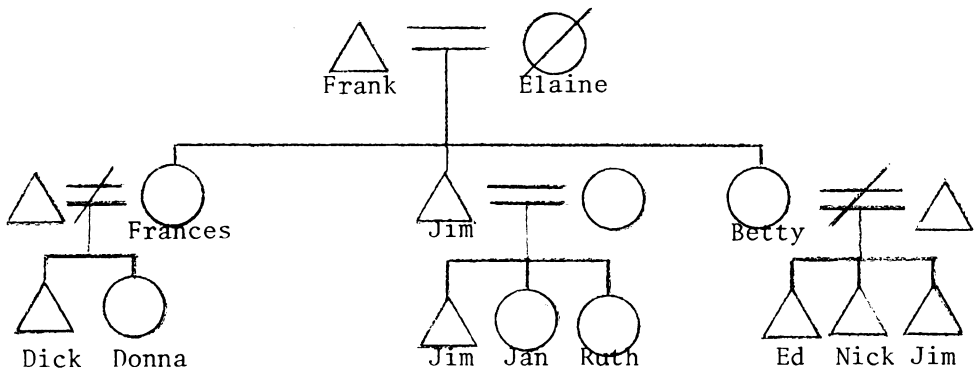

FIGURE 2

KINSHIP DIAGRAM OF MR. HAUSER'S FAMILY

Mr. Hauser's father had been a mortician and also owned a furniture store and ambulance business. As a young man Mr. Hauser helped out in all three of the family businesses as well as managing a newspaper distributorship. He completed two years of college before he dropped out because of an illness which, apparently, was never diagnosed. He never returned to college although, by his and his daughters' reports, he was a bright student and enjoyed learning. Before his marriage, Mr. Hauser became a private pilot and barnstormed across the country before opening his own flying school. The Depression and his marriage put an end to this undertaking and Mr. Hauser eventually settled into a series of business and real estate ventures, periodically working with his older brother who had taken over the family business. He retired from the real estate business when he was in his seventies and lived for a time with each of his daughters. At the time I met him, Mr. Hauser was living in his own apartment but within a year moved to a retirement

center. The move was initiated by his daughters because Mr. Hauser had been having episodes of confusion for several months and was having increasing difficulty with memory loss.

Frances was Mr. Hauser's oldest child and Betty his youngest. Both were divorced and worked full time. Frances's children were grown and she lived alone in a trailer home. Betty and her three teenage sons lived in a home in the same neighborhood. Both women had daily contact with Mr. Hauser. For the first several months of the study, Frances drove him at noon to a friend's home where he stayed until late evening when Betty drove him home. Both women's relationship with Mr. Hauser had been strained when he was a younger man, largely because of what they characterized as his rigid and controlling personality. As Mr. Hauser had more difficulty with his memory he also became, in his daughters' view, much more flexible and appreciative of his relationship with them. During the time of the study, Frances and Betty assumed progressively more responsibility for managing Mr. Hauser's affairs. They did this with a great deal of concern for allowing Mr. Hauser to maintain his dignity but with the perception that his memory loss and confusion would become worse and that he would progressively lose his ability to make independent decisions.

The Hamiltons

Virginia Hamilton was a 77 year old widow who had moved from another state to a retirement center near her son Jim's home a few months before I met her. Her husband had died two years earlier several months after being diagnosed as having Alzheimer's disease. Mrs. Hamilton had grown

up on a farm in the Midwest and had met her husband when she was attending college. She and her husband had four sons, three of whom now lived in other states. A kinship diagram of Mrs. Hamilton's family is presented in Figure 3.

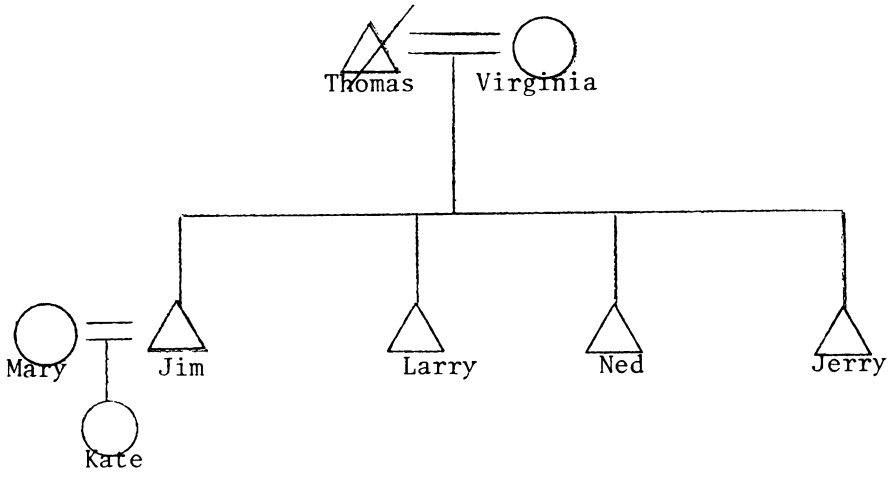

FIGURE 3

KINSHIP DIAGRAM OF MRS. HAMILTON'S FAMILY

In addition to caring for her family, Mrs. Hamilton had been very active in volunteer activities and political organizations in her community. She visited nursing home patients on a regular basis and regularly participated in committee work for the Republican Party and several public service agencies.

After her husband died, Mrs. Hamilton began to have difficulty with memory loss and confusion. Eventually this became so severe that her sons decided she could no longer live alone and they found her an apartment in a retirement center in X, the city where her oldest son lived. After she moved to X, she was seen in the assessment clinic where the cause of her confusion was diagnosed as severe hypothyroidism. This was treated with medication and her condition

improved markedly.

Jim was Mrs. Hamilton's oldest son. When a younger brother who l
the same state as Mrs. Hamilton noticed her progressive memory lo
contacted Jim who made several trips to visit his mother and eval
her situation. Jim and this younger brother made the decision to
Mrs. Hamilton to a supervised living situation. Of Mrs. Hamilton
sons, they were the two who actively participated in the decision
explained this by saying that one of his brothers lived in a dis
state and had just taken a new job and the other was epileptic.
Although both Jim and his brother had each found what they consid
suitable living situation for Mrs. Hamilton, Jim decided that it
be better to have Mrs. Hamilton move near him. His brother trave
good deal in his work and would not be able to see Mrs. Hamilton
regularly. Jim was a high school teacher with summers and evenin
relatively free. He, his wife, or one of their children visited
Hamilton daily, frequently taking her out for drives or to their
for dinner. Jim assumed responsibility for her care, closely mon
her responses to medical interventions and to her new environment
well as managing her financial affairs.

The VanDykes

Evelyn VanDyke was an 86 year old widow who had moved to an apart
X several months before I first met her. She had grown up on a f
the Midwest and was a twin. Mrs. VanDyke's mother was blind and
her two sisters were reared by their parents and her maternal
grandmother. Mrs. VanDyke had three sons. Her oldest son, Mel,

close to her, another son lived in a distant city and the third lived in another state. A kinship diagram of Mrs. VanDyke's family is presented in Figure 4.

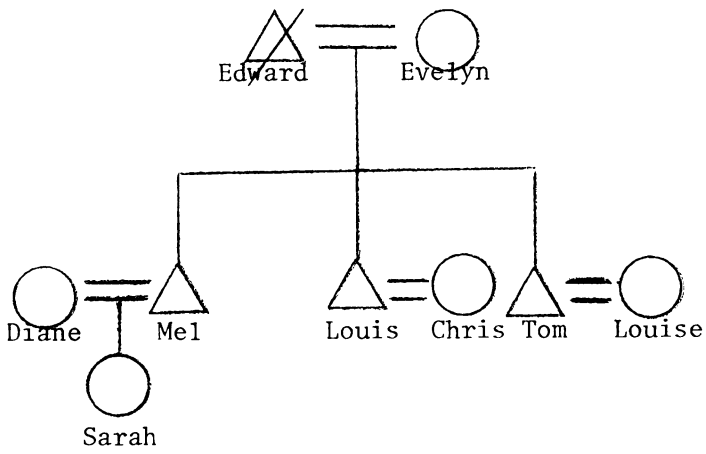

FIGURE 4

KINSHIP DIAGRAM OF MRS. VANDYKE'S FAMILY

Mrs. VanDyke and her husband, a newspaper editor, had been prominent members of their community. Mrs. VanDyke founded a county historical museum and, when she was in her fifties, went to college and completed her masters degree when she was 63. After her husband died, she continued to manage her home as well as many of her community projects until she decided she was no longer able physically to handle all the activity. She moved to X to be closer to her son as well as to her older sister who was in a nursing home.

Mel was Mrs. VanDyke's oldest son and, according to the report given at the clinic by his brothers, he was also her favorite. According to the same report Mel's wife, Diane, was the least favored of Mrs. VanDyke's daughters'-in-law. Diane and Mel were aware of the strained relationship between Mrs. VanDyke and Diane but were puzzled by its

cause. Although Mrs. VanDyke maintained control over her quite substantial finances, Mel assisted her in planning and she frequently called him for advice. The closeness with her son and conflict with his wife created a difficult relationship not only for Mrs. VanDyke but for Mel and Diane as well. The tension in the relationship increased as Mel and Diane perceived Mrs. VanDyke to be undergoing a change in personality and becoming progressively more preoccupied. Mel agreed with his wife that he had always been inhibited by Mrs. VanDyke's forceful personality and he was unwilling to confront her about many of the things which concerned him in her behavior.

Mrs. Thompson And Her Daughter

Elaine Thompson was 69 years old when I first met her. She was an only child and had grown up in the Eastern United States. Mrs. Thompson and her husband, who had advanced Alzheimer's Disease and lived in a nursing home in another city, had six children. Two of Mrs. Thompson's daughters lived close to her. One of these daughters was Grace who participated with Mrs. Thompson in the study. Mrs. Thompson's oldest daughter lived in another state and the rest of her children lived in other cities. A kinship diagram of Mrs. Thompson's family is presented in Figure 5.

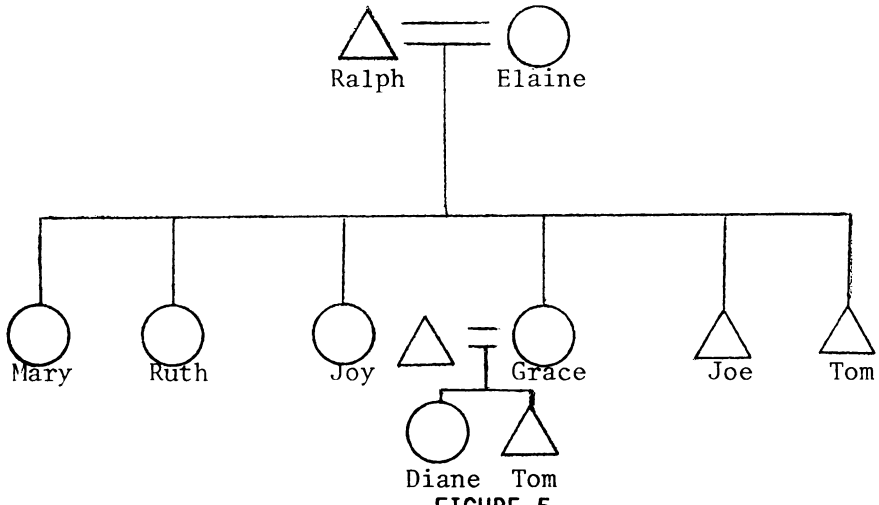

FIGURE 5

KINSHIP DIAGRAM OF MRS. THOMPSON'S FAMILY

Mrs. Thompson had spent the earlier years of her marriage caring for her six children. After they had left home, she took up golf and bowling and won numerous league trophies in both sports. After her husband retired, he and Mrs. Thompson vacationed in different parts of the country and spent time with their children and grandchildren. As her husband began to show signs of progressive confusion and memory loss, Mrs. Thompson spent much of her time caring for him. About two years before I first met her she had had a serious heart attack and some time after this made the decision to place her husband in a nursing home. When I first met her, Mrs. Thompson lived alone in an apartment in a retirement center where she had moved a few months before I met her. For a year prior to this move she had been living with her daughter, Grace, who cared for her while she recovered from a severe stroke.

Grace was Mrs. Thompson's fourth child. She described her relationship

with Mrs. Thompson as having been extremely difficult when she was an adolescent and young adult. As Grace became older and had her own family, she became closer to Mrs. Thompson although some of the conflicts never resolved. When Mrs. Thompson had a stroke and needed continual care, Grace and her brothers and sisters initially decided to place her in a nursing home. When they went to visit possible homes, Grace decided that she could not agree to place Mrs. Thompson in a nursing home without giving her a chance to recover in another environment. She decided to take her into her home and care for her herself for a year. At the end of the year, Mrs. Thompson had recovered sufficiently to be able to live independently.

RELATIONSHIPS WITH STUDY PARTICIPANTS

I presented myself to all of the participants in this study as a student who wanted to learn from them about the experience of growing old. I explained to older participants that I was interested in learning what their experience of aging was like; I explained to their adult children that I wanted to learn about their experience of their parent's aging. I explained to clinic staff that I was interested in knowing what it was like for them to be health professionals working with older adults as well as what their experience of assessing the patient and family participants in this project was like.

Several of the older people expressed initial hesitation about participating in this study because they were uncertain that they had anything of value to offer. After the purpose of the research had been explained to them they agreed that if I thought they could be of help,

they would be happy to participate. After the first interview, all of the older people indicated that they enjoyed their participation in this project. This is consistent with the findings of Rowles and Reinharz who have indicated that older people frequently enjoy research interviews because they serve as an opportunity to visit, to reminisce, and to be of service (1988). Several of the adult children mentioned the therapeutic benefits of participation for them and for their parents. They spoke of their parents need to feel useful and indicated that they themselves benefited from the impetus the interviews gave them to reflect on their experiences with their parents as they became older.

With some of the older people and with their children, my stance as student evolved over time into that of consultant about aging matters, confidant, and friend. Most of my interviews took place in their homes and these people were invariably hospitable and gracious in allowing me to learn from their experiences and in sharing with me what, in some instances, were painful issues for them.

My approach to clinic staff was based on my previous association with them as a co-worker. For two years prior to formally beginning this research, I was the social work member of the assessment team, a position which allowed me to develop close professional and personal relationships with staff members. Several months before beginning this research, I had begun to discuss it with the clinic staff and they agreed in principle to participate. When I had formalized the method I was going to use in the study, I submitted it in writing to each staff member and discussed the implications of their participation at a staff meeting. Their questions concerned the possible effects of

participation on patients and families and the approximate amount of time that staff would be involved as well as the nature of their involvement. No staff member objected to participating. On the contrary, their response was one of interest and encouragement. As the study progressed their support of the project continued and they remained open to considering the implications of findings which, in some instances, were contrary to their own constructions of events in the assessment clinic.

Problems in relationships with participants

Despite the overwhelmingly positive responses to participation in the study, I encountered some difficulties in my relationships with participants. These difficulties occurred primarily in two areas, role confusion and maintaining confidentiality.

Role Confusion: Confusion about my role existed for some of the older people and for their children and may be accounted for, at least partially, by my functioning as a member of the clinic team for the initial two months of the project. Older participants, particularly Mr. Hauser and Mrs. Thompson who became involved in the project at its inception, occasionally requested information about the results of their assessment or about the significance of diagnoses they had been given, or medications or treatments that had been prescribed at the clinic. In these cases it was a simple matter to either answer their questions or to refer them to the appropriate clinic staff member.

The problem of role blurring became particularly problematic for me,

however, when informants indicated that they were confused or irritated by some aspect of the clinic situation. For example, Mrs. Thompson indicated that she would be extremely distressed if the clinic were to suggest that her driving be limited in any way. When she discussed this with me, I was aware that the clinic staff (which at the time included me) had decided to recommend that she pass a driver's test before she resumed driving. Although I chose not to indicate to Mrs. Thompson that I knew of the clinic's decision, I was ambivalent about my choice. On the one hand, as an anthropologist I was eager to hear her responses to the issue of driving without intervening to influence those in any way; on the other hand, because of my role as the clinic social worker, I felt a need to prepare her for the clinic's decision which I knew she would view negatively. To complicate matters, I was concerned that if I were to tell her the clinic's decision her response to me would affect our relationship and the possibility of continuing our interviews. While I chose not to say anything to Mrs. Thompson about the clinic's decision I did alert the clinic staff that she was going to find their recommendation very difficult. At the time this approach seemed to me a reasonable way of facilitating Mrs. Thompson's participation in the assessment process. In retrospect, however, the approach seems to me clearly indicative of a protective stance which I took toward Mrs. Thompson precisely because she was a patient and I was relating to her primarily as the clinic social worker rather than as an anthropologist.

My relationship with Mr. Hauser and his daughters was also characterized by some role blurring. During my first interviews with him, Mr. Hauser was extremely upset over what he interpreted as the clinic's slowness in giving him information about his condition and, specifically, about his

ability to continue driving. He was also clear in these interviews that not understanding the clinic's rationale for procedures and decisions and feeling that he had no control over them was even more aggravating to him than the decision itself. As in Mrs. Thompson's case, I knew before Mr. Hauser did that the clinic was going to recommend that he stop driving. I did not share this information with Mr. Hauser but I did share his concerns with the clinic staff. As a result, the way in which the recommendation to discontinue driving was presented was modified to include an even greater emphasis on giving information about the rationale for the recommendation than the clinic normally did (although they routinely made an effort to do this) as well as giving Mr. Hauser the option to notify the state board of licensing himself or to have the clinic notify them that he would no longer be driving.

Mr. Hauser's daughters repeatedly told me how much Mr. Hauser's participation in the project meant to him and to them. They occasionally told me that I had become a "major support person" to Mr. Hauser and on the occasion of their decision to have Mr. Hauser move to a life care community, they asked that I persuade him to go. I told them that I would be glad to discuss the move with him but that I would not try to influence his decision. I discovered later that this was a difficult position to adhere to since Mr. Hauser tended to take positive statements I made about any situation as evidence that I supported the situation totally.

One final illustration of role blurring was mentioned by Mrs. VanDyke's son who told me that following my telephone call to her to arrange our first interview, Mrs. VanDyke had told him that the clinic was sending a

"follow-up person" out to check up on her. It is difficult to tell from the transcripts of our interviews how Mrs. VanDyke responded to my repeated explanations of the purpose of my visits and the nature of the study. She appeared to understand and did not raise any questions but her responses may in fact have been influenced by a perception that I was part of the clinic team and was "checking up" on her.

A word needs to be said here about the potential for role confusion that existed because I am a member of a Roman Catholic religious community and wear an identifiable religious habit. None of my informants were Catholic and I was aware in my contacts with them that my habit might have influenced their responses to me. While none of the adult children commented directly in the interviews about my being a Sister, four of the five older respondents commented on the fact that I was Catholic or that I wore a religious habit. None of their comments indicated that informants experienced any difficulty with my being a Catholic Sister. Neither did their comments indicate that they saw this as anything other than a mildly interesting feature of our relationship.

Confidentiality: The issue of confidentiality became explicit in two instances. Both involved children of older informants requesting copies of their parent's interviews with me. In one case this involved a videotaped interview, in the other a copy of the transcript of an audiotaped interview. In both cases I said I would be happy to release these if the older informants agreed. Each case resolved differently. One family did not want me to pursue getting their mother's consent to release the transcript. The other family wanted the videotaped interview and the older informant was eager that they have it.

METHODS

Because I was interested in learning about the experiences of aging from people who had physical problems as they became older as well as from people whose aging was marked primarily by problems of memory loss or confusion, I selected clinic patients who were being evaluated for one or the other of these problems. In the following section the selection criteria I used are explained in detail.

Criteria for selecting participants

Only patients over the age of 65 were selected. Although chronological age is becoming increasingly controversial as a defining characteristic of "old age," 65 is still a generally acceptable marker for inclusion in the category of "old" (Kaufman, 1986; NCOA, 1976). Patients were selected who were referred to the clinic for evaluation of either of the following conditions:

A. A physical impairment with no evidence of memory problems or confusion, or;

B. Mild memory loss or confusion as defined by the results of the Folstein's Mini-Mental Status Exam that was administered at the time of the clinic nurse's visit to the patient's home. I used the results of this exam as the criteria to determine mild cognitive impairment (i.e., a score between 23 and 27 indicates mild impairment while a score

between 28 and 30 indicates normal cognitive functioning). A copy of the Folstein's Mini-Mental Exam is contained in Appendix B.

Because I was interested in comparing the older peoples' experiences of aging with those of their children, at least one child of each older participant had to be willing to participate in the study. I limited my selection to parent-adult child groupings for two reasons; first, because adult children represented the largest group of family members accompanying older individuals to the clinic and second, because including a range of possible relationships occurring in the clinic population (e.g., spouse, grandchild, friend, neighbor) would raise significantly different issues which would have been too cumbersome to include in a single study.

I invited patients to participate who lived within a twenty-five mile radius of the clinic so that extensive interviewing could be conducted with relative ease. The one exception to this criterion was Mr. Brown who lived in a nursing home in another city. However, his daughter lived near the clinic and I interviewed Mr. Brown when he visited his daughter's home.

Interview Methods

I conducted a series of ten interviews with Mr. Hauser and six with Mrs. Thompson over the first nine months of the study. I also had two interviews with Mrs. Thompson's daughter and two with Mr. Hauser's daughters during this time and one interview each with the physician,

nurse, and psychiatrist who had been involved with them in the assessment clinic. The interviews ranged from 45 minutes to two hours in length. Case conferences during which clinic team members discussed diagnostic and psychosocial information about Mr. Hauser and Mrs. Thompson and formulated recommendations about their continued treatment were also recorded as were the family conferences where these results were shared with Mr. Hauser, Mrs. Thompson, and their families. The interviews were open-ended and only after I had analyzed the recurrent issues raised with each set of participants did I develop an interview schedule to use with additional participants. I developed the interview schedule to include the major issues generated by these interviews after completing a total of twenty-four interviews with Mr. Hauser, Mrs. Thompson, their children, and the clinic staff. I then used this schedule as a guide for interviews with the three subsequent older participants and their adult children. A copy of the interview schedule is contained in Appendix C. A summary table showing the total number of interviews held with all participants is contained in Appendix D.

The older participants and their adult children were interviewed separately. These interviews usually took place in their homes although on occasion they occurred in restaurants or in the assessment clinic. Interviews with the assessment team members took place in their offices at the assessment clinic.

Methods of Analysis

All interviews and selected staff and family conferences were audiotaped and transcribed verbatim. I analyzed the transcriptions as well as the written documentation in the older participants' clinic records in three phases which are similar to those described by Kaufman (1986).

Initially I analyzed the material for words or phrases that recurred often and appeared to signify "pieces" of topics that were of interest or concern to the participants. I then did a computerized search of all of the transcripts for these recurrent words and for words that were similar and grouped the sections in which the words were embedded into categories. These initial categories included such items as parent - child relationships, independence - dependence, driving, death, peer relationships, medical care, and work. I reviewed my listing of categories with Mr. Hauser, Mrs. Thompson, and their children to assure that I was accurately capturing their perspective.

After the first several transcriptions, I began analyzing new transcripts immediately for these categories. I then began to compare transcripts in the following combinations: initial with later transcripts of the same participants; transcripts of interviews with all related participants (i.e., the older participant, his or her adult children, and the assessment clinic staff); and transcripts of "like" participants (i.e., older participants, adult children, clinic staff). These comparisons, based on Werner and Schoepfle's method described in Chapter 2, resulted in a list of discrepancies as well as patterns of congruence. These are discussed in detail in chapters 4, 5, and 6.

It became clear early in the project that the information I was receiving from older participants and from their children was of an essentially different quality from that which I obtained from the clinic staff and from clinic records. In addition, the information from older informants and children was inextricably linked whereas information from the clinic perspective, even when it concerned these participants, was of a distinctly separate nature. In reporting the findings of the study, therefore, the interviews with older participants and their adult children are treated separately from information obtained from the assessment clinic staff.

CHAPTER 4

THE CULTURAL CONSTRUCTION OF AGE: THE OLDER PERSON AND THE FAMILY

This chapter focuses on the ways in which older participants and their children constructed their experiences of the older peoples' aging. The dynamic nature of construction as it was discussed in Chapter 1 is accented here as participants tell in their own words how they made sense out of their experiences. [4] The participants' stories and reflections reveal the active nature of their involvement with the phenomenon of aging. Age, particularly "old age," was not a static construct to be assumed at a given point in time. Rather these participants fashioned unique meanings out of the events which occurred as they grew older. The power of the older people's sense of themselves becomes evident as they instill uniquely personal meanings into their life experiences, comment on the continuity of their experiences with those of previous generations of family or friends, and share their thoughts about death and dying. [5] Their children's constructions become evident as they reflect on what it is like for them to witness a parent's aging. The complex bond between the children's sense of self and their relationship with their parents becomes evident as they share memories of their parents as they knew them in the past and tell how

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[4] See pp. 4-5 for an explanation of the term, 'construction'.

[5] See p. 5 for a definition of the term, 'self-identity'.

they see them in the present.

Using excerpts from interviews, the older peoples' views are juxtaposed with their children's to illustrate the specific similarities and differences in their perceptions. Each family grouping is treated in a separate section and the specific issues which surfaced around their constructions of age are presented at the beginning of the section. A summary which highlights the similarities and differences in their views is included at the end of each section. The chapter concludes with a discussion of the sense of continuity which the older participants experienced in growing older as compared with the disruptive impact which it had upon their children.

Mr. Brown And His Family [6]

Mr. Brown and his daughter and son-in-law had very similar understandings of his aging. None of the three focused on Mr. Brown's chronological age as being of any particular significance in describing who he was. They enjoyed each other's company and maintained their interest in the events of each other's lives. While they were realistic about the difficulties occasioned by Mr. Brown's limited mobility after he fractured his hip, all three of them looked for the positive aspects of the changed relationship that resulted from it.

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[6] See p. 1 for a biographical sketch of the Browns.

Mr. Brown

John Brown's vitality and enjoyment of life, past and present, pervaded our interviews. For him life was meant to be lived to the fullest and one sensed his eagerness to share in what life had to offer. He had a store of good memories and spoke of his childhood and adolescence as times of great enjoyment.

JB I pretty much reflect I think the training I got when I was a youngster.

SMC You think so, huh?

JB I think so. My mother and dad were nice. My sister`s a nice person.

SMC Uhhuh.

JB And all my friends were nice (smile).

SMC ...Did you have a lot of fun when you were growing up?

JB Loads of fun.

SMC Did you? Cause that seems to come through loud and clear from what you say ().

JB Yeah, we had a lot of fun. () school, (), and I met my wife there. One of the kids, there was a whole gang of fellahs and girls by the church () and we'd go swimming in Lake Z., bought hamburgers and hot dogs, ice cream cones. We found, one of the girls one time, () park, she found a five dollar bill...And the whole gang () went down to the ice cream parlor and got some of those high cones. [7]

As a young married man, Mr. Brown moved with his new wife into a neighborhood where he quickly developed close friendships.

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[7] J. B., Interview # 2, p. 17

JB We were just like big kids then. (....) but we had a good time. We had a lot of friends down there, lot of good times. We've been fun loving people all our lives. [8]

Mr. Brown's relationship with his wife was also characterized by closeness and a shared sense of enjoyment.

JB Like (), my wife and I were very (). My wife liked to travel.

SMC Uhhuh.

JB And I liked to travel. We (traveled?) quite a bit. We enjoyed every minute of it. She, she was quite a gal.

SMC Was she really? Now is that, who is that over here in this picture.

JB That's my wife.

SMC Ah, she's a lovely woman.

JB We were married () 54 years.

SMC Were you really. That's a long time.

JB Well, it didn't seem so long....We have had a lot of fun in our (), liked to entertain. She was a good cook. She always had somebody around. Holidays, we had a cottage for 23 years, she always had somebody up there.

SMC Did she really?

JB Yeah. I enjoyed it. [9]

A superficial analysis might give the impression that Mr. Brown had been spared many of life's difficulties. Yet we remember that he was a man who had suffered for more than 20 years with Parkinson's disease, who was living in a nursing home recovering from a fractured hip at the

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[8] J.B., Interview # 1, p. 6

[9] J.B, Interview # 1, p. 18

time of these interviews, and who still mourned the death of his wife whom he dearly loved and whom he had taken care of during the five years prior to her death. A more concentrated analysis revealed another theme that accounts for Mr. Brown's spirit and vitality in face of adversity. He described himself as a "fighter" who believed that hardships in life are inevitable and are meant to be faced as challenges and accepted with grace. As a result, Mr. Brown interpreted many of the earlier difficulties in his life as occasions for reflecting upon his relative good fortune. An example of this philosophy can be seen in Mr. Brown's response to my question about his life during the Depression.

SMC How about the depression. Did that have a big impact?

JB (). The Depression was 1929.

SMC Yeah, yeah.

JB And we were married, 1931. One of the years in there I made $700 total.

SMC () gosh.

JB I was lucky. I was never laid off. I worked 3 days, 4 days a week. That was pretty good money for ().

SMC () that was ().

JB Lot of people laid off, went on Welfare. Nothing they could do about it.

SMC How did you manage in those days?

JB (). Had a lot of fun.

SMC Did you?

JB We got a lot of friends who were living (near us?) for years after we were married. We had a good group there for coming around.

SMC Hmhm.

JB It got so, I had a 28 Chevrolet. I couldn't find any parts for it () so there were a lot of parts missing and I (laugh) but it ran.

SMC But it ran huh.

JB Oh yeah. I was quite mechanically inclined in those days. If anything went wrong I'd fix it.

SMC You'd fix it yourself yeah. () So then it didn't seem like too much of a hardship to you?

JB No.

SMC Personally.

JB No. We had a daughter come ()then, in that time, 1932.

SMC My gosh.

JB No, it didn't particularly seem (). We knew that other people were having trouble, we knew that so we got along the best we could..... We were lucky I was working four hours a day, three days a week. I was a painter (), painted bumpers. I was ().

SMC You what?

JB I was glad to work four days a week.

SMC Yeah, yeah. Well, sure I suppose if people around you weren't.

JB Oh yeah.

SMC Well you've had quite a lot of experiences in your life.

JB I know. And most of them have been good ones.

SMC Have they really?

JB Yeah. I enjoyed life (). We had a lot of fun. [10]

In similar fashion, Mr. Brown used his experience of increasing physical limitations as he grew older as an occasion for discovering an inherent goodness in people as they responded to him.

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[10] J.B., Interview # 2, p. 8

SMC Are there things you like about it? Getting older?

JB I don't know. I get a lot more attention than I used to when I was younger.

SMC Do you?

JB People are real nice, people are real nice to you. You'd be surprised how nice they are. And I've never had any occasions since I've been having problems to find anybody who wasn't. Oh, some are nicer than others but they've been very, very good to me. People in the church, people, friends outside the church. I'm very fortunate. [11]

Although he found his physical limitations a particular source of frustration in light of the value he placed on his freedom to move about, Mr. Brown confronted his disabilities as he had other difficulties in life - with pragmatic grace.

JB Oh, yeah. I can go with this thing (his walker) pretty good. I don't go without it because of balance.

SMC Well, yeah. And that's probably smart.

JB I don't want to break the other hip (laugh).

SMC No, no. Does it bother you at all to have to use the walker?

JB You mean personally or

SMC Yeah.

JB No. I know I've got to do it so why worry about it.

SMC (laugh). That's what I mean about your philosophy (laugh).

JB Well, you've got to meet the challenge. It's a challenge. I don't like when they just give up and lay down and wait to die.

SMC No, it wouldn't be much fun.

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[11] J.B., Interview # 1, p. 6

JB No.

SMC Some people do though.
JB I know. A lot of people here that do that.

SMC Are there.

JB Yeah. And they carry somebody out there every week, sometimes more than one. And nobody would grudge it, they've had a good life and they're not enjoying themselves. They're not comfortable. I'm not ready yet (laugh). [12]

Mr. Brown's theme of living life to the fullest is perhaps nowhere more striking than in the following excerpts when he reflected on the changes which he has experienced over the past months.

SMC ... What, one other question to balance out. I had asked you what the hardest part of it was, you know, getting older and having the problems that you've had. Has there been anything good about getting older?

JB Well, I'm still alive.

SMC (laugh)

JB Oh, I don't object to retirement. I've enjoyed it, had a real good time. And I've been very fortunate in the things I have done and the things that have happened. I think. Maybe other people wouldn't think so.

SMC But you're the only one I'm interested in so (laugh).

JB But I do, I feel I've had a full life.

SMC Uhhuh, uhhuh. And you still feel that way?

JB Oh yeah. I'm not going to give up.

SMC You sure don't seem like it.

JB No. I've got a lot to be thankful for. [13]

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[12] J.B., Interview # 2, p. 12

[13] J.B, Interview # 2, p. 15

Mr. Brown was realistic about the limitations which growing older had placed on him, particularly as they affected his freedom to come and go at will. However, his sense of joy in life, even when it included difficulties, made him eager to continue living fully. He was both grateful for his past and aware that he had more he wanted to do in life. Although he was aware of becoming older, Mr. Brown made a clear distinction between knowing he is old and thinking of himself as old. He did not identify himself as old and consequently his age was neither a particularly meaningful aspect of his identity nor was it an obstacle to his desire to continue to enjoy life.

Joan and Bob

As mentioned earlier, Joan and Bob, Mr. Brown's daughter and son-in-law had a view of Mr. Brown's aging which appeared remarkably similar to his own experience. They were the only participants in this study who did not consider their parent as old. They were also the only ones whose parent had had a debilitating disease which began in middle age. Joan hinted at the possible relationship between the disease, which had been a constant factor for years, and her perception of her father's age.

SMC In terms of how you think about him, do you think of him as old?

J (laugh) I guess I hadn't thought about it. Um, he keeps telling us he's 81 (laugh).

SMC That's not necessarily the same as being old but (laugh).

J (laugh) I know but I don't think I thought of him as, well I don't know. A couple of trips we took last year with him um, he was having difficulty um, not with the pace of the trip but with getting in and out of the car, in and out of the rest area and so on. You think either he's getting older and has more trouble managing or it's the Parkinson's. I think I

tend to blame it on the Parkinson's more than age. [14]

Bob was also aware of Mr. Brown's declining energy and mobility but he related it to Mr. Brown's broken hip rather than to age or to disease.

B Well particularly since breaking his hip and going around with a walker and sometimes in the wheelchair it makes you (laugh) conscious of the fact that his vigor is gone and he's not as mobile as he once was. [15]

Joan and Bob's description of Mr. Brown's relationship to his wife and his capacity to respond to her illness and death indirectly supported Mr. Brown's own characterization of himself as a "fighter".

B 'Cause Dad always was very independent. I think the death of your (Joan's) mother was hard on him.

SMC That was, refresh my memory.

J '85.

SMC '85.

J It was March of '85.

SMC Ok, so three years ago, three and a half.

B They were very close.

SMC That's what I gathered from

B Did every thing together.

J And very interdependent. Almost unhealthily so.

B (laugh)

J Mother didn't drive the car for, how many years before she died? It was a lot of years. Everything they did they did together as long as she was able. And then

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[14] J.& B.R., Interview # 1, p. 6

[15] J. & B.R., Interview # 1, p. 12

> he had to take over some responsibilities that she couldn't participate in any more. Dad has not really been real healthy for quite a few years. He has the Parkinson's and he's lived with that for about 20 years. And it was always mother's fear and deep seated belief that he was going to pre-decease her. She knew that she was going to have to learn to get along without him. For years that was kind of a recurring theme. She just knew that he wasn't going to hold up. And he did and here he is. Did very well I would say after her death. He started to gain weight. I, I don't think she had any idea how much her care debilitated him, how hard it was for him to care for her physically and how hard it was for him to see her as ill as she was.[16]

Joan and Bob acknowledged Mr. Brown's closeness to his family as well as his love for travel and saw his increasing age as partially responsible for having given them more time to engage with him in these activities.

B ...he's traveled a lot with us since mother's death and uh, he's always greatly enjoyed that and he enjoys his family very much. Very fond of the granddaughters...

SMC ... In terms of all of the changes and your father getting older, is there anything about that that's been good that you would say or has it all been more or less negative?

J Hm...Let's see.

B I think traveling together has been good.

J Yeah.

B For both him and us. We uh, made it a point to take him with us when we visit the granddaughters and uh, I think it's been good for both of us, both Dad and ourselves.

J That was not a response so much to his getting older as it was to, well, when mother was alive we traveled together on a number of occasions, usually in separate cars at that time. Now he goes with us. I'm not sure

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[16] J.& B.R., Interview # 1, p. 19

that was a function of his being older, it was a function of his being able to travel again.

B Well he, once mother died he wouldn't have gone alone I don't think.

J No.

B So, I think the fact that, and we took him to visit his sister in Buffalo...

SMC And that's been good in the sense of spending more time with him?

B Hmhm.

J Hmhm. And getting to see where the granddaughters lived. Last summer the younger granddaughter moved to a, a farm outside X. And we went out to help with the move and he went with us. And we, I mean I wasn't sure how this was going to work (laugh).

B (laugh)

J And we stayed at a, we have a travel trailer and he stayed in a motel that was about a block away from where we stayed and so we'd go over in the morning and pick him up, bring him over to the trailer for breakfast and then we'd go and help them with whatever was going on. It probably slowed us down a little bit but he got to see where they had been living,he got to see the campus where Jan has been for umpteen years, then helped move into the house at the farm. So he saw them in their environment and I think that was really good. We went to church there too, went to their church and they have a coffee hour after the service and we went to that so he got to meet some of the people in their lives and I think it was really good. And the same thing in South Carolina. He went with us several times. When the younger grandson was born he didn't go. We went down to help out when the baby was born and he was christened the Sunday after Christmas and we went down for that and Jan and Michael were here for Christmas and we all five traveled together. And that was one of the nicest

B ()fun thing.

J Experiences that we had. Yeah, we had a really good time traveling together. And we'd stop overnight and get three motel rooms together, go to meals together. It worked out really well....

B It's been a real plus yeah. [17]

The highly congruent constructions which this family had of Mr. Brown's age are evident in the relative insignificance to them of his chronological age. None of the three focused on age as a central locus of meaning. Mr. Brown and his daughter were well aware of his chronological age (as evidenced by Mr. Brown's comment that "I know I'm old" and Joan's comment that he "keeps telling us that he's 81,") but age was not a defining characteristic which accounted in any significant way for who Mr. Brown was. While Mr. Brown recognized his physical frailty he still maintained that "I don't think I'm old." His daughter and son-in-law were equally cognizant of Mr. Brown's diminished vigor and the increasing difficulty he had in moving around freely but neither cited his age as the reason for this. Joan was aware that age might be a possible source of her father's increased frailty but expressly rejected this explanation in favor of Parkinson's. Bob did not mention either Parkinson's or age directly as the source of Mr. Brown's frailty but instead spoke of the walker and wheelchair Mr. Brown used since fracturing his hip as a reminder that he was no longer as mobile as he once was.

Mr. Brown and his family also were in agreement that there were some positive features to Mr. Brown's becoming older. Mr. Brown focused on peoples' kindness to him as he has become older while his family spoke of the opportunity to spend more time with him in family gatherings and travel. While Mr. Brown's family did not expressly articulate Mr.

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[17] J.& B.R., Interview # 1, p. 14

Brown's theme in identifying him as a fighter, their description of his survival of his wife's illness and death confirmed Mr. Brown's own understanding of himself.

Mr. Brown, Joan, and Bob had lived intimately with the experience of Mr. Brown's daily struggle with Parkinson's disease for more than twenty years. Parkinson's had become for them a familiar explanation of physical frailty. As Mr. Brown became older, retaining Parkinson's disease as the explanatory framework for his increasing frailty obviated any need for them to seek an explanation in his increasing age. Because "old age" had not become a central feature in their construction of Mr. Brown's identity as he grew older, this family seemed able to continue in their traditional, congruent understandings of who Mr. Brown was. In addition, Mr. Brown's continued enjoyment of life, of travel, and of family were characteristics which his daughter and son-in-law valued highly. Being able to share experiences which capitalized on these characteristics as Mr. Brown became older undoubtedly contributed to the congruency of this family's construction of Mr. Brown's age.

Mr. Hauser And His Daughters [18]

In marked contrast to the congruent constructions of Mr. Brown and his family, the Hausers had significantly different views of Mr. Hauser's aging. Old age was, for Mr. Hauser, unpleasant but inevitable. He approached his aging rationally as he did most things in life. He read and gathered information about the effects of aging and did what he

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[18] See p. 26 for a biographical sketch of the Hausers.

could to arrange his lifestyle so as to postpone its onset as long as possible. When, in spite of his efforts, he felt old age encroaching he both resented it and was grateful he had delayed it so long.

As Mr. Hauser entered his eighties he began experiencing problems with memory loss and confusion. In contrast to Mr. Brown who had had a debilitating illness for years, Mr. Hauser had been in excellent health until this problem occurred. He approached this difficulty in typically rational fashion. He looked on his memory loss as not unusual in someone his age and focused his energies on developing strategies to minimize the dysfunction.

There was a notable difference in the way Mr. Hauser's daughters viewed his aging. As opposed to their father's fairly sanguine approach, they found Mr. Hauser's memory loss and confusion devastating and it triggered for them the sudden awareness that their father was "old". Because his intelligence had been a hallmark of who their father was for them, his memory problems caused Mr. Hauser's daughters to experience him as "not the same man" they had known all their lives.

Mr. Hauser

Frank Hauser approached life methodically, with calm curiosity, and with an air of amused detachment. These characteristics can be seen in his response to my question about which of the names for people over 60 he applied to himself.

SMC People have all kinds of terms, I mean they call people old people, elderly, senior citizens. You

know, you've got all kinds of names for people over 60.

FH Yup.

SMC How do you refer to yourself or how do you think of yourself?

FH I'm having a hard time placing myself in a category where I belong, I guess (laugh).

SMC Do those categories make any sense to you?

FH Oh, I don't find them too objectionable. It's just like I'm sitting on the sidelines watching the show go by more or less. I don't feel too personally involved sometimes when they talk about old folks. I don't think they're referring to me.

SMC You don't think about you like that, huh?

FH No.

SMC What kind of people do you think they're referring to?

FH Well, I think they are referring to my type but I'm having a little hard time putting myself in the older bracket. I'm accustomed to, I mean it's been so gradual that nobody's paid any attention to it as such. I mean they don't refer to me as an old man. I don't catch that if they do (laugh). [19]

Like the other older participants in this study, Mr. Hauser clearly did not identify himself as an old man although he acknowledged that by chronological age he "belonged" to the category of the old. His lack of identification with this category is expressed even more clearly when he speaks of his high school classmates (some of whom were younger than he) as "they" aged.

SMC The last time you went to one (high school reunion), what was your experience of your classmates? How did they seem to you?

FH I thought that they were older than I. But they weren't. They seemed to age rather more rapidly than

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[19] F.H., Interview # 1, p. 8

know, you've got all kinds of names for people over 60.

FH Yup.

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[19] F.H., Interview # 1, p. 8

usual.

SMC More rapidly?

FH Yeah. As they got older and there was more of them that died, I mean, it made it more emphatic that there aren't that many left. In fact when you get a half dozen left out of sixty, and most of those that died, died in the last five, six years or something like that. I mean, when they get to about that age they drop off very fast. [20]

In order to understand Mr. Hauser's view of his own aging, it is useful to understand his views on other areas of his life and on what was important to him. In the context of how he saw the rest of his life, his view of age is remarkably consistent.

Mr. Hauser was quietly proud of his intellectual abilities and a lifetime of hard work and he prized his capacity to maintain a dignified presence in the midst of any difficulty. A family "legend" of sorts had grown up around Mr. Hauser's business abilities and his intellectual prowess. In separate interviews, Mr. Hauser and his daughters shared the story of Mr. Hauser's beginnings as a successful entrepreneur at the age of six.

SMC ...Were you working when you were in high school?

FH Yeah.

SMC Where'd you work then?

FH Oh, I had a newspaper business, retail. I had kind of a () agency for the 3 or 4 Detroit papers, and that's all of them. I was the only one in the State that had a ()agency like that.

SMC You distributed them, is that
FH Yeah (). Oh, I had something like 30 or 40 boys most

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[20] F.H., Interview # 1, p. 10

of the time that were available.

SMC That wasn't when you were in high school though was it?

FH Partly, yeah.

SMC Were you doing that when you were in

FH I started when I was (laugh) about 6 years old.

SMC You're kidding.

FH No, I was, it wasn't anything wonderful but by the time I graduated from high school I was making more than the superintendent was and he was aware of it (laugh). And that bothered him more than it did me (laugh). [21]

The version of this family story which Mr. Hauser's daughters' told me highlighted the same themes.

B He could do anything. He started working full time when he was five...

B For the whole town of X...big knot on his shoulder and the newspaper bag dragging on the ground and delivering the papers before

F I remember older ladies telling me about that when I was ()...Now I can't believe his folks would let him do that but

B I can. Look at the work ethic he had. He had to get it from somewhere...

F ()He's worked just about his whole life and this is difficult too now because he's not working. [22]

Mr. Hauser's propensity to develop successful strategies can be seen in the following excerpt. He downplayed his academic achievements as a young man, crediting his ability to develop a successful strategy

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[21] F.H., Interview # 5, p. 14

[22] F. & B.H., Interview # 3, p. 7

rather than superior intelligence for achieving high grades .

SMC What made you decide to go to college?

FH Oh I had a notion I wanted to take up aeronautical engineering. Of course that was ()tough courses. And I did all right in high school. I was valedictorian.

SMC Were you?

FH Yeah.

SMC Somehow I'm not surprised but

FH I was, I don't know whether I was smarter that much or not but I seemed to know how to work it by doing what I didn't have to do lots of times. Like for instance I don't think in some courses I didn't have to make an assigned presentation all year because I got through with that in good shape, got top grades. I didn't have to take the finals. So I didn't have to take finals all the way through high school I don't believe.

SMC My goodness.

FH And it wasn't necessarily that I knew that much (laugh) but it worked ().

SMC You did well during the year.

FH Because I did volunteer presentations and that worked the magic. I'd read ahead a little and things like that which, and I knew usually, I did a lot of reading, and I knew the courses. They didn't catch me very often when I didn't (). There weren't very many that could say that honestly, even that were groveling about how hard the work was. () being a little ahead and things like that, and I, I did my share of real studying, I wasn't being that way, so I got through in good shape. [23]

Mr. Hauser approached his own aging with a similarly methodical view of developing an effective strategy for meeting "old age". When his strategy failed him, he resented it.

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[23] F.H., Interview # 1, p. 12

SMC What is it that makes somebody old, what is it for you? Is it age, is it the way you feel? Because in our society we've pretty arbitrarily said people over 65, we put them in this category. But a lot of people are saying like yourself that the category really doesn't fit. But what makes somebody old?

FH I wonder about that too, and I don't know just how you'd express it. I kind of resented encroaching old age but I felt alright and to all outward appearances I was alright. Then when things started sneaking up on me a little, I resented that. 'Cause I figured I tried to behave myself and do what I was supposed to do and not wander too far from the approved way you handle old age approaching. And I guess I did alright. I can't remember - looking - anything that I did too badly to avoid old age.[24]

Part of Mr. Hauser's understanding of what old age was supposed to be came from his early experiences living with his grandfather and his father as they grew older. His memories of them had a lasting influence on his expectations of what his own aging was going to be like. His grandfather's experience with rheumatism was a prototype for Mr. Hauser's own experience with arthritis.

SMC Did anybody ever tell you what old age was going to be like?

FH Not specifically. Not just for the information I don't think. My grand dad lived with our family. He was a Civil War veteran. Of course that goes back a while. And he lived with us until he died and that was several years. That was my only direct acquaintance with old age except my Dad was seventy-eight I guess when he died. And you could see that they were losing their faculties gradually. When it got towards, my grand dad, the one who was the Civil War veteran, he was not much older than my Dad I guess, when he died. About eighty.

SMC About eighty. When you said that they were losing their faculties, like what did you notice about them?

FH Oh, my grand dad had rheumatiz for instance. And that bothered him quite a little. He couldn't get around

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[24] F.H., Interview # 1, p. 12

very well. He just had the onset of, what most of them have I guess, old age and other symptoms that I suppose are more or less standardized. They're things that come at a certain age, they're apt to. ...

SMC ...What, when you were noticing him getting older, do you ever remember him saying anything about getting old?

FH No, not per se, but he got grumpier. Yeah, he wasn't feeling very good. His rheumatiz was getting to him and bothering him quite a lot. He couldn't walk very far and , oh, hardly any distance. That bothered him a lot, that he couldn't get out and walk or do anything when the weather was bad. Of course I'm a lot the same way.[25]

The influence which his father's experience had on Mr. Hauser's construction of aging can be seen in this excerpt:

SMC How about your father? Do you remember him saying anything about getting old?

FH Hm. It came on quite gradually but persistently. I mean,he didn't improve very much. He had something of a setback from every go-round he had with any kind of ailment. so it was, well I think that's general. I think when a person gets older they don't survive these little onsets that don't give you too much trouble to begin with. They come on stronger as you get older.[26]

An important part of Mr. Hauser' approach to life had been to carefully distinguish between what was inevitable and what could be controlled. His energy was devoted to what could be controlled. What was inevitable he treated with detachment.

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[25] F.H., Interview # 2, p. 15

[26] F.H., Interview # 2, p. 22

FH I mean, I don't fret about stuff a great deal, or, we should have done something differently. If something happens, why, I write it off I guess. Because I don't, I don't think I worry about things a great deal. I think the ones that get more attention are something that I can do something about. ()Something that I can't anyway, why, I take the attitude I guess, there's not much you can do about it.[27]

When he spoke of his own aging, Mr. Hauser adopted a similarly rational approach.

SMC In your mind, is old age something to be avoided?

FH No, its natural I feel. I'm reconciled to old age. I'd rather stall it off (laugh) which is natural I guess and I figure I've done a lot better than a lot of people I've known.[28]

The same theme emerged in a later conversation:

SMC What did you think about for yourself, what it was going to be like getting old? Or did you ever think about it?

FH Yeah, I thought about it. I did what I thought might help or something but it seems to me there isn't an awful lot you can do. You can slow it down a little.

SMC What did you think it was going to be like?

FH About the way it turned out. I mean I was pretty well set for it (laugh).

SMC It didn't come as too much of a surprise, huh?

FH No. The way it is now, I don't expect it's going to get very much better. They can do something for my ailments but they are progressive sorts of things and usually at my age, I'm 81, going on 82 now, and that's, you can't expect miracles hardly.[29]

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[27] F.H., Interview # 4, p. 21

[28] F.H., Interview # 1, p. 31

[29] F.H., Interview # 2, p. 23

As this attitude of accepting the inevitable shaped Mr. Hauser's construction of aging, it also structured the way he felt about death, the epitome of things inevitable. His discussion of the consecutive deaths of classmates highlights this theme in relation to his own death.

> FH The county paper today, I didn't see it, somebody told me about it, there's a fellow that, I think he was a year behind me at school, he died up here in W. You get that all the time. But it doesn't bother me too much. I mean I don't feel that it threatens me any although I realize that it's getting closer. But I don't get morbid about it. It's a natural process and the best you can do is just do the best you can. And I haven't any misgivings that bother me. I mean I don't have anything eating at me that I should have done something differently or anything. Seems as though I did the best I knew as I went along and this is no time to start recriminating (laugh).[30]

The last two years of Mr. Hauser's life had been marked by periods of confusion and a continuing problem with memory loss. The impact of these troubles for Mr. Hauser and his daughters will be discussed in detail in the following chapter. What is noted here is his response to these frustrating and, at times, frightening developments since it illustrates his characteristic tendency to develop strategies for handling difficult situations. It also highlights the importance Mr. Hauser attached to maintaining his composure and dignity as well as his minimization of difficulty - in this case by characterizing memory problems as a "common ailment" of older people.

> FH ...There again, I do have that problem with recall, remembering conversations or things that have happened an hour ago or a month ago or things like that. I have trouble keeping track even of the days, things like that. Actually I hadn't thought much about it before but apparently it's a common ailment of most older people I guess. Now there's some that don't

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[30] F.H., Interview # 1, pp. 14-15

have that problem but it isn't unusual...and you can't do much about it. I mean like if I can't remember what day it is, or what day of the month or what day of the week, I can't recall enough related items to straighten it out very well, except that I have found that if I mark certain days on the calendar that I know are proof enough to me that (laugh) I'm on the right track.

SMC That you're going in the right direction, huh?

FH (laugh) It hasn't been any particular handicap for me since I use that way of figuring out. [31]

By fashioning his view of aging around his lifelong style of rationality and minimization of difficulty, Mr. Hauser was able to maintain his sense of self, a sense in which old age did not play a significantly disruptive role. In contrast, his daughters experienced Mr. Hauser's memory loss as a devastating problem which struck at the heart of their father's personality and was the reason they began to identify him as being "old".

Frances and Betty

Unlike Mr. Brown's family, who tended to attribute his frailty to a disease process rather than to being old, Mr. Hauser's daughters made no distinction between the disease affecting his mental abilities and "old age".

SMC I guess basically what I'm asking is do you think of him as old?

F Um, more just this last

B Nine months to a year.

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[31] F.H., Interview # 4, p. 32

F Year, yeah, its just, I hadn't until that time and then his memory problems he's had this past year have forced me to realize that he's getting older and that I have to start treating him a little different than I had before. I mean, Dad always remembered everything and now we have to remember for him and these things force you into realizing that he is getting older.

SMC Hmhm. That's what you mean by treating him a little different?

B Yeah, you know, in terms of, he was always the Rock of Gibraltar. You never reminded Dad of anything, you never told him anything, you never corrected him. I mean there was absolutely no need. The bank tried that on a couple of occasions and they were proven wrong.

F Mother was delighted (laughter). She could hardly wait to tell Dad when he got home that the bank had called and he'd made a mistake and then they called before he got home and said, we should have known Mr. Hauser wouldn't make a mistake, we're sorry. And she was so disappointed (laugh).

B And so it's made a whole different ball game right now.

F Yeah, it's so different now because I mean he will ask me about you know helping him like with his checkbook and how to unlock a door, you know.

B Well, like yeah, there for a while ()

F ()have me go over and help him unlock the door.

B Forgetting how to write a check, forgetting how to address an envelope ().

F () yeah, it's ()the things that he'll ask me to help him with,

B Things that we have joked about for years and all of a sudden they're not funny any more.[32]

Mr. Hauser's daughters confirmed the central place which knowledge held for him as a younger man. It was the importance which Mr. Hauser had

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[32] F. & B.H., Interview # 1, p. 19

always attached to this value that made his present condition particularly painful for them.

B He always put such a high price on mental strength, on remembering things, on having the answer to everything. I mean in his youth he read the encyclopedia, he read the whole Harvard classics, um, cover to cover just because you should know those things.

F And then he'd remember them.

B And remember them.

F I mean you could ask him

B ()the 3 Detroit newspapers everyday because he should know what's going on. And he knew it. Um...so I think that's why the confusion is harder to deal with. [33]

The pain which Frances and Betty experienced over Mr. Hauser's confusion can be seen in Betty's description of his response to a televised college football game.

B ...I dropped him off at Elaine's and I knew they were going to watch the game and I watched the last half of it with Frances and I went back and picked him up. And so I'm really yukking it up and, I mean it doesn't happen often (referring to the team that won)...Well, he was just real flat about it and that's not his style.

F Oh no. He's usually right in there pitching for U of X (laugh).

B Yeah. And so then we got out in the car and I was sort of smoothing it out and said, "well it was a really good game even though <u>your</u> team didn't win. But it was a good game, you have to admit it was enjoyable." And you know he usually would have gone along with it about then and kind of bent (laugh). Good old Dad. And he said, "I don't think so. I couldn't follow it. I couldn't understand it, it didn't make any sense to me." He said, "I have been watching (Coach X's) games for years." He said,

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[33] F. & B.H., Interview # 1, p. 21

"this one didn't make any sense to me and I didn't enjoy it at all." And you just go, oh, I'm so sorry. Yeah, it's just so different....I end up shedding a tear, you know, before I get home thinking, whoever's living in there isn't the man that I've known for the last forty years. [34]

Despite the pain which the radical change in Mr. Hauser's personality caused them, his daughters could also identify some positive features which had resulted.

B ... The other one that we've talked about and it's a blessing, I mean, we're really enjoying it, but Dad wasn't one to say anything positive. I think I related to you the instance when I dropped out of grad school just recently well, as much for Dad as for anything else, () more time. And he said, well maybe you can find a graduate program that's easier for you (laughter). Now that's more old Dad. But of late he's been wonderful about telling us that he appreciates us, that he appreciates what we're doing... But he's been so much more appreciative of us and verbalizing it.

F Hmhm.

B I mean for years I've told him I loved him and he'd go, Uhhuh, and probably in this last year he's told me back at least 3 or 4 times. And that's probably more than I've heard it from him in 40 years. So you know, it's real different, it's almost out of neediness I suppose or (starts to cry). [35]

Mr. Hauser's memory loss and episodes of confusion were a central feature of his aging both for himself and for his daughters. Maintaining mental astuteness had always been an organizing dynamic of Mr. Hauser's life. When his mental capacities began to decline, Mr. Hauser and his daughters experienced him as losing the control he had always known.

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[34] F.& B.H., Interview # 1, pp. 3-4

[35] F. & B.H., Interview # 1, p. 15

There was a marked discrepancy however in the ways in which Mr. Hauser and his daughters approached the problems of memory loss and confusion. Mr. Hauser was embarrassed by his inability to remember names, dates and appointments but he used his characteristic organizational skills to develop strategies to compensate for his losses. He developed an elaborate system of making notes of questions he wanted answered and of appointments he had scheduled. He also used humor as a strategy to cover his embarrassment at his forgetfulness and worked at taking a philosophical attitude toward his difficulties. When his strategies were successful and he avoided embarrassment, he congratulated himself that he "had saved the day."

Mr. Hauser's daughters, however, were devastated at the loss of the man they had known as their father. They had always seen Mr. Hauser as a dominant force in the family and his mental control had played a large part in this dominance. When Mr. Hauser began to ask his daughters for help, they were overwhelmed at the extent of his need particularly when they compared it to his characteristic self-sufficiency and it was at this point that they identified him as "old." While Mr. Hauser was embarrassed at his inability to control his emotions as well as he had in the past, his daughters welcomed his emotional vulnerability and perceived this as the one aspect of change in Mr. Hauser's behavior which made it easier for them to continue to care for him. In addition, Mr. Hauser's willingness to express his affection for his daughters and his gratitude for their help had the effect of healing many of the hurts and misunderstandings which his earlier reserve had precipitated.

THE HAMILTONS [36]

Like Mr. Hauser, Mrs. Hamilton also experienced difficulty with memory loss and confusion as she became older. However, the cause of Mrs. Hamilton's problems - hypothyroidism - was treatable and she had already improved significantly by the time I first met her.

On the surface, Mrs. Hamilton and her son, Jim, shared a similar view of her aging. Both equated old age with inactivity and insofar as Mrs. Hamilton had become less active than when she was younger both she and her son thought of her as old. As Mrs. Hamilton became older, her confusion and memory loss were a major concern to her son. Even when these had improved significantly, Jim still spoke of them as a serious difficulty. On the contrary, although Mrs. Hamilton was aware that she had difficulty with memory loss and that she sometimes became confused, she did not consider these major issues.

Mrs. Hamilton

As the mother of four sons and an active participant in community affairs, Mrs. Hamilton placed a high value on activity and companionship. The critical importance of activity can be seen in Mrs. Hamilton's response when I asked if she thought of herself as old. She fashioned her view of old age around the concept of activity and equated feeling old with not being able to walk as far as she used to.

SMC ... Well, let me ask you one question. Do you consider yourself old?

VH Well, it all depends.

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[36] See p. 28 for a biographical sketch of the Hamiltons.

SMC (laugh) On?

VH On, you don't feel like you're too old unless you, I can't walk as far as I used to.

SMC Uhhuh.

VH My legs don't take me. And then sometimes, as I said, this confusion comes on. So I know that I can't be in my forties anymore (laugh).

SMC That's what lets you know, huh?

VH Yes.

SMC Uhhuh. But as far as what you, you know, feel about yourself, um, do you feel old?

VH No. I don't think anybody ever does.

SMC You don't think so huh?

VH No. Not unless you let yourself.

SMC Uhhuh.

VH You don't want to let yourself get old where you sit and do nothing.[37]

The stories Mrs. Hamilton told of her childhood provide the context for understanding her view of herself as she grew older as well as the abhorrence she felt for inactivity.

VH I've always been busy. I was a very active person from the time I was a child.

SMC Really?

VH I never liked to sit around. I remember when I was just a little girl playing with dolls, Sunday would come and I'd say, Mama can I go to so and so's house with my dolly, can I have so and so come here. I didn't want to sit all afternoon by myself. I've never been a loner.

SMC Uhhuh, uhhuh.

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[37] V.H., Interview # 1, p. 18

VH I've always had to have people around. [38]

VH As I said I've always been an active person even when I was a little girl. I never liked to sit around and do nothing. I was always doing something. And we lived on a farm just outside, well it was a small fruit farm. And of course I had my animals and I had my activities outdoors and I had some things outdoors so that I kept busy.

SMC Yeah, it sounds like that would keep you, a youngster pretty well tied up.

VH I can still see myself swinging. My father put up a swing on a branch of a tree for me and I'd sit and swing and swing and swing (laugh). [39]

As a child, Mrs. Hamilton absorbed the values of her family, particularly of her mother. This is evidenced especially in her desire to help other people. This drive has manifested itself in years of volunteer service in her community. It is also one of the reasons she was anxious to participate in this study.

VH ...Well I'd be glad to [participate in the study] if I can do anything that'll help people in the future, to help the senior citizens. As I said, I did so much of that before I came in here (the retirement center). I worked in the nursing home. And we worked with some of these older people and helped them with things. I guess that's the way my mother raised me, she was always doing for people and that's the way that I do too....If I can do anything to help anybody else you know, in the future, why um, that would be doing just like my mother, you know, things that she did, like for this neighbor. I was raised that way, if you can do anything to help anybody else, you do it.

SMC You do it.

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[38] V.H., Interview # 1, p. 5

[39] V.H., Interview # 1, p. 12

VH That was the attitude in our family. [40]

The themes of the goodness of activity and helping others permeated Mrs. Hamilton's remembrance of older people she had known earlier in her life. She looked back on the older women she was closest to as a child and her description of them revolves around what she remembers them doing.

VH My mother lived to be in her seventies.

SMC Uhhuh.

VH And I think about that sometimes. But in those days when she was living, you went to live with your children, there really wasn't much to do. She sewed, she made clothes. She loved to sew and she made clothes for the whole family which kept her busy.

SMC Yeah, yeah.

VH Kept her hands busy and her mind busy. [41]

SMC ... When you were younger, Mrs. H., were you ever around older people?

VH My grandmother lived with us.

SMC Ah.

VH My mother's mother lived with us. But you know she just sat.

SMC Did she?

VH And also we had neighbors that we were very close to. See we were on a fruit farm, you know they're small. and uh, so we had a neighbor that we were very close friends with and her mother lived with them. And all she did was sit in the bedroom all day and rock.

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[40] V.H., Interview # 1, p. 14

[41] V.H., interview # 1, p. 8

SMC Uhhuh.

VH And she'd go out to meals. They'd take her out to the dining room or the kitchen to meals. And she'd just rock and how pitiful that was.[42]

A central theme in Mrs. Hamilton's construction of age was her equation of old age with inactivity. Inactivity was the worst possible calamity that could befall her and from childhood she rebelled against it with a vengeance.

VH I was born in 1911, you know how old I am.

SMC That makes you?

VH 77.

SMC 77. You hate the word aging though, huh?

VH Yes.

SMC Why?

VH 'Cause I just don't like the idea (laugh) of getting old I guess. I was the mother of four sons and I never had time to sit down at one time.

SMC Uhhuh.

VH And I've always been so busy. Now to sit and do nothing is just driving me right up a wall.[43]

Mrs. Hamilton's negative view of associating old age with inactivity was reflected in her disparaging identification of some of the other residents of the retirement residence as old. Her identification was a disparaging one and served as a significant factor in her choice of friends.

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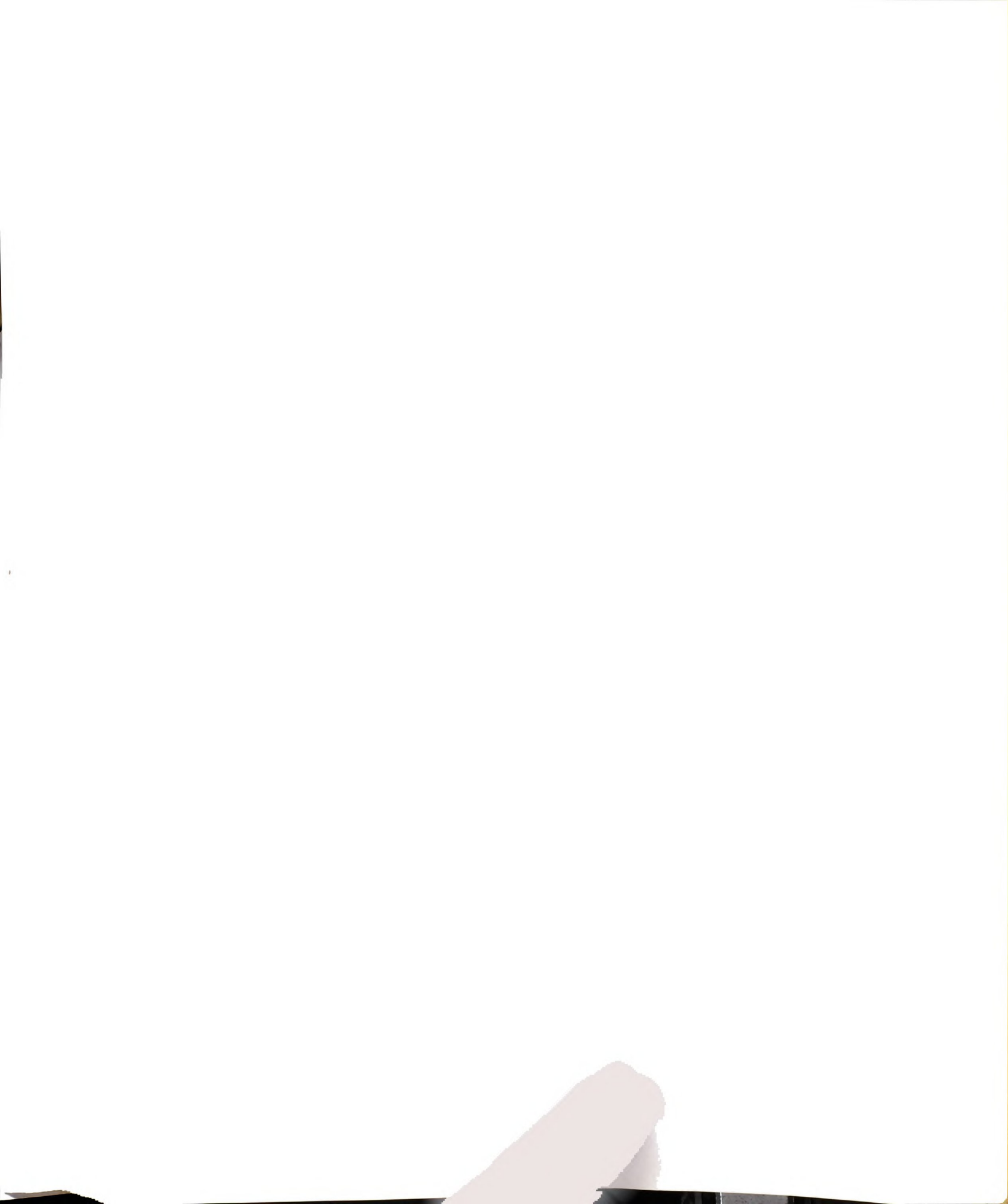
[42] V.H., Interview # 1, p. 8

[43] V.H., Interview # 1, p. 15



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[42] V.H., Interview # 1, p. 8

[43] V.H., Interview # 1, p. 15

SMC You know we talk about old age but we really don't know a lot about it.

VH Well, a lot of it's mental. It's your outlook and your attitude towards things. See and I try to keep things going here so I don't just sit and go this way (slumps her head on her chest) like some of those people do. They just sit and don't do a thing. They're not active in anything and keeping active is the important thing.

SMC How about the rest of the people here, do you consider them old?

VH Some of them, and some of them I'm good friends with some of them.

SMC The ones that aren't

VH Yeah. They aren't the ones that you know...just sit, no. Some of them get out, they can do better than I can walking...And they get out and take walks every day and you know, things like that. And that's good. [44]

Mrs. Hamilton's views on death were consistent with the value she placed on activity and, conversely, her dread of being immobilized by illness. She wanted death to come quickly when it came and was grateful that her husband had died only a short time after being diagnosed as having Alzheimer's disease.

SMC ...what I'm hearing you say is that getting old is an attitude more than anything else.

VH I try not to get depressed about it. I just ask the Lord to be with me and then all of a sudden take me and let's get it over with (laugh). [45]

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[44] V.H., Interview # 1, p 10

[45] V.H., Interview # 1, p. 20

SMC Was he (her husband) sick for a while before he died?

VH No, not too long. It ()Alzheimer's Disease, and ()advanced (). We had him at X [hospital] 'cause they knew something was wrong and they put him through all the tests and they said it was advanced Alzheimer's. Instead of taking it a couple of years to go, he went down in 4 months.

SMC Oh my goodness, really fast.

VH Yes.

SMC Ah dear.

VH But then maybe that was good rather than see him take a couple of years and gradually go down.

SMC Yeah. That would be very hard for you ().

VH Oh it was very hard but on the other hand I thank the Lord for taking him fast instead of just dragging on...[46]

Like all of the older participants, Mrs. Hamilton's experience of herself becoming older was consistent with the rest of her life experiences. Her awareness of her chronological age did not mean that she thought of herself as old. She equated old age with inactivity and isolation, states which she had vigorously rejected since childhood. As her environment grew more circumscribed with her move from the home where she had reared her family to a succession of apartments and finally to the structured surroundings of a retirement center, Mrs. Hamilton clung to her ability to stay active and involved with other people. As her sphere of activities narrowed, Mrs. Hamilton was confronted with the memories she had from her childhood of older women sitting and rocking. She rebelled against considering herself in this category and she continued to be as active as possible within the

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[46] V.H., Interview # 1, p. 20

confines of the retirement center.

Jim

Mrs. Hamilton's description of herself as always having been an active person is supported by her son's remembrance of her as a young mother.

> JH My mother (), she was trying to put bread on the table, sew our clothes, do the washing, break up fights. There were four of us boys. Saw all her gray hair? We all gave her one-fourth. Gray haired lady and we all gave her a fourth. [47]

His remembrance of his mother's participation in activities is very similar to Mrs. Hamilton's own description of herself earlier in her life.

> SMC Is part of, is part of what, you know, in terms of the way she is now versus the way she was before all of this started happening, uh, that kind of need for constant activity, is that any different than it was before?
>
> JH You mean for activities during the day?
>
> SMC Yeah.
>
> JH No, that was, that was there before.
>
> SMC That was always there
>
> JH She, she, in the home town like I said, church, United way, just, hospital bazaar.
>
> SMC She always kept going.
>
> JH She always kept going...She was very much involved with knitting and everything, crocheting, needlepoint, () with other women (), plan for the county fair, setting up the Republican booth. That's been there,

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[47] J.H., Interview # 1, p. 3

there's no difference. [48]

Jim also describes his mother's desire to be of service and to be involved with other people as a lifelong pattern. The fact that this pattern had become disturbed by Mrs. Hamilton's confusion was of great concern to Jim.

JH ...She moved into town in X before we moved into Y. She lived in the house by herself, she'd jump in the car and go to this neighbor and that neighbor (). Come to find out, I didn't know this until ()months later, but she'd start early in the morning, this lady friend of hers, she'd just gotten up, still be there in nightgown and housecoat, she'd come in and want to have coffee and everything. Didn't want to sit alone. Wanted to get out and make the rounds and see people all during the day. Some of them were a little, got a little tired of her so called pestering. ...She told you even as a little girl she didn't like to be alone. She has

SMC Yeah, she,she did say that yeah.

JH Six, seven years old, take her dolls on Sunday down to play with other people. (). So now, now that her mental process is coming back a bit, now I've got to try and find some way to help her feel needed. You know get some purpose. You know, all this time I've been talking to her, well you can help other people, there are other people worse off than you are and you can help them. Well within the last 6 months that's not been really true. She's gone downhill (), now she's coming back. Now, now there's a nursing bed section in Arborview.

SMC Yes.

JH The activities director talked to me one time, maybe Mom could go down and help in that section.

SMC Oh, that would be

JH But up to a couple of weeks ago, she'd have gotten lost going down the hall.

SMC Yeah.

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[48] J.H., Interview # 1, p. 12

JH In Arborview. And, and it's a long hall (). Maybe, in another month or two if she gets back mentally, maybe she'll be able to help somebody down there. She has a ()very urgent desire to feel needed, wanted.

SMC Yeah, and that's

JH Which is a desire all of us have. [49]

More than any other characteristic, Jim identified his mother's inability to be as active as she had been earlier as both the most indicative and most frustrating aspect of her "old age".

SMC ... do you think of your mother as old?

JH She's 77, Just turned 77 June 6th...Someways yes and someways no.

SMC Can you say which is which?

JH Well in her physical body she's old. Arthritis of both knees, just her physical appearance, her physical way of getting around. [50]

SMC Yeah. What's, what's been, you know out of, 'cause it sounds like there's been some pretty major changes for you in relationship to her you know as all of this has happened, um, what's, what's been the most difficult part of that for you? Of her getting old?

JH Well, it's been very exasperating...and also very frustrating to watch her go downhill mentally. But now that we're remedying that, now that she's coming back up mentally, I suppose the physical part of it, watching her body not do what it used to do. She has arthritis in both knees, she's taking medicine for that. She wasn't taking it like she was supposed to this past year and she could barely walk down the hall. Now with this medicine Dr. X prescribed about a month ago, she can walk to the car. You know it's not really curing the arthritis but it's () relieving the pain so, watching her body, watching her just being

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[49] J.H., Interview # 1, p. 13

[50] J.H., Interview # 1, p. 8

> frustrated not being able to do things. Uh, she, she realizes it too, she can't do what she used to do and it's really frustrating for her. So watching that part of it, the confusion mentally and going downhill.[51]

Mrs. Hamilton's memory loss and confusion were major sources of concern to her son. However they were not of major significance to Mrs. Hamilton even though she was aware of them. What was a major concern to her was her inability to get around as well as she had in the past. This limitation in her mobility prevented her from being as active and as involved socially with other people as she had been accustomed to all her life and the degree of isolation which limited mobility entailed was the source of her greatest difficulty and the feature which she associated with being "old."

Mrs. Hamilton's son appreciated the high value which his mother had always placed on volunteer and social activities. In fact, this characteristic of his mother's was a central feature which Jim used to describe his mother as a younger woman. Despite the significance of impaired mobility in Jim's construction of his mother's aging, however, her difficulties with confusion and memory loss were also deeply troubling features of his construction. The impact of these problems on Jim can be seen from his description of the frustrations he has experienced with his mother's aging. While he recognizes that "we're remedying" the mental decline, he still cites this as one of the most difficult things he has had to face in his mother's aging.

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[51] J.H., Interview # 1, p. 11

THE VANDYKES [52]

Mrs. VanDyke, her son and daughter-in-law had very different concepts of her aging. This family played out a conflict which is not uncommon in relationships between older parents and their adult children. They held diametrically opposed views of Mrs. VanDyke's competency and her ability to live independently. Mrs. VanDyke presented herself as an active, involved, and productive member of the community. Her son and daughter-in-law described her as being isolated and morbidly preoccupied with death and financial concerns. It was impossible in my interviews with this family to gauge the accuracy of either construction. What was evident was the striking discrepancy both in their constructions of age and in the degree of frustration they experienced because of those constructions. If Mrs. VanDyke was aware of her son and daughter-in-law's perception of her behavior, she showed no signs of it to me. On the other hand her children were seriously concerned about her ability to function independently and continued to interpret her behavior as lending support to their assessment.

Mrs. VanDyke

Elizabeth VanDyke prided herself on her intellectual achievements, her initiative, and her capacity to organize an approach to any problem life had to offer. A recurrent theme in my interviews with Mrs. VanDyke was the formative impact which her mother's blindness had on her and the unusual nature of her childhood which resulted from it.

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[52] See p. 30 for a biographical sketch of the VanDykes.

EV My father had five women to support, his wife, her mother and this sister, and then along came a pair of twins of which I was one. And he needed a boy and he got two girls so we had to do something about that. And it, sometimes it was in the stable and sometimes it was driving horses on the () and that sort of thing when we were altogether too young. And my sister chose to be the boy in the family and I had to, we both had to do a lot of things outdoors, but I had to look out for mother after (her twin) was fourteen and went to high school. So I learned to sew beginning at eight years old. [53]

EV I was a twin... and mother was blind when we were born. So we had experiences that matured us. I'm sure that we were much more mature when we started to school at three and a half years.

SMC Three and a half when you started school?

EV Yes, because mother couldn't keep track of us and the hired man, we were on a farm and the hired man's wife was the teacher and she saw the picture. And she said send them to school. And Dad would take us when the weather was bad but by the time we were four and we were walking the half mile to school. So I've had some unusual experiences and they've all been enriching. [54]

EV My point is that I've had some valuable experience to meet a Depression, or to meet anything. [55]

Mrs. VanDyke had been very active in community activities in addition to caring for her husband, three sons, and her semi-invalid father-in-law. When she was in her fifties she returned to college and obtained a masters degree when she was 63. From that time until she moved at the age of 85 from the city where she had lived all her married life, Mrs.

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[53] E.V., Interview # 2, p. 20

[54] E.V., Interview # 1, p. 7

[55] E.V., Interview # 2, p. 11

VanDyke devoted much of her time to the development of an historical museum for the city. She was proud of the work she had done there and was touched by the response of city residents to her when she moved.

EV So the city of X, with a few strong hints gave us the Library for $10. There had to be something change hands...My husband and the ex, just then ex-president of X College raised $350,000 to restore it for a museum. We used every cent of it. Now we have an endowment fund that is around $50,000 and growing all the time, memorials and that sort of thing. And I am the curator emeritus since I've been here, well, since () I knew I was coming here. And they had a party and the present curator who has been there thirteen years now did an excellent job of arranging it. They arranged for refreshments for fifty people and there were 350 people. [56]

Mrs. VanDyke approached the limitations and losses which she experienced as she grew older with the same organizational abilities which she had used in her earlier accomplishments.

SMC Do you have any regrets about that decision to come here (to X)?

EV No. When I made the decision, I'd considered every phase of it and there isn't anything that would change any one of them. I couldn't bring my husband back to life and I couldn't take care of about twenty rose bushes and I couldn't mow the lawn. It was getting expensive. I had two different men who did different things in the gardens and it was getting so expensive. And I just knew the time had come, like when I was 86 I knew the time had come I better not drive. And I make those decisions and then that's behind me. [57]

In a way similar to Mr. Hauser, Mrs. VanDyke also was very matter of

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[56] E.V., Interview # 2, p. 16

[57] E.V., Interview # 2, p. 16

fact about her death. She felt prepared and saw death as a natural outcome to the gradual accumulation of years. In addition, her sense of organization also pervaded her thinking about dying. Mrs. VanDyke had one more responsibility to fulfill. She was legally responsible for managing the affairs of her older sister who had been incapacitated for a number of years. If her sister were to die, Mrs. VanDyke would be ready to follow. Death would free her children from the need to care for her if she became incapacitated and she had done what she wanted to do in life, with one exception.

SMC Well, you've had a very full life it sounds like.

EV I have. And if my sister should die tomorrow I would be ready to go the next day.

SMC Would you really?

EV I don't want my children to have to go, with the same genes that she has and she hasn't known who she is for 11 years, I don't want them to be, have. And I've done my share and I've been everyplace that I want to go, except Maine (laugh). And maybe heaven will be like that (laugh).....

SMC ....Do you think very much about dying?

EV No, no.

SMC You just sounded very matter of fact about it.

EV I'm, to answer your question more fully, I've been prepared for this. I knew that if the sun rose the next morning one after another that I would be naturally a day older and the end product of that is to get old and then to die.[58]

Mrs. VanDyke regarded aging as not simply inevitable, but as a facet of life which one was reminded of daily.

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[58] E.V., Interview # 2, pp. 18-19

SMC ...Are there things that you like about getting older?

EV No. I don't think I would say there is. But there isn't anything that I, that I wasn't prepared for. You see it all around you and you know if the sun comes up in the morning, that day is going to add one day to your age. And you're lucky if you're alive.[59]

As was true of the other older participants, Mrs. VanDyke did not consider herself old. Her intellectual realization that each sunrise added another day to her age did not prevent her surprise when, periodically, she reflected on her chronological age. Rather, the cyclical nature of day following day left Mrs. VanDyke with a strong sense of her life having been "one experience" into which age had slipped unaware.

SMC ... Do you think of yourself as old?

EV No, actually I don't. I can't believe, I just can't believe that I am 86 years old. It just seems as though it's all been crushed into one experience.

SMC Crushed? How, how do you mean?

EV Well, it's just every time the sun rises there's another day and another, it just happens so casually.[60]

For Mrs. VanDyke, age was not a central focus of meaning. On the contrary, the times when she did reflect consciously on the fact that she was 86, the awareness took her by surprise. She articulated a belief in life as an ongoing process in which she had played, and

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[59] E.V., Interview # 1, p. 16

[60] E.V., Interview # 1, p. 7

continued to play, an active part. She approached the losses she experienced as she became older with the same matter of factness which she had approached other painful events in her life. She s freely of death and her readiness for it and gave the impression being actively engaged in organizing her life in preparation for end.

Mel and Diane

The matter of factness which characterized Mrs. VanDyke's articul of her experience of growing older was not a characteristic which son and daughter-in-law recognized in their relationships with th mother as she had grown older. On the contrary, Mel and Diane, M VanDyke's son and daughter-in-law, found her becoming progressive obsessed with planning for her funeral and with arranging her fir affairs. They were tempted to view Mrs. VanDyke's preoccupation a change in her personality; yet they realized that she had exhibit of the same characteristics earlier in her life around other issu They suspected that the changes they noticed might be the result they viewed as a lack of purpose in a woman who had ordered her w life in relationship to the achievement of goals.

SMC I guess the first question, just so I'm not assuming anything, and that is do you think of your mother, and your mother-in-law as being old? Do you think of her as that?

MV Oh, yeah, I'm beginning to (laugh). It's just come that way in the last few years. I didn't think of her being old six, seven years ago when she was close to 80 but it seems like all of a sudden she's getting old. I guess I am too (laugh).

DV I, she doesn't have to be old. I don't think of her

as old when we have good times but something, her personality has changed a great deal in the last six months.

SMC Has it really?

DV Hmhm. She has, she chose to move up here a year ago and we really had a lot of fun. She came out and helped us can tomatoes and she came out to can peaches and we were doing fun things together. Suddenly that no longer exists. She, I'll let Mel tell you how she talks now (laugh). And we don't know why. I think I do, but. We don't even like to go up there, do we?

MV Well, it just seems like it's getting real morbid. She, she talks, she has oh, just casually a year ago mentioned that she wanted to be cremated. Well, I just, of course I don't think much of that. And I didn't even want to talk () about and I just changed the subject and that was it. So when, she didn't bring it up for quite a while and then about six months later she brought it up again and now it's just, it just seems like every once in a while she has to talk about it and as a spin off from that maybe, she's gotten on to a deal now about where does she find out about donating her organs.

DV She is obsessed the, I would say the last six months in discussing her money.

MV And the money thing.

DV Just drives us up the wall. And discussing dying. [61]

DV You asked a few minutes ago why in the last six months we thought there was this sudden change. I can give you what I think. She has no goals. Absolutely none. Until she moved to X, she had organizations she attended. She really made a great contribution to her community down there...So it's as if she wakes up in the morning and she really doesn't have a goal. [62]

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[61] M.& D.V., Interview # 1, pp. 2-3

[62] M. & D.V. Interview # 1, pp. 14-15

Mrs. VanDyke's family suspect that her lack of purpose happened at a definitive point after her move to X.

DV ...She planned her own moving...And she decided what furniture...was to be moved, she made all the arrangements herself to sell what was to be sold and they had a real big sendoff for her there in the community...The mayor declared a Elizabeth VanDyke day.

SMC Oh, my gosh.

MV Oh, big deal.

DV Oh, this was a really, it was very, very nice. she was a good citizen really. Well she came up here and for six months she's getting settled in her apartment. She's getting her address changed, her insurances changed, all these things, catching her breath, she was tired...And after about the first of December everything was done.

MV Her insurance you know and that kind of thing, bank accounts

DV () all done.

MV () shuffled around.

DV And she, all that's left now is to sit down. I swear she sat down in the chair one day and said, well I've got everything done, I'm ready to die. And nothing happened.[63]

Mel and Diane also suspected that Mrs. VanDyke's husband had played a significant and unrecognized, by them, role in relationship to Mrs. VanDyke. They credited some of the difficulty they saw Mrs. VanDyke experiencing to the fact that her husband no longer provided a balance for her.

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[63] M. & D.V. Interview # 1, pp. 16-17

MV Yeah, I think my dad, probably when she got off on these tangents, I think he probably you know, set her down and said, let's go with something else now.

DV I was

MV It's hard to, because so many of these things started about the time he died you don't know whether it was the sudden lonesomeness and all that or the fact that that's when she hit 82. And it probably is a combination and several other things too but it, yeah, it's hard to tell. I mean, if he was still alive I wonder if she'd be like this.

SMC If she'd be doing this?

DV ()

MV Because that would, that drives him right out of his mind.[64]

It is obvious from these excerpts that Mel and Diane had a remarkably different view of Mrs. VanDyke's aging than she herself did. Mrs. VanDyke viewed herself as continuing to be an involved and capable member of her family. She spoke of her responsibilities to her sister and to her children and reflected matter of factly, although with some surprise, at the passage of years which would lead ultimately to her death.

Mrs. VanDyke's son and daughter-in-law, on the other hand, saw her as becoming obsessive about her body, about death, and about her finances. They interpreted her behavior as the result of no longer having a purpose in life and also as a consequence of not having the balance which her husband provided in earlier years. They disagreed totally with Mrs. VanDyke's construction of her level of involvement in activities with other people and indicated that her ability to give the

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[64] M. & D.V. Interview # 1, pp. 32-33

impression of involvement while in fact she was very isolated was symptomatic of "clever senility." It is difficult, and quite possibly counter-productive, to speculate here on which construction comes closer to being the more "accurate." A more useful approach is to recognize the extent of the discrepancy between the constructions and the possible sources of the discrepancies. Analysis of the interview material indicates that while Mrs. VanDyke is at ease discussing her eventual death, her son and daughter-in-law find such discussion morbid. Mel and Diane believe that Mrs. VanDyke spends an inordinate amount of time on the subject of death; one might hypothesize that Mel and Diane's aversion to the subject of Mrs. VanDyke's death had the effect of creating in her a compulsion to be heard on the subject. Mel's description of the sequence of events surrounding the phenomenon of Mrs. VanDyke's fascination with the subject of her death lends some support to this premise.

> She has oh, just casually a year ago mentioned that she wanted to be cremated. Well, I just, of course I don't think much of that. And I didn't even want to talk () about and I just changed the subject and that was it. So then, she didn't bring it up for quite a while. And then about six months later she brought it up again and now it's just, it just seems like every once in a while she has to talk about it. [65]

I will discuss Mel and Diane's responses to Mrs. VanDyke's approach to death in the following chapter. Here it is sufficient to suggest that what her children viewed as an obsession with death may reflect a continuation on Mrs. VanDyke's part of her propensity to plan her affairs in meticulous detail.

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[65] M. & D.V., Interview # 1, p. 3

Mrs. Thompson And Her Daughter

Mrs. Thompson and her daughter Grace had highly congruent views of the "onset" of Mrs. Thompson's aging. Both clearly identified the event of her stroke as the moment when she "became old." Beginning from this perspective, however, mother and daughter developed highly divergent constructions of the nature of Mrs. Thompson's old age. As she began to recover from the effects of her stroke, Mrs. Thompson regained much of her vitality and no longer thought of herself as old in the way that she had when she was physically so dependent. Once Grace had identified her mother as an "old woman," however, the identification was permanent.

Mrs. Thompson

Despite the fact that she had had a serious heart attack two years earlier, Elaine Thompson considered herself a very active, energetic woman until she suffered a stroke at the age of 69. She described herself as a "fighter" and her fierce determination was evident in the story she told of her response both to her heart attack and to her stroke.

ET And I had that experience in Florida when I had my heart attack. Which I didn't know I was having a heart attack. And I went and played nine holes of golf after having

SMC After the heart attack?

ET After this severe pain in my chest (laugh). Well, see I had an angina condition and it was a lot different. And I thought, Oh I can't be having a heart attack you know. But it seemed just like a truck was going over my chest. And of course my husband, I couldn't get through to him on it. We had gone shopping and we had an appointment with my brother-in-law to go golfing

and then I'm a nut on golf, I like

SMC Are you really?

ET Yes, I was. So we, I started feeling better after we sat in the car and I told my husband I said, he said, well let's go. I said, no, I can't move. Just leave me alone for a few minutes. And that was hard for him to do because he couldn't understand why. And I didn't want to go through the talking of it and wear myself out. And in case it was more serious than I thought. and so, anyway, we went and met my brother-in-law at the golf course and I played nine holes, with a golf cart of course. But it's a wonder it didn't kill me, now that I look back. [66]

SMC But when you had the stroke, what was the hardest thing about that?

ET Oh, it frightened me.

SMC Did it?

ET Oh, yeah. Because I woke up and I had to rub this leg, you know,you have those cramps during the night. And I got, it was early in the morning and I got up and I put my legs over and I went to rub my leg and I couldn't use my left hand. Oh, then it frightened me 'cause I was alone.

SMC Oh, dear

ET So anyway I got a hold of the doctor and my son and he came over and he took me to the hospital 'cause I didn't know what to do you know. And of course the operator, she gave me a hassle because she said there was, the number wasn't in existence. And I said, yes it is because I've been calling the doctor for months you know. And I got frustrated and I said if you don't hurry up I'm liable to pass out. I think I'm having a stroke and I have to get a hold of the doctor. Well, then, she panicked. And right away she said she was going to call, oh, what do you call it, the 9

SMC 911?

ET Yeah, right. And I said, no, don't do that because I want to get a hold of my son. And I thought I should

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[66] E.T., Interview # 1, p. 11

> get a hold of my family first you know and let them know what was going on. And, so then, it was odd and then he never thought much about a stroke you know, 'cause he never knew and so then I walked out to the car with him, hung on to him of course. And then he said afterwards, he says, mother I wonder if you should have walked out. We should have maybe called the ambulance. And I walked down the stairs and everything and I was alright. I just hung on with this right hand. And, but anyway, it worked out alright. But the doctors frightened the children. I don't know if Grace told you or not. I just heard about it the other day, that he said I would not survive the stroke.[67]

Mrs. Thompson credits her ability to recover as well as she has from the effects of her stroke to her determination.

> ET Oh yeah. I think I'm a lot better than I was. Oh yeah, I can see that, how I can get around. And I have a lot of determination.
>
> SMC I gathered that.
>
> ET (laugh) That's I guess what keeps me going. Otherwise I don't think I would be able to. I was determined I was not going to be bedridden any longer than I was for those two months or to land up in a wheelchair for the rest of my life. I didn't want neither one of them if I could help it. And thank God, God was with me and helped me with my leg and I was able to walk.[68]

Although in retrospect Mrs. Thompson saw her heart attack as contributing to her "old age", she experienced her "oldness" as having begun definitively with her stroke. She found it a traumatic experience which she clearly distinguished from the experience of aging which preceded it.

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[67] E.T., Interview # 1, p. 15

[68] E.T., Interview # 1, p. 21

ET ...Well, mine [experience of aging] was fine until I had my stroke. I enjoyed getting older. I was well, you know, I was ok.But then after my stroke, forget it.

SMC That really changed it?

ET Oh, yes. Everything fell apart. [69]

ET ...So with that [heart attack] and my stroke, I'm telling you, everything is happening just the last few years.

SMC It's all coming together, isn't it?

ET Yeah, right. Where before that I felt real good and did, you know, a lot of things. But just since then, of course, then I've dreaded getting older.

SMC In your mind,is it that getting older is associated with all these health problems?

ET Yeah, because before that my health was very good all my life.

SMC After you had the heart attack, did you have a period of time in there where you felt pretty good?

ET Yeah, I felt pretty good, not too bad. I had to slow down of course.

SMC Uhhuh. Do you remember did you think then that you were getting old?

ET Hm, not too much. Uhuh.

SMC No? But after the stroke was different?

ET Oh yeah. The stroke was different, yeah. And I don't know, I don't think the doctor could have stopped it you know. I had a lot of stress and I think that's what brought a lot of it on. [70]

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[69] E.T. Interview # 1, p. 14

[70] E.T., Interview # 1, p. 15

Although the stroke was the event which marked her entrance into "old age," Mrs. Thompson also felt age encroaching on her as her husband's condition grew worse. She placed a high value on closeness to her family and she had enjoyed her husband's early years of retirement because it gave her more time with him. His illness and her eventual need to place him in a nursing home were some of the major problems Mrs. Thompson experienced in becoming old.

SMC Can you, when you think back to how it was before you had the stroke, and you say you enjoyed getting older.

ET Oh, I did because I was doing things I wanted to do. Until my husband got sick of course, and that didn't help matters. [71]

ET I, mind wise I felt that I wasn't getting that old,you know. But body wise I felt it, you know. But like I say, I enjoyed it until I had the stroke and my husband got sick and all that. Well then that took a lot out of me. Still is. [72]

Mrs. Thompson viewed her aging as having two distinct phases separated by the event of her stroke. Before her stroke she enjoyed getting older. She had leisure time for her own interests and was happy to spend extra time with her husband in his retirement. Her stroke ended that phase of her aging and Mrs.Thompson abruptly entered a second phase, one in which she dreaded aging because of the difficulties it implied. Despite the difficulties she had experienced since the event of her stroke, however, Mrs. Thompson still was appalled at the

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[71] E.T., Interview # 1, p. 19

[72] E.T., Interview # 1, p. 16

possibility that she might be considered old. She clearly articulated the mind-body dilemma which was at the heart of the tension between her vigorous spirit and frail body.

ET ...See the whole thing is, the mind doesn't feel old but the body does.

SMC So your mind feels young.

ET Oh yeah, right. It always has. I thought, oh I can't believe I'm getting as old as I am (laugh). [73]

Grace

Grace's perception of her mother's aging was affected by a series of conflicts which she had experienced with her at different points in her life. For example, while Grace acknowledged the importance of family "togetherness" to her mother, she believed that this demand for closeness created tensions between Mrs. Thompson and her children.

G ...I don't think my father had a lot of expectations but I think my mother did and voiced them, you know.

SMC Of the kids you mean?

G Yeah. And uh, we resented her intrusion, resented any expectations of showing up for the family gathering, the traditional family dinner and those kind of things.

SMC Oh, and she expected that?

G Oh yes. Every Sunday, that kind of

SMC Every Sunday?

G Oh, every Sunday

SMC After you had left home?

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[73] E.T., Interview # 1, p. 22

G (laugh) So there was a lot of, you know, separation needing to be done.[74]

Grace strongly concurred with her mother's characterization of herself as a fighter. She was also in agreement with Mrs. Thompson's belief that her determination, more than any other single factor, enabled her to recover as well as she did from her stroke. However, for Grace, her mother's fierce determination at age 69 triggered a series of memories of her mother's equally fierce determination when Grace was a child.

G ...It's, you know, it's scary. It still triggers the same childhood things in me, you know. And I was talking to my sister about that. I says, did that happen to you? Well, she says, Mother never really penetrated me. She said, no, it really doesn't because I can ignore it like she doesn't exist. But it does. I get that same fearful, yeah, oooh.[75]

As it did for Mrs. Thompson herself, the stroke was the event which precipitated Grace's awareness of her mother as "old". For her it was a traumatic realization with enormous implications.

G ...I couldn't adjust to the reality of it, of seeing a dynamic person turned into a very helpless, old woman. It appears it happened overnight.

SMC This was the time she had the stroke?

G Yeah, yeah. And it was so dramatic. It was such a dramatic physical change. And then I, of course, started noticing the mental changes and emotional changes and it was just overwhelming to me ().Um, so it was very difficult, very (), and it was time for me to grow up. And I had no background for that, nothing to relate to. I didn't have grandparents that I really remember, in any kind of caretaking role. I mean, watching my parents I had never experienced

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[74] G.E., Interview # 2, pp. 19-20

[75] G.E., Interview # 1, pp. 6-7

> anything like that before. So it was a whole new ball game. And it was, I think I went more on instinct than I did brainpower. I really did.[76]

Perhaps because the realization that her mother was an "old woman" came so suddenly and so traumatically, it precipitated what was to be a major difference between Grace and Mrs. Thompson's construction of old age. Although both saw the event of the stroke as triggering the onset of old age, Mrs. Thompson's recovery from the effects of the stroke modified her construction so that "old age" became in effect a reversible process. Grace had no such reversibility as part of her construction. While she recognized her mother's physical improvement, Grace later became concerned about her mother's emotional responses to the limitations imposed by the stroke and her concern served to solidify the awareness that her mother was "old."

Both Mrs. Thompson and Grace acknowledged that determination was the most significant factor in the dramatic recovery she made from her stroke. Whereas Mrs. Thompson was proud of her determination and the improvement she had made because of it, Grace was clearly ambivalent. On the one hand she praised her mother's fighting spirit and clearly gave her credit for overcoming formidable obstacles in her process of recovery. On the other hand, Mrs. Thompson's determination triggered earlier memories of her mother's determination as it entered into Grace's childhood relationship with her, a relationship characterized by Grace as a power struggle. The ways in which Grace constructed her mother's aging and the issues it raised for both Mrs. Thompson and Grace in their relationship illustrate, perhaps more clearly than any with

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[76] G.E., Interview # 1, p. 9

other participants in this study, the power of the aging process to precipitate the resurgence of unresolved childhood issues.

DISCUSSION

The power of each older participant's sense of self to shape the experience of aging is evident in the unique constructions presented here. They offer a striking contradiction both to the stereotype of old people as a homogeneous grouping and to the stereotype of old age as a period of inevitable and progressive loss.

While these older people were clearly aware that they had experienced losses as they aged, they actively engaged in facing their losses in ways that were consistent with their sense of self. Mr. Brown looked on loss as a challenge to be faced and an occasion to realize the goodness of people who were there to help. Mr. Hauser focused his energy on gauging the nature of the loss and its implications and developing strategies to deal with it. Mrs. Hamilton faced her losses by expending her energies in activities that involved other people. Mrs. VanDyke assessed her losses and organized a plan that would allow her to live comfortably with them. Mrs. Thompson fought her losses and won some surprising victories over them. Their active engagement with the losses they experienced as they grew older allowed these participants to fashion meaningful, and unique, approaches to advancing age. Losses became occasions to assert and continue to develop the self-identity they had begun forming early in life.

In most instances, adult children had a more difficult time than their

parents in facing the older participants' aging. For the older people aging was a process, difficult perhaps, but of a piece and continuous with the rest of their lives. They fashioned its meaning for them out of their sense of who they were and what was important to them. On the other hand their children, with the exception of Mr. Brown's family, experienced their awareness of their parents' aging as a profound disruption of their lives as they had known them. (The reason for the Brown family being an exception here is that they did not perceive Mr. Brown's age to be a significant factor in their relationships since they attributed the changes that accompanied his aging to the progression of Parkinson's Disease rather than age).

One reason the adult children perceived their parents' aging as a disruptive force may relate to the intimate connection between their own sense of self and their relationship to their parents. The children identified some significant feature of their parent as a key factor in who they were <u>as their parent</u>. When this feature changed, the children were faced not only with relating to a parent who seemed significantly different to them. In addition they had to face the fact that this change demanded that they assume a different relationship to their parent than the one to which they had been accustomed. Frances and Betty had to overcome their hesitancy to help Mr. Hauser in areas where previously he would have resented their interference. Jim had to make the decision that his mother, whom he identified as a capable and active woman, was no longer able to live alone. Mel and Diane were no longer able to enjoy the company of the mother they had known as an interesting and capable companion. Grace's awareness that her mother was "an old woman" after her stroke made her realize that it was time for her to

grow up. The implications of these differences in experience between the older participants and their children were obvious in the contrast between their views of the nature of old age. As we shall see in the following chapter, the older people felt old only occasionally and never for any significant length of time. Once their children experienced them as old, however, they identified them permanently as being old, a state which they perceived as one of irreversible decline.

CHAPTER 5

FEELING OLD VERSUS BEING OLD: THE ROLE OF TROUBLE IN THE CONSTRUCTION OF AGE

At the heart of the distinctive constructions of aging fashioned by each of the study groups were specific circumstances which they defined as troublesome. These circumstances were unique for each participant and coincided with the values which were important to them. What was consistent across groups, however, was the difference between the way older people and their children saw the relationship between trouble and age. Old age was a passing feeling which the older participants experienced when faced with particular kinds of trouble. For their children, on the contrary, old age was a permanent state of decline which generated a series of troubles precisely because it impinged on some central characteristic of the parent-child relationship.

In this chapter the circumstances which each of the study groups considered troublesome are discussed. The chapter format corresponds to that of the preceding chapter in that the construction of trouble is considered separately for the older participants and their children in each study group. The significance of the central themes which were identified for each older participant in the preceding chapter are seen here as the logical basis for their construction of trouble and consequently for their intermittent sense of <u>feeling old</u>. Similarly the adult child's perception that his or her parent had lost an essential

personal quality is seen as the event precipitating the perception of the parent as being old. The significance of changes in established patterns in the parent-child dynamic which resulted from identifying the parent as old are seen as the basis for the children's definition of what they found troublesome.

Trouble in the lives of Mr. Brown and his family

As noted in the preceding chapter, Mr. Brown's daughter and son-in-law were the only adult children who did not think of their parent as being old. In addition, while Mr. Brown was similar to the other older participants in clearly indicating that he did not think of himself as old, he spoke only once of the relationship between the trouble he had with his physical limitations and thinking he was "different" now than he had been as a younger man. The lack of importance of Mr. Brown's age to this family's relationships made them significantly different from the other study groups. Despite this difference, the situations which this family defined as troublesome were similar to the other participants in that they related to values that were important to them and to changes in long established parent-child relationships.

Mr. Brown

As we saw in the preceding chapter, Mr. Brown prided himself on his independence and his ability to "pick up and go" which had been a critical factor for him in his years of travel with his wife and later with his children and grandchildren. When this freedom was hampered by a slow recovery from his broken hip Mr. Brown experienced a tangible,

though fleeting, sense of discontinuity in his sense of himself.

SMC Do you consider yourself the same way, or think of yourself the same way now as you did when you were younger or do you think you're very different?

JB Oh, I think I'm quite different.

SMC Do you?

JB In things I can do and (can't). I don't feel old. I know (), I know I'm old but I don't think of being old. I know everybody gets old.

SMC Umhm. In terms of the way, I mean granted that physically there's been a lot of changes.

JB Oh yeah.

SMC Over the years. In terms of how your, how you kind of approach life, is it much different from the way you always used to do you think?

JB I don't think so. Except that I have the inabilities which I can't predict. But I don't think I feel too different.

SMC Uhhuh, uhhuh.

JB Except as I say, physical. [77]

Like all of the other older participants, Mr. Brown did not consider himself old. His feeling that he was "quite different" from when he was a younger man arose from his physical inability to do what he had once done. That his physical limitations would be the source of the one exception to his unchanged sense of self is not surprising given the high value he placed on his freedom to come and go at will. In another excerpt we can see the relationship between the importance Mr. Brown attached to his independence and the development of a fresh source of trouble for him. Speaking of his move to the nursing home, Mr. Brown

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[77] J.B., Interview # 2, pp. 21-22

revealed that his restricted freedom was a source of difficulty for him.

JB They're all very nice people here, kind and considerate. The food is good. I don't mind.

SMC Umhm.

JB Except I'd like to be out on my own.

SMC Well, yeah.

JB Been independent too many years for () incapacitated.

SMC Yeah. Do you feel like you are incapacitated?

JB Yeah. 'Cause I can't get out by myself any more, can't go and come as I want to.[78]

Later in the same conversation Mr. Brown identified the event of the fall in which he broke his hip as having marked the turning point from independence to dependence. Even as he considered the possibility of leaving the nursing home in the future, he acknowledged that his days of living independently were over.

SMC ...It sounds when you talk like it was kind of a before and after. I mean there was a time when you could keep on going and, you know, pick up when you wanted and so on. In your mind what made the difference?

JB Broken hip.

SMC The hip, yeah. That did it, huh?

JB Yeah. That stopped my circulation quite a bit. But it's coming back slow but sure. But I'm planning on getting out of here one of these days.

SMC Do you think so?

JB Oh, yeah. I'm planning on it.

SMC Ok.

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[78] J.B., Interview # 2, p.22

JB I mean, making a move into an apartment or something like that, smaller apartment.

SMC Rather than the house?

JB Oh, I don't think I'll go back. I'd have to have someone there with me.

SMC Yeah.

JB Not that I can't get around and do things but I'm afraid of falling again.[79]

Realizing that he would not be able to live alone again, Mr. Brown was also faced in the nursing home with another trying situation - meeting his need for companionship. Since he was a child, Mr. Brown had valued the fellowship of other people and, as we have seen, many of his memories were of times spent with friends and family. As an older man, Mr. Brown relied heavily on the friendship of his neighbors and church members. When he moved into a nursing home to recover from his broken hip, he followed a similar pattern of forming friendships with other residents and with staff members. When he experienced the inability of some of the people in the nursing home to participate in the exchanges central to friendship, he found this difficult.

JB ...I feel real lucky the way I see some people are in here. You never realize what's going on until you get in a place like this. Then you've got a lot to be, be grateful for you are the way you are.

SMC Umhm. Would you, are you pretty much in better shape than a lot of the people here?

JB Oh, yeah. Yeah. A lot of them can't even feed themselves.

SMC () yeah.

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[79] J.B., Interview # 2, p. 32

JB And they have to be wheeled in their wheelchairs to the dining room and they get down there and they just sleep. It's not a desirable situation. [80]

JB There's some people in the dining room that can't even talk.

SMC Yeah, yeah.

JB And when they do you can't understand them. [81]

A clear connection can be seen in Mr. Brown's description of situations which he found troublesome and the values which he placed on independence and companionship. Mr. Brown was distressed when these values were threatened by his physical dependence and contact with nursing home patients who were unable to carry on conversations with him.

Joan and Bob

As we saw in the preceding chapter, Mr. Brown's daughter and son-in-law associated his physical limitations with Parkinson's Disease rather than with his age. Because of their familiarity with the disease and Mr. Brown's continued ability to participate to some degree in the activities which they had enjoyed together as a family, Joan and Bob did not identify their father as having lost any essential aspect of his identity for them. However, they did confront situations which were difficult precisely because they conflicted with long standing

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[80] J.B., Interview # 2, p. 12

[81] J. B., Interview # 2, p. 18

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[80] J.B., Interview # 2, p. 12

[81] J. B., Interview # 2, p. 18

expectations in the parent child relationship. These involved assuming responsibility for Mr. Brown's financial affairs, an area which earlier had been "off limits" for them.

In addition, Joan and Bob were well aware of Mr. Brown's desire to be independent and had supported him in continuing to live alone even though they worried about his safety. Her father had always been an independent man and Joan was very reluctant to encroach on his freedom. Before he broke his hip, he had had a series of falls and these heightened the tension Joan felt in considering his need for living in a more protected situation. When she spoke of the falls, Joan articulated the difficulty she had even thinking about limiting Mr. Brown's independence.

> J He has fallen several times. This is not the first time laugh). Nor the last...another time he was raking leaves which he shouldn't have been doing anyway, and he fell, he tends to fall backwards.
>
> SMC Yeah.
>
> J And he fell, he was in the area between the sidewalk and the curb and he fell so that his head was out in the street. And this, this sort of thing really scared us. But I've been real reluctant to push him, to say, you know you shouldn't live there alone any more. Haven't been able to do that. [82]

Joan's concern for her father's safety also made her anxious around him after he had fractured his hip. Her previous enjoyment of Mr. Brown's visits was changed to apprehension when he came to visit after fracturing his hip.

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[82] J.& B.R., Interview # 1, p. 19

J I guess I feel a lot of responsibility when he's with us to kind of look after him and make sure that he's okay. I get a little bit uptight.

SMC When he's here.

J Yeah.

SMC Is that different than what it used to be or has that been

J I'm getting now about where I was when he used to come to visit. The first few times we had him here was really, very, uh, draining. Because I was so concerned...I think the first we had him here was in February.... And I just wasn't sure if we could manage taking care of him. And every time he comes, I relax a little bit because he does, well, every time he comes he's doing more for himself, more independent. And so I'm relaxing. It's getting more like it used to be. [83]

The concern which Joan and Bob had for Mr. Brown was compounded by the fact that they lived at a considerable distance from him. When they told the story of the night Mr. Brown fractured his hip, the difficulty and guilt they experienced trying to support him from such a distance were evident.

J ...And the Friday night he fell, I talked with him on the phone. I was supposed to go to a shower that night and after I hung up the phone I thought, you know, I shouldn't go to that shower. I should go up there. Because he was feeling kind of dizzy and just wasn't feeling good. And then he calls about 11:30 and

B And the paramedics were in the house.

J Yeah.

B After having had to break down the door to get in. Oh, boy.

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[83] J.& B.R., Interview # 1, p. 23

J He, he was turning down the thermostat and I think, what I think happened, he's not sure, when he turned, it upset his equilibrium. And he didn't think it was broken. And he crawled into the bedroom.

SMC This is when he fractured his hip?

J Yeah. THat was the time he fractured his hip. And so I really wish we had gone up to X. 'Cause he said, you know, you couldn't have kept me from falling, nobody could have kept me from falling. Well, that's true but

B Somebody could have left the paramedics in (laugh).

J Yeah. Somebody could have left the paramedics in.

B Without knocking the house down.

J He wouldn't have had to crawl into the bedroom and find the right button to push for the paramedics. He has a phone with buttons on it, all he had to do was punch one button. He wouldn't have had to go through all of that and wait half an hour for them to get in.[84]

In addition to the conflict Joan and Bob experienced between their concern for Mr. Brown's safety and their long-standing respect for his independence, they also experienced a problem when Joan needed to assume responsibility for her father's financial affairs.

J And then since he fell, he had been trying for some time before to include us in what was going on with the financial affairs and so on. And I was brought up to think that what was my parents' financial business had nothing to do with me. I, they always were rather close mouthed about it.

B Don't pry (laugh).

J And so that was something that was separate and I didn't ask questions. Well he's been trying to say, you know, there's this, there's this, there's this, this is where this is. And I really wasn't listening. I had a very difficult time dealing with

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[84] J.& B.R., Interview # 1, p.32

that. [85]

The central importance which Mr. Brown's independence had played in his relationship with Joan over the years can be seen in her reluctance to assume responsibility for his finances. Even when he was telling her that he wanted help, Joan had difficulty taking over an area in which her father had once made it clear he wanted complete control.

While Mr. Brown and his daughter and son-in-law had some significantly different constructions of what constituted trouble in Mr. Brown's aging, the issue of Mr. Brown's independence was a central feature for all of them. Mr. Brown defined his inability to come and go at will that occurred after he fractured his hip as a major trouble. Even after he had recovered, Mr. Brown was sufficiently concerned about being alone in case he fell again that he changed his lifestyle so that he could remain in a nursing home. The struggle for a readjusted balance between independence and dependence was a determining factor for Mr. Brown in reorienting major portions of his life after he fractured his hip.

Joan and Bob had been engaged in a similar struggle even prior to his fracture. Their concern for Mr. Brown's safety made them vulnerable to worry about his welfare and to feeling guilty when things went wrong. Both worry and guilt were enhanced by the fact that Joan and Bob lived at a distance from Mr. Brown and were dependent largely on phone conversations to determine what might be happening. An additional area of concern arose for Joan, and vicariously for Bob, when Mr. Brown

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[85] J & B.R Interview # 1, p. 13

needed their help with the management of his financial affairs. This issue was problematic precisely because it concerned an early parent-child prohibition.

The importance which Mr. Brown's independence played in his relationship with Joan, and to a lesser extent with Bob, influenced both their definition of what they found troublesome as he grew older and also how they responded to the trouble. Their basic stance in relationship to the difficulties they identified was to support whatever decisions Mr. Brown made even if these were contrary to what they might have wanted. Even though Joan's sense of her father's desire for privacy regarding his finances was so strong that she did not initially hear him ask for help, she responded when it became clear to her that he wanted her assistance. We will see in the next chapter the implications of this approach as it related to the clinic's recommendations for treatment for Mr. Brown.

Trouble in the lives of Mr. Hauser and his daughters

As we saw in the preceding chapter, Mr. Hauser and his daughters experienced very different degrees of distress over the difficulties he experienced as he grew older. Although father and daughters were in agreement that memory loss was a significant problem, Mr. Hauser minimized the difficulty by framing it as a problem common to many older people and developing strategies to disguise the loss as much as possible. His daughters, on the other hand, were devastated by the loss of the competent father they had once known.

In this section I focus initially on Mr. Hauser's description of his response to the death of his only sister since this was the event he defined as causing him to identify himself, at least temporarily, as old. Included in his description are key components of loss of control, loss of composure, and bewilderment. As we look at other events which Mr. Hauser experienced as he grew older, these same components are basic to each situation which he found troublesome. Insofar as he could avoid these elements, he did not experience particular difficulty even in situations which had the potential to be problematic or which his daughters found difficult.

Following the analysis of trouble from Mr. Hauser's perspective, I discuss his daughters' definitions of what they found difficult. As seen in the preceding chapter, the primary component of Frances and Betty's definition of trouble in their father's aging involved their perception that he was no longer "the same man" they had always known. Most frequently this perception was triggered by Mr. Hauser's confusion or memory loss since this undermined their life long image of their father as an intelligent and forceful man. A second component of difficulty for Frances and Betty arose from their need to assume responsibility for making decisions about many of Mr. Hauser's health and financial affairs. Previously these were areas in which he would not have tolerated their interference and, even though he now appeared grateful for their help, his daughters still felt apprehensive about assisting him.

Mr. Hauser

A prime source of trouble for Mr. Hauser and a major contributor to his sense of feeling old was his response to the death of his only sister. Since he had spent many years working in his family's funeral home, he considered death a familiar and natural event which ordinarily did not unduly upset him, even when it was the death of other family members. His sister's death, however, was a profound blow from which he did not recover for some time. Mr. Hauser was so stunned at his response that for him it marked a turning point in his life, the transition to feeling, however temporarily, that he was old.

SMC Do you think of yourself as an old man?

FH Only in this last month or so. It's been quite a transition from the period before that.

SMC What made the difference?

FH Uh,...about last February my sister my only sister, had heart attacks and strokes, everything one right after the another until she died here...about two weeks ago. But that was kind of a shock for me...kind of took more out of me than I had imagined. I had seen death time after time. I mean in the business there nothing fazed me but this was a little different.[86]

Although his grief over his sister's death was profound, it was not this that Mr. Hauser found so difficult. Rather it was his inability to control his expression of grief. When he talked about his response Mr. Hauser's concern for control is evident. He minimized the outward effects of his grief saying that he did not believe his reaction was obvious and that it was not something he was unable to control. At the

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[86] F.H., Interview # 1, p. 15

same time he admits he was overwhelmed and still felt the effects of his loss.

> FH So it kind of knocked me for a loop in a way. I don't think it was too obvious but I knew that I was pretty shaky there for some little time...I couldn't maintain my composure. Sometimes I felt as though I had to blubber which, I never cried when I had even close friends and like that. Nothing bothered me that much. With her it was a little different thing...But it wasn't something I couldn't control. I mean it just kind of overwhelmed me once in a while. That's for the first few days. After the burial was over with, why things were back to normal basically. But I felt the effects of it. Still do.[87]

His inability to contain his expression of emotion undermined two characteristics on which Mr. Hauser had always prided himself - his ability to exercise firm control in maintaining his composure and a stoical minimization of difficulty. His failure to recover quickly from his sister's death left Mr. Hauser bewildered and this bewilderment increased his sense of feeling old and out of control. In the other incidents which Mr. Hauser related as being troublesome, these same components are evident.

As we saw in the preceding chapter, Mr. Hauser had approached life much like a puzzle to be solved. Knowledge and having the right information for each situation provided him with the key which he needed to enter situations with a sense of mastery and control. He devoted a good deal of his life to ferreting out this information. He also took considerable time to analyze as many aspects of a situation, pieces of the puzzle if you will, before he made a decision about how he was going

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[87] F.H., Interview # 1, p. 16

to put them together. Against this background, the situations which Mr. Hauser defined as troublesome throughout his life stand out clearly. For example, when he talked about his wife's long struggle with multiple sclerosis, Mr. Hauser did not discuss the years of care which she required or the disruption of his family's life which her disease caused. Rather he focused on his frustration because he could not get adequate information about her illness.

> FH She was a complete invalid, but not too long. By the time she got to where she couldn't help herself she was at the end of her rope. I mentioned that that had gone on for, she had it when we were married and I didn't know it and the doctors didn't know it. They didn't even tell us that that's what it was for, you probably wouldn't believe it now, but it was something like ten years and she was really in bad shape. And I didn't have any idea what it was and finally we did a little investigating on our own and found out that that's probably what it was and pinned them down to it. And, "Well, we kinda think it might be." And they finally could admit, and did admit, the same doctors that had been denying it for years, they admitted they suspected that's what it was for quite a while.[88]

In similar fashion, as he became older Mr. Hauser defined as troublesome those times when he was frustrated in his search for information which would help him to master the limitations which were associated with his growing older. In talking about his memory loss, Mr. Hauser was not as upset with his condition as he was with what he felt was a lack of information about his condition.

> SMC Does it [memory loss] bother you very much?
>
> FH No, not in the serious sense. Now I don't get down and weep about it or anything of that sort. I mean I know that that's, and I don't know where I got the

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[88] F.H. Interview # 2, p. 15

information (). I can't remember that any of the doctors told me that I had that problem even when that's what I came in for. Or that that's, that it might get worse or, I can't remember them discussing it with me.

SMC Does that mean that you think they might have and you can't remember or?

FH I think when I would ask them point blank questions sometimes they could give me point blank answers. Straight answers. But they don't seem to, they haven't had the chance to prepare their information or something, they have to have a conference or something. That's fine if they get around to it but when it's something, to me it's something that's very obvious, that I have a fairly serious problem in some areas, that it wouldn't be that difficult for them to come up with some explanation. I'm a little disappointed in their responses that way. And maybe it's my fault, maybe I haven't come right out point blank and told them that I want to know right now or something I've never, that's up to them, when I ask for the decision they'll let me know when they get it determined accurately. I thought that should be good enough but it hasn't gotten anywhere. At least, that's the way it seems to me.[89]

In view of the value he placed on maintaining control of situations both by processing relevant information and by preserving his composure, it is not surprising that Mr. Hauser defined the memory loss and episodes of confusion which he experienced as he grew older as his major "trouble".

SMC You know, with all of the things that you've mentioned that you've had some trouble with, like the arthritis and the trouble with balance and the diarrhea that's now cleared up, you know, a number of physical problems and then you also mentioned the memory, difficulty with your memory. Which of those would you say is the hardest for you to live with?

FH Probably memory because I can't cover it up (laugh). Now, I have to think twice usually before I say what day it is or what day of the week it is or anything of

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89 F.H. Interview # 4, p. 21

> that sort. And I try to make it available on the calendar. So if I need prompting it's usually available without being embarrassing. That's what I hate, to admit that I don't know what day it is, day of the week, day of the month or whatever. If it gets away from me, if I can't have something to tie on to, kind of, feel kind of lost.[90]

The same difficulty with having to give up control was evidently the basis for Mr. Hauser's distress when he gave up driving.[91] His inability to drive forced him to face both his limited capacity for walking long distances and his need to depend on his family for transportation. This dependency was particularly difficult for him because he felt he lacked the excuse of ill health for his dependency. His resulting frustration left him feeling "like a has been."

FH Have you ever had to give up the car?

SMC No, I haven't.

FH It's something to behold. Can't walk very far. That's another thing I can't do. I can't, I have trouble with my legs. I can't walk over about, I go once around the block at normal speed, not carrying anything especially and that's far enough. I mean I can go farther but I'm just about

SMC You have trouble.

FH Yeah, I'm asking for trouble if I force myself. So, you don't get very far.

SMC Once around the block.

FH Once around the block especially if you're going shopping or have anything to do involving any distance at all, you don't get anywhere and then you're up against it.

SMC How do you manage?

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[90] F.H. Interview # 1, p.21

[91] The circumstances of Mr. Hauser's decision to stop driving will be discussed in detail in Chapter 6.

FH Not very well (laugh). Oh, the girls are good. I mean, I can't blame them for anything, they're wonderful. And I have a nephew that's here and in college too, and some grandchildren that are coming up that are old enough so that they can take over and drive and that sort of thing. So I haven't suffered for it especially. I feel so silly. From my point of view there's nothing the matter with me and here these girls are running their legs off trying to do the work that they have to do and I expect them to furnish me transportation. Well, I try to hold down on it as much as possible. Even so, it's, it makes you feel a little bit like a has been. [92]

Frances and Betty

As seen in the last chapter, Frances and Betty had begun to identify Mr. Hauser as old during the year preceding our first interview. While they recognized that his sister's death had a profound impact on their father, his response did not mark any significant change in their identification of him as old. Rather it was one more indication of how he had changed into an "old man", a process of change which had begun - for them - at least a year earlier. Their identification of their father as old was equated with his memory loss and served as an explanatory framework around which they interpreted behavior which previously they had chosen to ignore.

SMC ... Um, did this [memory loss], this all happened you said like within the last 9 months to a year?

F Well it's been coming on but it's really been more pronounced since (his sister) has been so sick....

B Since last January...

F And then when she passed away it just, it was really, Dad doesn't like to show emotion and he bottles things up inside and I think

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[92] F.H., Interview # 3, p. 18

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F And then when she passed away it just, it was really, Dad doesn't like to show emotion and he bottles things up inside and I think

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[92] F.H., Interview # 3, p. 18

B ()it started you know, our concern started before that, that's why we came to the Assessment Center the first time.

SMC Yeah.

B But it's been so, I mean those were instances that you get concerned about this day and then things seem to smooth over and you think, Oh well, maybe I imagined it (). It's not quite as bad as I thought... Two and a half years ago when I bought this house, that's when there were instances like he'd call me at work to find out how to lock my door and it was just a turn lock. And before the divorce was settled he bought the house, which was humorous. I mean, he had enough money in the bank to buy the house and buy the house and buy the house. But he didn't have any credit cards and didn't have a credit rating and they weren't sure they were going to let him (laughter). At any rate it came time and he was, he had been a realtor for a while since he retired, but he was having a hard time figuring out the forms, remembering where to sign. But it was still at a point where I was sitting right there and I could make enough jokes. I was concerned that they weren't going to let him buy it if they didn't think he knew where to sign on the dotted line. And you could cover, just sort of yuk it up and go through it. There is no covering up any more.[93]

As with all of the adult children participating in the study, Frances and Betty had most difficulty in areas which had been a central focus in their earlier relationships with their father. They remembered in detail numerous incidents which illustrated Mr. Hauser's pursuit of information and the value he placed on learning. To these women, their father symbolized control and stability and a mental competence that brooked no interference from anyone. It was this remembrance of him which made them identify his episodes of confusion as particularly difficult for them to handle.

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[93] F & B.H. Interview # 1, p. 17

B And it also brings up so many issues where you didn't question him on those issues, you didn't offer to help. I mean all hell would be apt to break loose if you were so much as to suggest that he might [not] know.

F He'd give you that look that you knew you'd ()(laughter)

B .. better leave the country (laughter). And now, we need to be asking those things, we need to be offering. I mean we need to tread where angels fear to tread.[94]

Betty and Frances remember as children that their father was extremely systematic and methodical. This characteristic, probably more than any other, provided them with stability in a home in which their mother's illness was a constant source of disruption.

B And he sat down at a certain time and he got up at a certain time.And you could almost set your clock by what he was doing.... and he would go and get his glass of milk and his banana and then you would hear the water run and he would rinse out his glass. And then the tin can would rattle and that was his cookie. And he'd do that and then he would walk to the front door and flick on the light to see what the temperature was and turn that out and close the door and go back to the bathroom and brush his teeth and then you knew he was on his way upstairs.[95]

As Mr. Hauser's confusion worsened, however, his methodical nature became an obstacle to his daughters' attempts to supervise his care.

F I mean there are times when I come over there, he's just terribly, terribly frustrated because he can't find things. I mean I got there one day and he misplaced his billfold and we looked and we looked and we looked for his billfold. And uh, it seems, what I've noticed has been, and I haven't brought this up to him because I thought it might be more confusing to

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94 F & B.H. Interview # 1, p.23

95 F & B.H. Interview # 3, p. 21

> him, but , he is very, very organized... and it's you know, like a teenager, one day they're a little boy and one day they're an adult. They kind of switch back and forth. Well he seems to be doing this, in and out of his confusion. And it's making it more confusing because he'll get a day when he's quite alert and he'll organize things like he used to. He'll get a confused day and re-organize the same things in confusion. And then he goes to find things and nothing is where, where he thought it was. And so I've been trying to figure out, you know, where he puts things in and out of confusion. Um (laughter) and you know, you kinda, certain things that he continually misplaces, you can think, Oh yeah, if he's in one state he usually puts it here and if he's in another, you know. But um, it's, it's just awful for him because he doesn't relate back and forth like, well he does (laugh) but not when he wants to. [96]

Mr. Hauser's daughters found the dependence that resulted from his cognitive impairment the most difficult part of his aging to cope with. When he began to ask for help with simple activities, Betty and Frances were devastated. They also had a very difficult time responding to his requests because of the resentment and anger their father typically manifested in his earlier life to suggestions that he might need help. Mr. Hauser retained many of his characteristic mannerisms ("that look" that Frances and Betty described) as he became more forgetful and confused. Even though the mannerisms no longer retained their earlier significance, his daughters still instinctively responded as they once had. A major source of their trouble with Mr. Hauser as he became older involved having to re-structure their understanding of the man who looked and acted in many ways as their father always had, but whose actions now had an entirely different meaning.

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[96] F & B.H. Interview # 1, p. 31

Trouble in the lives of Mrs. Hamilton and her son

Mrs. Hamilton and her son both placed an inability to be active at the heart of their views of trouble in Mrs. Hamilton's aging. However, they had different perspectives both about the reason for her decreased activity as well as the event which precipitated it. In very different ways, mother and son devoted enormous energy to combating the threat of Mrs. Hamilton becoming inactive. Mrs. Hamilton made deliberate choices to socialize with other residents and to enter into activities at the retirement center when she began feeling depressed. Thus, both her definition of trouble and her solution were consistent with the value she placed on remaining involved with people.

Jim Hamilton spent long hours arranging his mother's health care so that physically she would be able to remain active. He spent equally long hours researching community activities in which she could take part and in negotiating her need for being with other people when her outgoing behavior caused a conflict with other residents at the retirement center. Jim saw these activities, as well as the lengthy process he had engaged in to move his mother into the retirement center, as a logical extension of his role as oldest son. His identification of his mother as old, an event closely followed by his father's illness and death, precipitated a change in Jim's relationship with his mother. He saw the active, nurturing woman he had always known begin having difficulty managing her own affairs independently while retaining her desire to be active and involved. With the help of one of his brothers, Jim began to compensate for his mother's decreasing ability to manage her affairs independently by trying to provide suitable places for her

to live and facilitating her involvement with community activities.

Mrs. Hamilton

As we saw in the preceding chapter, Mrs. Hamilton equated old age with inactivity and idleness and she rejected being associated with it in any way. A highly social woman, she eliminated from consideration as possible friends any of the retirement center residents whom she saw as inactive. It is not surprising then that not being as involved as she once had been was the most difficult part of aging for Mrs. Hamilton.

Her husband's death was the most painful event Mrs. Hamilton associated with becoming older. Her view of this pivotal trouble contains the elements she most rejected in old age. She defined the loss of a spouse as the most difficult thing that happens as people grow older. For Mrs. Hamilton, who prized relationships with other people, the loss of her husband meant the loss of her closest relationship. She saw his death as the event which triggered her decline in activity and her problems with memory loss and confusion.

VH Now what brought it (confusion) on me, I was just fine,in fact I was an extremely active person until my husband died and it just threw me off.

SMC Uhuh, uhhuh.

VH 'Cause after all as you get older you live for your mate.

SMC Ah.

VH And I just lived for him and then when he was taken I just went blah...for a while...After all I'd had him

for 52 years, it just wasn't easy to give him up. [97]

In a fashion consistent with her belief in the value of keeping busy and not giving in to idleness, Mrs. Hamilton dealt with her grief over her husband's death by trying not to think too much about him and choosing to get involved with other people.

VH You uh, start to bring yourself up...as time goes on.

SMC How did you do that?

VH Just time.

SMC Yeah.

VH And activities.

SMC Really?

VH I got involved in activities. You can't just sit. And you can't sit on that television.

SMC Umhm.

VH I certainly don't do that. I never have.

SMC Yeah. Do you think about him very often?

VH Well, I try not to because I get depressed. [98]

As we saw in the previous chapter, Mrs. Hamilton believed that she would only feel old if she let herself become inactive. Her fear of this was so strong that even though she spent most of her day with other residents Mrs. Hamilton still felt the loss of being as active as she

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[97] V.H. Interview # 1, p. 13

[98] V.H. Interview # 1, p. 14

once had been.

SMC But what's the hardest thing for you in getting old?

VH Not to be active in things I think. Now that's me. As I said, I was the most active person from the time I was a little girl. I never sat still. And I've always been active...I was extremely active in volunteer work in nursing homes. I'd go and read to them on certain days or play bingo with them. And I just liked to do. I can't sit like this and watch the idiot box.[99]

Jim

Like his mother, Jim saw Mrs. Hamilton's inability to be as active as she once was as the crux of her "old age." However his perspective of the event which precipitated her decline differed from Mrs. Hamilton's view. Although he recognized the significance of his father's death in adding to his mother's difficulties he saw it as one in a series of upheavals which Mrs. Hamilton endured in a short period of time. In Jim's view, his mother became old following her hospitalization for treatment of pneumonia some time prior to her husband's illness.

SMC That's one of the things that's real tough to pin down when you talk to people is basically, you know, what makes someone old.

JH For her, she and my Dad were going along, no problem. They were Mr. and Mrs. Volunteer in that little town... Volunteered in church, United Way... Then in March of 1986 she came down with pneumonia, in the hospital a week. Finally they almost pushed her out the door. You know how they do in hospitals...She wasn't recovered. But after that her voice was shaky, um, I and my brothers noticed a big change. Just the

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[99] V.H. Interview # 1, p. 19

way she acted...and then he (his father) died in August of '86.... So uh, but things weren't too bad until my mother had that bout of pneumonia. So from that point, boy, March of '86, from that point on, wow, she had the change of her life. Physically, mentally, everything. Everyway, her life just, complete upheaval....

SMC And it was that one event that ()

JH Main event. Big two story farm house. After that, she had tinges of arthritis, but after that it was hard for her to get upstairs, up and downstairs. [100]

The significance of seeing his mother become old when there was a change in her level of activity is highly congruent with Mrs. Hamilton's own understanding of old age as inactivity. In Jim's recollection, the fact that his mother had difficulty managing stairs after her hospitalization led rapidly to a downward spiral of events culminating in his mother's severe confusion.

JH They decided to sell that house and move into a single story... My Dad was still alive at the time but it was hard for her to get up and downstairs. And then everything really fell apart that summer. Then uh, so she moved into town for, uh, not quite a year. This was after my Dad died and uh, very depressed, kept going downhill, so she thought it would help if she moved nearer my epileptic brother in X. So we got her into a retirement center in June of '87 down in X...Then she kept going just, just a little every time. I'd go down there once every couple of weeks with their check book. And she was starting to scribble off there, she'd write the checks dated 1987 when it was '88, she'd forget to enter checks. She'd forget about appointments. So, into last Fall it was just going a little more, a little more, till around Christmas time. Then she was really bad. [101]

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[100] J.H., Interview # 1, p. 4

[101] J.H. Interview # 1, p 15

Jim's realization of Mrs. Hamilton's inability to continue living alone led him to take responsibility for her care, a new role for him in relationship to his mother. He made the decision to move her to the retirement center near his home and pursued the medical care she needed. In many respects he adopted the energetic pattern of practical care he described as his mother's style when she had been caring for him and his brothers as children. Although he never defined the work involved in managing Mrs. Hamilton's affairs as troublesome, the time and energy they demanded clearly were stressful for him.

> JH ...I've been running down to Toledo every two weeks for a year. And uh, in fact moving her last June I messed up my back. And I went to therapy here for a week, no, couple of weeks. [102]

Jim's role involved him not only in coordinating his mother's health, social, and financial affairs but also meant that he was the one notified by the retirement center when his mother's behavior became problematic. Because of Mrs. Hamilton's confusion, she was handicapped in her ability both to socialize and to serve others. Although she recognized this as a difficulty to some extent, it was her son who was more pained by the problems she was having in this area. Mrs. Hamilton's typical heartiness had not been diminished with age and her desire to socialize with other residents of the retirement community met with disapproval. When the situation was becoming problematic, it was Jim who was requested, implicitly, to handle the difficulty.

> JH There's been some feedback by some of the people there to the head man. The head man talked to the number

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[102] J.H. Interview # 1, p. 8

two person in charge and the number two person called me. Said that, uh, my mother would go over and sit down next to [someone] in the lobby and start striking up conversations and a lot of people don't like that. My mother's not the most, she doesn't have polished manners and is not a, not from the socially elite class. She comes from a farm family in X that didn't have much, lived through the Depression, raised four of us boys (). And we didn't have much money, didn't come from the upper crust. So there are a lot of upper crust ladies there at Arborview I found out. Lot of hoity-toity, but not all of them. A lot of them resented that, and they do resent it. So they complained to the head man, uh, about, your screening process should be a little more thorough. She shouldn't have been let in.

SMC Did they say anything to your mother?

JH No. They talked to me and I talked to my mother, tried to soften the blow. I said, look, you can't just go in down the lobby and strike up conversations with anybody. You know, wait till some people maybe come by and, listen, there are some ladies there that are down to earth, very friendly, stop by, they know her problem, chitchat. I said those are the ladies you want to talk with. But if there's a group in the corner I wouldn't go over and start chatting with them. You don't want (), you don't want the headman to ask you to move. If they ask you to move, you know, where am I going to move you? [103]

Mrs. Hamilton's ability to remain in the retirement community was a major concern to Jim. He tried to coach her to follow the institution's tacit rules of acceptable behavior and negotiated on her behalf with the community's administrator.

SMC Have you gotten any feedback since you've talked to her? Is that working or

JH Well, I guess. I haven't, I haven't, the tape won't show it but I'm crossing my fingers. I haven't had the main man call me in the last three weeks or month. So far so good, but I uh, I don't know. I remind her, and for a while there I'd remind her, now don't just go around the lobby and talk to everybody and the next

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[103] J.H. Interview # 1, p. 6

> day I'd say, did you remember and she'd say, remember what. Now when I say that, she says, I know, I know, you, you talked to me about that...But she can't uh, she just can't strike up conversations (). Main man, I figured I just better take the bull by the horns so I made an appointment with him at Arborview. I'm going to sit down and talk with him, say we better talk. Says I heard through your number two person. Said, yeah, well he talked to all of his staff at staff meeting about several people and my mother was one. Staff agrees she's improving. Number one staff agrees, number two, she hasn't had enough time to adjust...Says we'll give her enough time (). I don't know what, how long is enough time. [104]

In addition to the difference in the way they constructed the origin of trouble in Mrs. Hamilton's aging, mother and son also differed in what they considered to be trouble now. Mrs. Hamilton equated "old age" with inactivity and her primary source of trouble lay in her inability to get around as well as she once did. She also acknowledged her memory loss and confusion as being a difficulty but did not identify it as a major source of trouble. She was content in the retirement center where she now lived and she concentrated on the high level of attention and care which her son and his family paid her and seemed to derive a great deal of satisfaction from this.

A major source of Jim's construction of trouble centered around providing the attention and care which his mother found so gratifying. Although he did not define it as troublesome, Jim's description of the level of coordination required to arrange for his mother's move to the retirement center, her participation in useful activity, and helping her to negotiate the norms of acceptable behavior at the retirement center were clearly a source of stress for him. Jim's role as responsible

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[104] J.H. Interview # 1, p. 6-7

provider for his mother was consistent with his role as eldest son the family. As with the other adult children participating in thi study, Jim's construction of "trouble" originated, at least parti in long standing family dynamics as these now became elaborated du the aging of a parent.

Trouble in the lives of Mrs.VanDyke and her family

As we have seen in the preceding chapter, the VanDykes presented t most divergent views of a parent's aging of any of the study group their view about aging differed, so did their perspectives on what constituted trouble as Mrs. VanDyke became older. Mrs. VanDyke believed that she had grown older very gradually, so gradually tha was surprised when, on occasion, she reflected on her chronologica She did not see herself as having changed in any dramatic way over years and presented herself as a competent and composed woman who calmly of her life and her approaching death. She did not think o herself as old and only referred to herself as having difficulty i being "older" when she felt that people were ignoring her.

As mentioned earlier, Mrs. VanDyke's son and daughter-in-law, articulated a deep sense of frustration and worry about their moth behavior as she became older. As mentioned earlier, they found he preoccupied with death and money and unwilling or unable to enter family and community activities as she once had. Their definition what aspects of Mrs. VanDyke's behavior were troublesome did not a from behaviors which were foreign to the way they had known her to the past. When pressed by my questions they agreed that Mrs. VanD

behavior was not remarkably different from what it had been as a younger woman. Rather Mel and Diane felt that the behaviors now were out of balance or were being played out in areas that they felt were inappropriate. They believed that while Doris' husband was alive, he had helped to keep her ideas in perspective and that since his death, that balance had been lost.

As the oldest son, Mel VanDyke felt frustrated in being able to deal with his mother's preoccupations. He admitted that he felt inhibited by her and grew increasingly more concerned as he watched her become, in his view, more isolated and unhappy. In turn, he found it more difficult to spend time with his mother. When he did, he found her steady stream of talk about money and death unnerving and tried to change the subject. Although Mrs. VanDyke did not speak of her family in this connection, in light of her view that being ignored was the sole trouble she experienced with growing older, she may well have found her son's response problematic.

Mrs. VanDyke

As we have seen earlier, Mrs. VanDyke believed that she had been prepared by her early life experiences to meet any eventuality and to make a contribution to society. From the time she was very young she had set out to make a mark on her world. The priority Elizabeth placed on "making her mark" and the skills she had developed throughout her life in order to do this had a great deal to do with what she identified as being troublesome to her as she became older.

The primary situation which Mrs. VanDyke found troublesome after she began to use a cane was the response she received from some people to what she felt was her age and her handicap. Given her experience of her blind mother and her drive to make a mark on her world, her observation is striking in singling out the difficulty she experienced with people who didn't "meet [her] eye" and who acted as though she "just weren't there".

> EV The only thing that really bothers me about being older and obviously handicapped, is in meeting people like, right out here in this hall. They look over your head or down at their own feet and don't meet your eye. And I think that's silly because there certainly are enough of us wandering around that are handicapped and old and wearing a cane and so on. Whether they're embarrassed by it or what, it doesn't embarrass me.
>
> SMC And you think it's because you're handicapped that they do that? Or because you're old?
>
> EV Yeah... There will be men come through the hall here and with carpeting I don't hear them and turn to lock my door and almost walk into one as I turn that way. and he could at least have cleared his throat when he saw somebody so he wasn't going to barge onto someone with a cane and scare them to death. And, but that's repeated quite often like in a grocery store you meet people who, they could walk straight through you. You feel they could walk straight through you because you just weren't there.[105]

The other difficulty Mrs. VanDyke experienced was some limited mobility after she suffered a fall which resulted in her being unable to stand or walk for any length of time. Freedom of movement had been an important part of organizing her life as she had wished and she identified her lack of mobility as troublesome precisely because it affected the way she organized her life.

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[105] E.V. Interview # 1, pp. 11-12

EV I feel that I have lost 50% of my mobility. Time wise I can only stand comfortably, not really comfortably, but I can stand it to stand in line or like paying for my groceries, half as long as I could before, which means about two minutes. Well if I'm stuck with someone who has to write a check or someone who sends the clerk for something that she couldn't find, that sort of thing, a delay of that sort, will double that time, my tolerance time. And that is, that's one of the biggest things, that I've lost so much mobility. And now not driving, I don't have the safety of the car to sit in on errands...Now it's a case...if I have the taxi wait for me it's a case of a mounting bill. [106]

As can be seen in these excerpts, the issues Mrs. VanDyke experienced as troublesome were, as they were with the other older participants, related to the themes which had been important to her throughout life. Having prided herself on having had an exceptional life and on having special skills to offer, she objected strongly to people who ignored her as she got older. Neither of these troubles appeared, in our conversations, to be highly traumatic to Mrs. VanDyke. They were, simply, troublesome but they were not things that were extraordinarily difficult for her to handle.

Mel and Diane

As with most of the other adult children, Mel and Diane's reasons for defining Mrs. VanDyke as old arose from situations which they defined as troublesome as she had become older. As we saw in the preceding chapter, Diane did not think Mrs. VanDyke had to be old and did not see her as old when they were having "good times." [107] It was only when

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[106] E.V. Interview # 2, p. 5

[107] See page 68

Mrs. VanDyke acted in a way that conflicted with their perspective on what she should be doing to be happy that Mel and Diane defined her behavior as problematic.

The crux of Mel and Diane's definition of Mrs. VanDyke's troubled, and therefore old, age revolved around what they saw as deliberate isolation and preoccupation with dying and with her finances. As she described Mrs. VanDyke's withdrawal from a group in which she had once been active, Diane's frustration and bewilderment were evident.

> DV ...Until she moved to X she had organizations she attended. She really made a great contribution to her community down there and of course she would have little things like the 60th anniversary reunion of her high school graduating class and this sort of thing. She still receives invitations to these things but does not want to go. And we attempt to encourage her and () you'd think we were taking her to Arizona or something...She has sent back, she was a Kappa Kappa Gamma. She sent back all of her pins, all this sort of thing to them. She, I guess you're supposed to do that, I've never been involved in a lodge or () but I asked her why she did it and she said well that's a part of my life that's all ended. I won't need it. I don't know if she wanted the attention that she would get from sending it back... or if in her mind her life is ended. [108]

Mel and Diane wanted desperately for their mother to be happy and they interpreted her choice to deliberately sever ties with her past and to discuss her death as evidence that she was not.

> SMC You know when we talked earlier () you said, you know, when she's 86 what do you do. Do you feel an obligation to do something?

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[108] M. & D.V. Interview # 1, p. 14

MV Well, I

DV We want her happy. She is so unhappy.

MV Yeah. I don't want her sitting out there moping away and

DV So unhappy () talk about dying. [109]

Interestingly, as Mel and Diane described Mrs. VanDyke's conversations with them it was not her death per se that she wanted to talk about. It was rather the details of her funeral arrangements and bequests, an activity which seemed remarkably consistent with her lifelong pattern of planning realistically and in detail for the future.

DV She is obsessed the, I would say the last six months in discussing her money.

MV And the money thing.

DV Just drives us up the wall. And discussing dying. But she does not talk about dying in the sense that

MV She doesn't say it.

DV That's right. But it's how she wants the service handled, who she would want to perform the service, who she doesn't want to be told. Oh, it's just, she's labeled, she spent the last couple of months labeling everything in the house, who should receive this. And I guess none of us have the courage to say to her, get off it. [110]

Mrs. VanDyke's concerns with planning her funeral and her financial affairs were creating a barrier which Mel and Diane felt helpless to surmount. They had reached a point where they dreaded spending time

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[109] M & D.V. Interview # 1, p. 24

[110] M. & D.V. Interview # 1, p. 3

with her because her conversation made them so uncomfortable. Th
views as to what constituted happiness did not include what they
as Mrs. VanDyke's morbid preoccupation.

> DV ...The dilemma for me is that I see a woman who's got all the money in the world, I mean she's wealthy. She's got three sons and their wives and the grandchildren who think she's the queen bee and she's in good health. And she doesn't know how to take advantage of this and have some fun with us. And she's leaving the situation where, oh my gosh we've got to go over there and it's sad.
>
> MV Yes it's a sad ().
>
> SMC Yeah, and you wonder
>
> DV The last years could be the best....Maybe there is a lot of comfort joy in planning your death, I don't know. I've never been confronted with this kind of thinking. [111]

The striking differences in the VanDyke family's understanding of
Elizabeth VanDyke's aging resulted in conflicts which appeared muc
severe for Mel and Diane VanDyke than for their mother. Mrs. VanD
appeared to be living as she wished and, if her degree of involveme
with friends and activities was not as extensive as she portrayed
this did not seem to cause her undue concern. Far from being upse
her approaching death, she spoke calmly of her readiness for it an
has been pointed out, planning her funeral arrangements was consis
with her lifelong approach to important events. Her son and daugh
in-law, on the contrary, found her discussions about funeral plann
morbid. Their unwillingness to listen to her plans may well have
the effect of making her more insistent in explaining the details
them. Mrs. VanDyke defined situations in which people ignored her

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[111] M. & D.V. Interview # 1, p. 46

being particularly troublesome as she became older. Ironically, in an attempt to keep her happy by distracting her from what they considered painful topics, her children were in fact ignoring her concerns and so, at least implicitly, contributing to her trouble.

Trouble in the lives of Mrs. Thompson and her daughter

Elaine Thompson and her daughter, Grace, had remarkably similar elements in their construction of what constituted trouble in Mrs. Thompson's aging following her stroke. However, their constructions were in conflict because they approached these elements from diametrically opposed positions. Three central elements in both mother and daughter's views of trouble concerned issues of family closeness, role reversal, and control.

Both Mrs. Thompson and Grace believed that families should be close and should stick together when a family member was in difficulty. Conversely, they also believed that parents should not live with their adult children. Neither woman apparently saw the potential for contradiction in these beliefs. It was only when they were faced with the possibility of Mrs. Thompson having to go to a nursing home that the conflict became severe for both of them, although for different reasons. After Grace made the decision to take her mother into her home for a year while she recovered from her stroke, Mrs. Thompson's gradual progress from complete physical dependence to independence set the stage for conflicts which resulted from role reversal and unresolved issues of control.

Mrs. Thompson

As we saw in the preceding chapter, Mrs. Thompson felt herself become suddenly old at the time that she suffered her stroke. The severe paralysis which resulted was a profound blow to this woman who prized her independence and physical stamina. With the loss of her physical independence, Mrs. Thompson was confronted with the necessity of accepting help from her children and this placed her in a situation which threatened some of her most deeply held convictions.

Before Mrs. Thompson was discharged from the hospital, her children had decided to place her in a nursing home. After visiting some nursing homes, however, Grace decided instead to take her mother into her home and care for her there. Mrs. Thompson was appalled at the thought of having to go to a nursing home. With that as her only other option when she left the hospital she felt that she had no choice but to go to Grace's home. She never gave up her belief, however, that it was wrong for her to be living with her daughter and felt that the decision to move in with Grace was one about which she had no choice.

> ET ...And I always said that I would never live with them you know. I know my daughter's girlfriends, well their mothers lived with them and I, I thought that that was bad. And they did too of course. And uh, it wasn't good for the mother, it wasn't good for the couple either. And uh, so, they uh, they never liked it and they didn't want me to do it either and I didn't want to, cause I kept telling them that, cause we talked about it. And there I had to go anyway, I had no choice.[112]

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[112] E.T., Interview # 5, p. 21

The issue of family closeness was complicated for Mrs. Thompson by her conflicting beliefs that while she should not be living with Grace she yet had a right to her care. The same conflict permeated her perceptions about her relationships with her other children. As she became more independent this conflict was heightened. While she was able to do more for herself, Mrs. Thompson felt that she still needed, and had a right to, her children's help. At the same time she felt she had to understand that their priorities were with their own families. The tension this caused was evident even in our earliest conversations. When I first began interviewing Mrs. Thompson, she had been in her own apartment for only a few months and was still dependent on her children to provide her with transportation. While she was grateful to them and sensitive to fitting her needs into their schedule, the toll this took on her desire for independence was evident.

ET ...and they've all just been wonderful helping and all that whenever they can. And of course I have to wait until they can do it, naturally. Like a lot of them will, a lot of parents I think tell the kids, well come on, I have to do such and such, and demand things where I'm not that way. I'd like to get going earlier and get these things done (laugh) but you can't pressure them either, you know.

SMC So you do it, like when they can?

ET Yeah right. 'Cause I feel there's nothing on me now but me, you know.[113]

As Mrs. Thompson continued to improve, the tensions with her children over the balance between her growing independence and her need to be dependent in some areas became more pronounced. As she felt her

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[113] E.T. Interview # 2, p. 18

children distancing themselves from her when she needed them, she grew angry and depressed.

> ET .... Oh dear, well that's the trouble you know, they get busy in their own lives which I can understand, but they can take one day a week out at least I would think. But they, they don't want to do it. Except L., like I say, she comes. It takes her a good hour to come here and she comes every week usually and uh. And I thought, well M. is only, well about 20 minutes away from me, she could come over once a week and uh, she has to go shopping anyway. She could shop here and we could both shop and I could take a basket and she a basket but no, she has no time, no time, no time (laugh). Oh dear. So I don't ask, I just take whatever they, they want me over ok, and if they don't, ok. And if they want to take me somewhere ok, otherwise I don't ask.[114]

As she recovered from her stroke, Mrs. Thompson began to think about driving again. Her children were adamant that she was not capable of doing this and the ensuing conflict heightened the tension she felt about regaining her freedom and control. The issue appeared to be particularly painful for Mrs. Thompson because it threatened her sense of competence as well as her desire to become independent once again.

> ET ...'Cause I know when I said something about driving, my therapist told me a long time ago when I was at Grace's' that I was capable of driving, they said, well I'm not going to be on the road when mother's driving (laugh).
>
> SMC Oh gosh.
>
> ET (laugh) Tell me when she's on the road. Right away they gave up on me see. They wouldn't give me a chance. And they still won't.[115]

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[114] E.T., Interview # 4, pp. 6-7

[115] E.T., Interview # 6, p. 7

ET But as long as I can handle that little old car (laugh) I'm going to drive. And the whole thing is I, it doesn't make sense Sister, they want me to have my independence and yet they don't want to give it to me. They want me to take cabs and buses and things like that. They want me to get around and do that. That's the reason they wanted me to move here. And I says why should I have to do that? If I have a car, why can't I drive it? Well, we're afraid you're going to kill yourself or somebody else and then we have to live with it. Well that's their problem (laugh), that's not mine.[116]

Like the other older people in the study, Mrs. Thompson defined as troublesome those situations which threatened deeply held convictions. Because she so valued physical stamina, independence, and family closeness, Mrs. Thompson's stroke plunged her into a situation which was fraught with conflict. The tension began in her own person when she recognized that her body no longer obeyed her. As we saw in the preceding chapter she defined the tension between her mind, which felt young, and her body, which felt old, as a primary circumstance causing her to feel old. When she was forced to depend on her daughter to take care of her, the conflict between her opposing norms -'I have a right to expect my children to take care of me' and 'It is wrong for parents to live with their children' became evident. Finally, as she began to regain her ability to live independently, Mrs. Thompson found herself in open conflict with her children who had different ideas than she did about what was appropriate independence.

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[116] E.T., Interview # 4, pp. 6-7

Grace

The issues of family closeness and her mother's independence also constituted the core of what Grace identified as troublesome for her in Mrs. Thompson's aging. In view of the tense relationship Grace had with her mother during childhood and adolescence, it was not surprising that a major source of trouble for Grace after Mrs. Thompson's stroke revolved around issues of power and control. The change in her mother from total independence to total dependence and the long period of recovery during which she was partially dependent and partially independent highlighted many of these unresolved issues.

Immediately after Mrs. Thompson had her stroke, Grace was appalled at the change in her and at first hoped that she would die rather than live as an invalid. When Mrs. Thompson didn't die, Grace had an enormous adjustment to make and felt in a very real sense that she had lost her mother just as surely as if she had died.

G You know, its funny, the first thing () and it might sound really cruel but that's alright, um, it was the initial reaction , Oh, we'll get her back on her feet. When I realized the seriousness of it according to her doctor, I didn't want her to get better, I would've much preferred ...that God's presence be known to her but certainly not for healing. And here she was, healing, and that was really quite a surprise and I was not prepared for that....

SMC ...Was she so different?

G Yeah, yeah, I lost my mother meaning her vitality, her independence, her strength, um, watching her enjoy life, she was very physically active, her attitude...to become a very helpless human being initially was appalling to me. [117]

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[117] G.E., Interview # 1, pp. 7-8

When Grace took her mother into her home and began to care for her, the conflict over issues of family closeness was dramatically heightened. When she first began to care for her mother, Grace adopted a distancing maneuver which she felt was the only way she could do this with some degree of composure.

G I treated her very much uh, like, my baby, ok. I would go in there in the morning, she was totally bedridden, and so I would go in each morning, "Good morning" huggy kissy. Um, which was not really easy for me initially. But I have always felt it was so sad that she couldn't get hugs and kisses from anyone so that was a big priority to me, and it was funny she responded to it very well. And so that's how we would start out the day. Uh, along with all the bathing needs, and the toilet needs, all those personal things, um, that I had to do (). I really didn't like that, but, uh, I think the only way that I survived that as sanely as I could was to come in as a parent. And I just totally, like tunnel vision. I would not allow myself to feel the other aspect or I wouldn't have made it. I would not have been able to do that. Because I found it very hard.

SMC So, you thought of her as?

G I thought of her as not my mother. I could not allow that. Um, when I realized what I had done and that was maybe two days later, uh, what I had really done (by taking Mrs. T. into her home) and what was really ahead of me, I just had to forget that that was my mother. And I, I was, I was just an individual taking care of (). That's how I really tried to look at it.[118]

Issues of independence and dependence which were a significant part of Mrs. Thompson's recovery from her stroke created a great deal of tension for Grace. They sparked many of the emotions which she had felt as a child and young adult around earlier issues of

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[118] G.E., Interview # 2, p. 12

power and control and made it difficult for her to maintain a sense of equanimity in caring for her mother. Grace very clearly referred to coping with these issues of Elaine's dependence and growing independence as a "balancing act".

G But I went through so many stages of dealing with my feelings myself in reference to mother. () emotionally charged really. And uh, but now, you know, I feel daughter -mother. Which is far healthier. You know, because there is an element of respect that I have now that I didn't have, for myself as well as for her. And it seems to make our relationship much better. I'm getting much more positive results. Um, I'm not needing to control her any longer, and therefore I'm getting better (). Uh, she's feeling more independent and taking a little bit more on for herself.

SMC Umhm, umhm.

G So, I think it's healthier. But it's a balancing act (laughs). () gets a little tough.

SMC How so, when you say balancing act?

G Uh, depends on the day, good days, bad days, you know those kinds of things, ups, downs.

SMC Umhm.

G But as we go through it, its getting easier. I'm not personally myself getting too far out of balance. It was very um, extremes of highs and lows initially, and, uh, scary, pretty scary.[119]

The working out of the "balancing act" was clearly seen in the story Grace told of the events leading up to Mrs. Thompson's move into her own apartment.

SMC What uh, when you say she was ready to go or she needed to go, what (), how did that decision get made?

G The decision was made before she came into my house. The decision was made, she didn't want to go to a

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[119] G.E., Interview # 2, p. 23

nursing home and that's where she was headed. And so () I said, ok mother, I said, if you're really serious about getting help, I said (), I said come to my house and we'll all work through this and we'll get you around and we'll get you back on your feet... But, I said, we'll do it for a year... But it was time for her to go when she was, she was, we went through all her therapy and she could handle herself in the kitchen, was able to get around () had everything all set up. And then when it was time for her to go we started talking and she would get angry when my husband and I would go out to dinner and she wasn't included even though we would take her out another time during that week. But we needed our private time of course. Those kind of things started happening. All of a sudden I didn't have, wherever I went she was there. And she was angry. And I thought it was getting out of balance, getting out of balance. So we talked. I said, mother, oh and she refused to go to () senior citizen uh

SMC Day care center?

G Yeah. She didn't do that anymore. She would not do that (). So I said mother, it's time for you to start reaching out. You're doing really well. What do you think? How do you feel about that? Well she agreed but she, she was not being honest. So that's when we started looking for different places and uh, found Evergreen Hills which to me was a blessing. I was thrilled we were so fortunate. But see, she wasn't ready, I don't think. But maybe she'd never be ready. I don't know. [120]

Grace's need to have her mother move into her own apartment became more pronounced as Mrs. Thompson began to regain her independence. Her mother's conviction that parents should not live with their children found an echo in Grace's feelings, affirmed by her year long experience.

G ...()that's what I learned, I could not have my mother living with me on a day to day basis. Uh, when we found Evergreen Hills, I felt that even if I had to go over there every day, it would be easier (). Then I could have my own life, with my husband, with my children, to do what I needed to do, what I felt good

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[120] G.E., Interview # 1, pp. 14-15

about. [121]

G ... but I do know this, I don't think, I really believe parents should not live with their children. Truly I do (). I think it's a very unhealthy situation for both parties...I could handle an elderly person, other than my parents, much better. Oh yeah, there's not the emotional () strain. And, uh, I'm much more compassionate. It's much easier to deal with a stranger than it is with a parent. [122]

After Mrs. Thompson moved out of Grace's home, the question of her driving became a major source of trouble for Grace, again because it expressed the conflict she had with her mother's growing independence. Grace had very rational concerns about her mother's driving. However the symbolic force of the issue lay in the dramatic tensions it generated around questions of control and power. In the following excerpt, Grace explains the thought process she went through after she removed her mother's car from the parking lot in Mrs. Thompson's apartment to prevent her from driving.

SMC Do you have any sense that she might be ok driving?

G Oh not really, no. I'd ride with her before the stroke and it was horrifying. The intensity, the intensity () was terrible. I wouldn't drive with her, no, I would not drive with her. Even the last few years I would not drive with her....I wish I had the right to sell that car 'cause I would have. I would sell that car. And I question myself, do I have the right? See those are those issues. I didn't know whether I had the right or not. Really I don't. I really, basically, don't have the right and when she told me that she was going to call the police and tell them I stole her car, I mean, yeah,she could do that, absolutely. There's nothing I can do. But that was kind of nice that she said that because it, aha, I don't really have that control, but I can do this.

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[121] G.E. Interview # 2, p. 14

[122] G.E., Interview # 1, p. 25

SMC And that's when you brought the car back?

G Yeah.

SMC So the car's back now but the keys are with?

G My sister.

SMC Your sister. And she's going to work out the road test?

G () But in good conscience I could not take the keys back to my mother because I know that she would hop in the car. And if she killed somebody, whether she did it with herself or not, including herself, I could not live with that. And I looked at myself and I said I cannot live with that. I can't. And it was the same kind of pull-tug whether she goes in a nursing home or not. I couldn't live with that either. And so I have, I have to be true to myself too. [123]

In her trouble with the issue of control as it related to Mrs. Thompson's growing independence, Grace struggled to find the balance between legitimate concern and her desire to control her mother's behavior. Eventually, she was only able to do this by consciously limiting contact with her mother and by completely withdrawing from involvement in Mrs. Thompson's resumption of driving.

Given the character of the long-standing relationship between Mrs. Thompson and Grace, the role reversal into which they were thrust as a result of Mrs. Thompson's illness stands out as a potent source of trouble for both of them. Mrs. Thompson's fierce determination to be independent and her experience as mother of six children made it extremely difficult for her to be helplessly dependent on the care of her daughter. On the other hand, Grace was appalled at the

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[123] G.E., Interview # 1, p. 19

helplessness of her once powerful mother. As Mrs. Thompson grew stronger and began making demands, Grace's childhood uncertainties and fears surfaced. As a result, Grace made the deliberate decision to consider Mrs. Thompson both as an infant and as a stranger, someone not her mother, in order to bring herself to provide the care that Mrs. Thompson needed.

Conclusion

While the older informants in this study made it clear that they did not equate "feeling old", which they experienced as a temporary and sporadic occurrence of trouble, with "being old", their children made no such distinction. On the contrary, the adult children translated their initial realization of their parent as "old" into a permanent identifying characteristic. Once they had identified their parent as old, this identification acted as a filter through which they perceived and explained their parent's subsequent behavior. In addition, the children frequently used the construction, "my parent is old" as a framework for reconstructing past events in a new light. For example, once Mr. Hauser's daughters had identified him as old they recalled aspects of his behavior two or three years earlier that they had chosen to ignore. Now, however, they saw those same behaviors as indications that, even at that time, he was confused and therefore "old." The identification by children also had the quality of irreversibility. For example, when Mr. Hauser was seen on a return visit to the assessment center, his mental status score had improved from 23, indicating mild cognitive impairment, to 28 which indicated normal cognitive functioning. Mr. Hauser's daughters, however, did not see the

improvement in his mental status as indicating any permanent change in his status as old. Rather they constructed the change as the result of his move to the retirement center and viewed it as a fortunate, although temporary, change in his condition. Similarly, Jim was still referring to his mother's memory loss and confusion as one of the most difficult parts of her becoming old even after Mrs. Hamilton's mental confusion had improved remarkably. Mel and Diane identified Mrs. VanDyke as "old" when she began focusing on arrangements for her death and the subsequent disposal of her property. Their construction of their mother as "old" was not altered by the assessment clinic's evaluation which basically indicated that Mrs. VanDyke was competent to continue living independently.

These conflicting constructions of old age - on the one hand, a temporary and reversible phenomenon, on the other an irreversible and deteriorating condition - had serious implications for the decisions older participants and their children made about the nature of help that was needed for those aspects of aging that they found troublesome. All of the children in this study responded to their identification of their parents as old and in trouble by contacting the assessment clinic for help. In the following chapter, the role which the clinic played in the participants' constructions of troubled aging is discussed.

CHAPTER 6

THE ROLE OF THE ASSESSMENT CLINIC IN THE CONSTRUCTION OF TROUBLED AGING

The visit to the assessment clinic was a significant step in the formulation of age and trouble by the older participants and their children. The clinic directly confronted their understandings of these issues since its purpose was precisely geriatric assessment and it only accepted older patients who were presented as having particular difficulty in aging. However, the impact of the clinic's evaluation and the meaning it had for participants varied widely. In order to understand its significance, this chapter explores the ways in which the older people and their children viewed the clinic and, in turn, how the clinic staff perceived these families.

As in the previous two chapters, I have considered each family group separately. In addition to comparing the views of the older people and their children, I have juxtaposed excerpts from their stories with data from their clinic records as well as from tapes of interactions which occurred in the clinic. The influence of themes in older participants' constructions of clinic interventions is demonstrated as well as the power of the participants' original constructions of age and trouble to withstand the weight of professional diagnoses and recommendations. The chapter concludes with a discussion of the clinic's assessment procedure as a ritual process potentially capable of

incorporating its patients into the category of "the troubled aged."

PARTICIPANT FAMILIES IN THE ASSESSMENT CLINIC

As we have already seen, older participants and their children articulated their constructions of age and trouble in large part through the use of "life stories" - richly detailed, eminently idiosyncratic, yet revealing issues and concerns faced by many, if not most, adults involved in a transition to increasing frailty. In contrast, clinic records used a highly standardized format to incorporate the information received from patients and their families. In addition, the interviews with clinic staff revealed that staff spoke of older participants and their families in similarly standardized categories. The interviews revealed both distance from, and highly focused articulation with, the phenomenon of troubled aging which was distinctively different from the immediacy and pervasiveness of the other study participants' involvement with the process. These differences can be seen clearly in the ways in which participants' stories were recast for inclusion in clinic records.

Mr. Brown, Joan and Bob

In preceding chapters we have noted the vitality and enjoyment of life which permeated Mr. Brown's accounts of his life, his relationships and even, perhaps most strikingly, his responses to his physical limitations. Mr. Brown's clinic records indicate that the clinic staff were aware of the kinds of activities which Mr. Brown enjoyed and had information about the nature and extent of his current relationships. Presumably, since the records indicate this awareness and since

questions about activities and relationships were part of the standard information collected from each patient, Mr. Brown or his daughter and son-in-law had told the staff many of the same stories they had shared with me. The comparison of these accounts with the documentation of the medical record reveals a striking difference in the quality as well as, in some instances, with the content of the accounts.

When I talked with Mr. Brown about his visit to the assessment center, he was very complimentary about the concern and attention he received from the clinic staff. At the same time he was emphatic that the visit to the clinic had not been useful to him. A comparison of the reason Mr. Brown gave me for agreeing to attend the clinic with the clinic's documentation of Mr. Brown's reason for being assessed give some indication why Mr. Brown did not find the assessment helpful.

SMC When you went down to (the assessment clinic) that time for that workup that you had..., was that useful to you personally?

JB (shakes his head)

SMC It wasn't, yeah.

JB At least I haven't, there's nothing been indicated yet that it was. We went for another one, to another doctor in X. But the laboratory reports are not, there's nothing that can help. they want me to take a brain scan...I said I've done enough things now and it hasn't done any good so I'll quit....They didn't, we didn't find out anything we didn't know before. Well, they treated me nice, took good examination, didn't make any decision...none that was important to me.

SMC Uhhuh, yeah. When you went down there did you have hopes that something might happen?

JB (nods)

SMC What were you hoping?

JB Well, I was hoping to find out what was wrong with me

(laugh). Find a cure for it.

SMC Uhhuh. You mean the Parkinson's?

JB Yeah. They try various things and, but they haven't found anything to do it yet....I can get by. I'm in good shape compared to a lot of people.

SMC Yeah. But if you didn't have it at all it'd be even better.

JB Oh, yeah. It'd be heaven. [124]

Mr. Brown's desire for "a cure", for his Parkinson's disease was translated in the clinic records as follows:

> "PRESENTING PROBLEM: Mr. B. reports his main concern is his inability to care for himself independently. He attributes this to his Parkinson's Disease."

It is impossible to know if Mr. Brown ever told clinic staff that he had come to them hoping for "a cure". It is quite possible that he couched his desire in terms which were appropriate for the clinic setting and which, ultimately, were translated as his concern about his "inability to care for himself independently". The difference in the interpretation of Mr. Brown's reason for coming to the assessment clinic had significant implications for the clinic's formulation of recommendations in Mr. Brown's regard as well as his response to them.

In order to understand this final outcome of the assessment visit, however, it is necessary also to note that Mr. Brown's daughter - not Mr.Brown - was the one who initiated her father's referral to the assessment clinic. It is enlightening to compare Joan's explanation to

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[124] J.B., Interview # 2, P. 13

me of why she arranged for the assessment with Mr. Brown's account of why he went to the clinic.

> SMC How did it happen, or how did the decision get made to bring him to the Assessment Center?
>
> J Our next door neighbor is Tom X...an internist...And Tom was over here just chatting with us one day and I was really frustrated with the level of care Dad was getting and the kinds of answers we were getting. Very, very inadequate. And I said to Tom, you know, my Dad has fractured his hip and he's got this, this and this. Who could we see that might give us some answers on what he can anticipate, what we can anticipate for him and so on. So Tom told us about the ... Assessment Center and we called I guess the next day probably and set up an appointment and made arrangements...and I had some concerns about, is this Parkinson's or is it something else, you know, is it being treated accurately. Because you know the Parkinson's has not progressed like Parkinson's. Like what I've read about Parkinson's usually does....But the reason we, we, at that point we didn't know what is going to be possible for him....I think part of it was frustration with the nursing center at that point,.. just not being comfortable with that place and that placement. [125]

Mr. Brown's clinic record condensed Joan's reasons for bringing her father to the clinic as follows:

> "PATIENT PROFILE: 81 year old white male referred by family for recommendations regarding management of Parkinson's Disease and possible relocation to a more independent living situation. The patient is widowed and is currently residing in a nursing home in X." [126]

As we have seen in the previous chapters, Joan spoke eloquently of her struggle to balance her concern for Mr. Brown's safety with his desire

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[125] J. R., Interview # 1, p. 33

[126] J. B. Social History, p. 1

to be independent. [127] Neither the ambivalence she experienced nor the logistical difficulties of providing "long distance" care are evident in the following clinic entries:

> "SOCIAL RESOURCES: Low to moderate risk. The patient's wife has been deceased for two years and the patient's primary support is from his daughter and her husband. The patient also has many friends in the X area and a great deal of church interaction with church members."
>
> "Mrs. R. identifies her main stress in being the primary caregiver is the distance between X and X for her visiting. She would be able to see her father more often if he were living at Arborview (retirement center in town where Joan lives)." [128]

As we saw in previous chapters, Mr. Brown's desire for independence, his love of companionship, and his belief that difficulties were part of life and should be considered as challenges rather than insurmountable obstacles were themes which pervaded his reflections about himself and his life's circumstances. He was being highly consistent with these values when he came to the assessment clinic hoping for a cure for his Parkinson's disease. His refusal to submit to additional testing once it became clear that a cure was not possible can be viewed both as an expression of his independence and also of his belief in meeting difficulties with resourcefulness (coming to the clinic) but also accepting limitations pragmatically. Mr. Brown's refusal to accept the clinic's recommendation about living more independently was a surprise to clinic staff who thought he would be eager to leave the nursing home. They had interpreted his desire for independence accurately but had not

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[127] See pp. 114 - 118

[128] J. B. , Social History, p. 2

appreciated the extent of Mr. Brown's fear as a result of being alone when he fell or his propensity to formulate what he considered realistic adaptations to his limitations. The following excerpts indicate both Mr. Brown's fear and his acceptance of the nursing home environment as a reasonable accommodation to his condition.

JB I, we've looked at apartments.

SMC Hmhm.

JB And uh well, I didn't think it was adequate for me.

SMC Hmhm.

JB The place was a retirement home and it was real nice. () I don't feel steady enough. I get out of bed, dress myself, I can do that. (Talking about the nursing home) They come around. If I need help

SMC You can get it.

JB And in the nursing home you have a call system. If anything happens, somebody's right there.

SMC Hmhm. Hmhm.

JB What had happened when I broke my hip, I was staying alone at home and I got up, getting ready for bed and I went to turn the furnace down which I always did. And I fell there (), had trouble getting back to bed. I couldn't get off the floor. So we have a phone on a stand next to the bed and I got into the bed and got the phone down and called 911. And they came, the police came with them but the house was locked and I couldn't get up to unlock it and () came through the back door with an axe. Took the back door off the garage (laugh).

SMC Oh, gosh. It sounds like a really frightening experience.

JB It was...That's what can happen when you're on your own...

SMC Now it sounds like your family doesn't want you to be alone.

JB They don't want me to be alone.

SMC Yeah. How do you feel about it yourself?

JB Oh, (laugh) because of what happened, I'm kind of nervous about it.

SMC A little bit leery, huh. Yeah. Had it worried you at all before that?

JB I got to a point where I fell a couple of times. That worried me a little bit but nothing ever happened to me until the last time I fell.

SMC Yeah, and just that experience.

JB Yeah. I was right at home on the carpeted floor and look what happened.[129]

Determining the degree of congruence among the discrepant notions of Mr. Brown, Joan and the clinic staff about why Mr. Brown had come to be assessed was a complex undertaking. The differences that existed among Mr. Brown's reason for agreeing to come to the assessment clinic, Joan's reason for bringing him, and the clinic staff's understanding of why he had come led, understandably, to a difference in understanding of the effectiveness of the clinic visit. Since Mr. Brown had hoped for a cure for his Parkinson's, he did not find the clinic visit useful and ultimately refused to follow recommendations for further testing even though he did agree to see a neurologist for one visit. Joan's discomfort with the medical treatment Mr. Brown had been receiving was somewhat more congruent with the clinic's understanding that she wanted help with the management of his Parkinson's disease. Clinic recommendations included specific suggestions to Mr. Brown's physician for medical management and Joan felt that the clinic visit had met that aspect of her concern. She also had some concerns about her father continuing to live in a nursing home as he had since his discharge from the hospital after treatment for his fractured hip. She believed that

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[129] J.B., Interview # 1, P. 14

Mr. Brown was capable of a more independent life style. However she had also made the decision prior to contacting the clinic that she would support Mr. Brown in whatever decision he made about his living arrangement. Consequently, the clinic recommendation that Mr. Brown move to a more independent living situation was already a moot point for Joan.

However, Mr. Brown's fear of being alone if he should fall (which was his primary reason for remaining in the nursing home) was not documented in the clinic records or well understood by staff. This discrepancy in construction led to Mr. Brown's rejection of the clinic's recommendation for a more independent living arrangement. In this case and because of the failure of the clinic to provide a cure for his Parkinson's disease, there was no congruence between Mr. Brown's construction of his trouble and the clinic's assessment.

Mr. Hauser, Frances and Betty

As Mr. Hauser talked with me about his experience of the assessment clinic, it was clear that, from his perspective, the clinic not only did not hear his story but actually compounded his difficulties by recommending that he not drive and by being less than forthcoming with information about his condition.

> FH It's basic, a person's ability to drive. I mean, you lash out at anybody on most anything else but it doesn't hit home like it does to tell somebody, "You can't drive". I've, I've been practically locked up right here, for the last two months. It's an awkward position to be in to drive all your life and then all of a sudden somebody, without any reason, they didn't offer me any really acceptable reason for saying that

I can't drive.

SMC Have they offered you any reason?

FH No, I don't believe so. Kind of funny, even some of these things that they're a little secretive about apparently. Uh, they aren't forthcoming and above board if you want to say it that way.[130]

As we noted in earlier chapters, Mr. Hauser prided himself on his ability to control situations by mastering relevant information. He made a concerted effort to do this in the clinic setting, writing down unfamiliar medical terms and looking up their meaning after he got home. His memory problems - as well as the amount of information and the way it was dispensed in the clinic setting - mitigated against his ability to do this successfully. In this case, Mr. Hauser's frustration with his inability to process information successfully was a source of real frustration for him. This, in addition to the clinic's recommendation that he discontinue driving, made Mr. Hauser's experience in the assessment clinic a devastating attack on his sense of self as he grew older.

FH ...Oh for instance whether I had a stroke or not, I think that that was in the early questioning and so forth. And I don't think I had a straight answer on that. It might be, I might have had a slight stroke or something like that but nobody came up and said that I had a stroke... I forget where it came up but it came up a long ways back. Several thought that it could possibly be Parkinson's disease. I don't know anything about, I don't know anybody who had it that I can think of. I probably have though 'cause it isn't that uncommon. And I know it's, to my knowledge it's a very crippling disease and it comes to midlife, I mean it isn't just for real old folks or, but I don't know that for sure. And its the sort of thing that you wouldn't want to happen to you or anybody that you know, especially, I mean. And still as I remember it,

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[130] F.H., Interview # 3, p. 14

this came up in conversation and when I tried to ask about it kind of got brushed off. I didn't ()

SMC You weren't satisfied with, with

FH No, and there's several other things that were involved with difficulty in swallowing, now one is this esophagus and the larynx, there's a term dysphagia that I don't know much about, word regurgitate, and Parkinson's. They're all, I marked them on the same, on the same list where (laugh) probably not very much connection between the different terms.

SMC No, actually there is. Dysphagia means difficulty swallowing.

FH I think I looked that up in the dictionary.

SMC Did you?

FH I think I did, because that was my idea of it, but I didn't find out from the doctors. So these, I know they have the tendency to throw some terms at you but they figure he wouldn't know it anyway or something. I don't know whether I, I don't think I have an inferiority complex. In fact, I try to keep informed on things and I'll go to quite a little trouble to find out what different things mean and study up on them, but every once in a while you get tangled up in terms and you ask a doctor, preferably an MD, and I don't get very far, usually. Sometimes they're very cooperative but there's so many things that can come up that you kind of make a nuisance of yourself if you aren't careful.

SMC You think that asking them is somehow making you a nuisance?

FH ...The general overall picture is that they, they aren't very informative unless you pin them down. They figure that that's their role I guess. [131]

The following excerpt from the family conference in which Mr. Hauser and his daughters were informed by clinic staff of his medical condition indicates that the physician did indeed comment on several of the conditions Mr. Hauser mentioned in the preceding excerpt. It appears

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[131] F.H., Interview # 3, p. 17

obvious in the transcript that the information "exchange" is heavily one-sided. Mr. Hauser is being given a great deal of information in a short period of time. It seems relatively easy to understand that he may have had difficulty processing both the amount and type of information he was given in this exchange. In addition to the physician and Mr. Hauser, Frances and Betty, Elaine - a friend of Mr. Hauser's, and I (who was the clinic social worker at the time) attended the conference.

Dr. ...It's still a little foggy um, uh, in terms of Parkinson's but we'll talk some more about that. Um, and anyway,obviously when I saw him was concerned about the, you know, what I perceived to be a significant change in the, in how well you were functioning. You were obviously having a lot of difficulty getting around, more difficulty you know, with your memory and visibly looked like you had deteriorated a lot in a short time. So that was a major concern and uh, the incidents that you people had described of, uh, you know, the particular memory difficulty at times and at times the periodic confusion. I think one example that comes to mind is difficulty opening a door, uh, yeah. That's kind of a concern to us particularly when you need or when you live alone. So obviously we were very interested in trying to come up with some answers to explain why you had deteriorated so much in that short period. And at the time you were not terribly aware you know of some of the problems. When I interviewed you, you talked mostly about your arthritis and less about the difficulty getting around and the memory problems. The other problem at that time was the swallowing and uh, obviously of concern to us but, and that of course prompted the use of the Reglan and we had the xray that showed some esophageal changes, changes in the motion of your esophagus, uh, that would provide some explanation as to why you were having difficulty with the swallowing but nothing to suggest a tumor, malignancy or anything which I think is reassuring.

FH That's good. [132]

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[132] F.H., Family Conference, p. 13

In the following excerpt, taken from the same family conference, it is obvious that Mr. Hauser was trying to understand the information he was being given. He responds appreciatively to good news about his health but questions whether or not the lack of indication of a stroke on his latest cat scan meant that he had not had a stroke at any time in the past. Apparently the physician accepted Mr. Hauser's comment, "Oh, I see" as an indication that Mr. Hauser did in fact understand the information he was being given. Obviously, from Mr. Hauser's comments about the difficulty he had getting information, this was a false assumption. It is also fairly evident in this excerpt why Mr. Hauser would have been confused about whether or not he had Parkinson's disease.

Dr. On exam it was obvious that significant change had occurred. Wasn't terribly expressive, just wasn't moving around very much and that was the most noticeable change. The rest of the examination, examination of the heart, etcetera was okay, blood pressure was slightly elevated but otherwise okay. Um, neurological examination, I felt showed some early changes you know, uh, compatible with Parkinson's. And you know, I think we have a better explanation now as to why that happened. Um, but there was no as you compared one side with the other, there was no change in strength or sensation which might indicate another, or, a small stroke as an example. There was no evidence of that.

FH Good.

Dr. Um.

FH At any stage?

Dr. Well we know from your cat scan in the past, Mr. Hauser, that there's been some damage, that in the past you've probably had a small stroke.

FH Oh, I see.

Dr. You know, and I think that episode, uh, the time you fell in the snow bank, which I know you don't remember, but

FH No.

Dr. Everybody else does (laughter). Uh, and uh, then subsequently the discussion you had on the telephone with, was it your sister, which

B Yeah, with Auntie Ceil.

Dr. Right.

B We're going back now a ways.

Dr. Yeah, yeah, yeah. Couple of years ago when you were really having a hard time knowing where you were and what was going on but probably, we probably caught you at a time when you were having a small stroke. And the cat scan did show an area which would indicate there may have been some damage. Um, but that's not a major concern at this time. The rest of the exam, you had, I mean, tremendous difficulty getting out of a chair. Um, and you know, you had to rock a number of times and really use the arms before you could finally make it and that was quite a change from the previous exam and you had a tremor that was more pronounced and your arms were more rigid and uh, difficulty when you walked and difficulty turning. And those are all features that we see with Parkinson's. Um, now, Parkinson's is a problem that can occur, it primarily affects muscle tone and the abnormality is at the base of your brain. Now people acquire Parkinson's and we don't know why but then there's a group when given certain medications develop features of Parkinson's. And Reglan is one of the , you know, one of the medications. All the medicines that can cause that include drugs maybe like antidepressants or drugs that are used for, maj, what we call major tranquilizers...So, that kind of prompted my request then to Dr. X to see you and let me go over that consultation. Very extensive exam. Obviously at that time we were still concerned about the memory problem and the possibility of some dementing process that sometimes we see with Parkinson's does sometimes occur...

S.W. Were you going to ask something earlier, Mr. Hauser? You looked like you were about to say something.

FH Oh, I was a little more concerned about this Parkinson's disease because before we got into

Dr. Yeah.

FH Because not much has been said about it you know, up until probably recently.

Dr. Right.

FH Could have had a lot to do with what happened and what could have happened. Like uh, I think it's been mentioned once or twice before as kind of a second thought that maybe I'd had a stroke. Well, I didn't hear anything further on that. I thought that would have been something important because if you've had one stroke you're sort of waiting around for the next one aren't you?

Dr. In some instances that's true

FH I mean, is that

Dr. Yeah, yeah. But you're on, you've been placed on some medication that would lessen your chances of having a stroke.

FH Well, see I wasn't aware of that. I was doing some cogitating on my own there. (laughter)

Dr. Well, I think that's part of the memory problem because that's something we did cover the previous time you were here....We did discuss the stroke phenomenon the last time you were in here and talked about that and talked about why you were on the specific medicines you were on that would counteract, you know, or help prevent any reoccurrence but I just don't think you remember that well.

FH Well I know my memory is not there like it usually is.

Dr. Yeah, yeah. But that's okay. We'll come back to that again Mr. Hauser. Uh, anyway, basically uh, Dr. X. and again, agreed with, at the time of his exam that there were sure, some signs of an early Parkinson's. Worried about, you know, the medication.[133]

This rather lengthy excerpt also illustrates the style of discourse which occurred in the clinic setting. The family conference was the time when patients and families were given the summary of all of the clinic findings. It was also intended as a forum for questions to be asked and for clinic staff to ascertain that patients and families were, in fact, understanding the information they were being given. In Mr.

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[133] F.H., Family Conference, p. 20

Hauser's case, the information was indeed dispensed but given the overwhelming amount of information, the unfamiliar terminology, and the anxiety he was experiencing at that time about the results of the assessment it is easy to understand why he felt intimidated by his inability to keep control of the information.

For Mr. Hauser's daughters, on the other hand, the clinic provided an explanation for their father's behavior which had been a source of concern for a number of months. While they remained concerned about Mr. Hauser's condition, Frances and Betty were relieved that they had an explanation of the source of their father's confusion and some idea of what to expect in the future. They were also relieved that the clinic had recommended that Mr. Hauser stop driving. It resolved an issue for them which they had felt powerless to confront effectively. In recounting her attempt to help Mr. Hauser deal with his frustration about the clinic's recommendation that he stop driving, Frances recalled the family's attempts to dissuade him from driving in the past.

F I know there are times when he'll say, "They didn't make it real clear that I was never to drive again. And then within five minutes he's come on around and said, "Well, they were real rude to tell me I could never drive again." You know, did they have to be quite that blunt about it (laughter). I said, Dad I think they had to be that blunt for you to know that that is what they meant, that you could never drive again because five minutes ago you weren't real sure that that was what they meant. ... And I said, really Dad, it didn't come on all of a sudden. It was quite a while ago that Betty and I were becoming very concerned with whether you could continue driving and how we would approach you on it. "Oh." I said, yeah, even before you were real sick because he thought he'd get better. And I said yeah, but even before you weren't, you were getting to the point where you probably shouldn't be driving...I mean I remember him being very careful when his Dad pulled that and I think, I think Auntie helped us on that because I

> remember we were concerned about his driving or always acted like we'd prefer to drive. She said, well don't you remember how Poppa used to drive. And he, she said you know he never got as old as we are and we were concerned about the way he drove. Well, Dad hadn't looked at it quite that way...It helped Dad to realize that, talking to him that way. And she could do it where it was hard for us to do it. There was a while there when I would say that I was concerned about his driving and he says, well you know, you're getting along in years too and maybe you ought to, you ought to be a little more careful or something.[134]

In Mr. Hauser's case, as in Mr. Brown's, a higher degree of congruity existed between the family's and the clinic's construction of the reason that assessment was needed. In both cases, the views of the older participant, the "object" of the assessment were markedly discrepant from those of the clinic. There was a marked difference between Mr. Hauser's and Mr. Brown's responses to the clinic recommendations, however. Mr. Brown clearly rejected the recommendations he did not agree with and his rejection was synonymous with not carrying them out.

It was equally clear that Mr. Hauser rejected the clinic's recommendation in his regard. However, Mr. Hauser did not refuse to carry them out. He capitulated to the request that he not drive although he continued to complain bitterly about the unfairness of the recommendation. In Mr. Hauser's case also the clinic looked much more obviously to his daughters rather than Mr. Hauser for leadership in carrying out their recommendations. Mr. Hauser's memory problems and episodes of confusion made him in the clinic's eyes, and, quite possibly in his own, incapable of making the necessary decisions regarding his

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[134] F & B.H., Interview # 2, p. 14

care.

THE HAMILTONS

As is true of all of the older participants in this study, Mrs. Hamilton's visit to the assessment clinic was arranged by one of her children. Her son, Jim, contacted the clinic after being told about it by a church member to whom he had confided his concerns about the diagnosis of Alzheimer's disease Mrs. Hamilton had been given by a family physician. As noted in previous chapters, during my conversations with her Mrs. Hamilton was aware, but not unduly concerned, about her problems with memory loss and confusion. Her clinic records, however, indicate that at the time Mrs. Hamilton was seen in the clinic, this was a major concern of hers.

> PRESENTING PROBLEM: The patient identified her main concern as her confusion and memory loss. Her son, Jim also notes her short-term memory loss and confusion, and her increased weight and arthritis as his main concerns.[135]

Mrs. Hamilton appeared to have little understanding of the purpose of her visit to the clinic when I asked her about it during our interviews. In her view she went because she was having difficulty with her legs and the clinic visit was largely an unremarkable event.

> SMC Uh, I don't know if you'll remember this or not. Sometimes if your memory comes and goes you may not, but do you remember being over at (the hospital)? At that assessment center where you would have been seen by a doctor and different people?

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[135] V.H., History and Physical, p. 1

VH Well, I know I was in a place like that.

SMC Yeah, yeah.

VH And they did check up on me physically.

SMC Right.
VH Because I was having trouble with my legs.

SMC Yeah, ok.

VH Yeah, I remember going there. I don't remember the details but I remember going.

SMC I was just curious what that was like for you.

VH Just another physical examination. You get to be our age, you don't think much about them.[136]

In contrast to Mrs. Hamilton's view that she went to the clinic because she was having trouble with her legs, clinic records indicate that the staff concentrated heavily on Mrs. Hamilton's hypothyroidism and only peripherally upon relieving her arthritis. In the documentation of Mrs. Hamilton's history and physical examination, there are four problems listed in order of importance with decreasing amounts of documentation attached to each successive one. The four are: 1) Cognitive impairment; 2) Depression; 3) Weight gain and 4) Mobility disturbance. "Mobility disturbance," Mrs. Hamilton's "trouble with (her) legs," is identified as follows: "The patient has been complaining of knee pain and knee instability and identifies pain in her knees."

Although clinic records noted Mrs. Hamilton's love of activity and her desire to be with people, they mention this as a descriptive characteristic and do not indicate in any way that decreased activity might have been a concern to her. The physician who saw her notes in

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136 V. H., Interview # 1, p. 23

his history and physical that Mrs. Hamilton's son "says that she and her husband were very active in various volunteer activities and did many things together." The record of the home visit mentions Mrs. Hamilton's previous activity and her involvement with other people but in the context of her tendency at the time of the visit to repeat herself. "Repeated self several times related to statements of previous lifestyle. Very people oriented - very active." Her involvement with her family and the importance she attached to serving others is referred to in this sentence: "After her marriage, Mrs. H. was a housewife and mother who was actively involved as a volunteer with civic groups and the Presbyterian Church."

Mrs. Hamilton's son, Jim, was most concerned about his mother's memory problems and increasing confusion. As a result he was extremely pleased with the outcome of his mother's visit to the assessment clinic. He was relieved to know that her memory problems were caused, at least in part, by the treatable condition of hypothyroidism rather than by Alzheimer's disease. In Jim's opinion, the clinic was a "saving grace" which was extremely helpful to his mother and to him. Jim's concern about his mother's confusion, which precipitated his call to the clinic, was also the clinic's major focus of attention.

Although in this case both Mrs. Hamilton and Jim were pleased with the outcome of the assessment clinic, their satisfaction resulted from two different definitions of what constituted "trouble". Jim was most immediately concerned about Mrs. Hamilton's confusion and progressively deteriorating memory. While he was concerned also about the pain she was experiencing as a result of her arthritis, this was a less urgent

concern at the time of the clinic visit. Jim was very pleased with the clinic's intervention which diagnosed and successfully treated his mother's confusion. He was also pleased that the medication prescribed at the clinic for her arthritis was effective in making Mrs. Hamilton more comfortable and increasing her mobility.

As we saw in the preceding chapter, "trouble" for Mrs. Hamilton consisted of being stationary, of not being able to be as active and mobile as she had been in the past. Mrs. Hamilton went to the clinic because she "had trouble with her legs" and she was pleased that they were less painful to her now. As was the case with Mr. Brown and Mr. Hauser, the clinic focus and outcome was fairly congruent with the expectations of the adult child (Jim). Mrs. Hamilton's expressed interest in keeping active was noted but there is no indication in clinic records that staff realized the significance to her of prescribing a medication that was effective in relieving the pain of her arthritis. In the clinic's construction of Mrs. Hamilton's "trouble", this appeared to be a more peripheral - or at least more simply handled - concern, certainly, than her severe hypothyroidism. The different ideas which Mrs. Hamilton and the clinic staff had about what was happening in the clinic did not interfere with Mrs. Hamilton's satisfaction with the results of the clinic visit. Even though she did not remember the details of the visit, and to all appearances, did not understand the reason her son wanted her to be evaluated there, she was grateful that her legs felt better.

THE VANDYKES

As noted in previous chapters, there were significant discrepancies between Mrs. VanDyke's construction of age and trouble and the constructions of her son and daughter-in-law. It is clear from the clinic records that these discrepancies were also very obvious to the clinic staff. The Social History section of Mrs. VanDyke's record reports the conflict in views which existed between Mrs. VanDyke and her family.

> "The patient describes being very active in the historical society and currently needing to write her memoirs and write the history of the county. Her sons report that for her Masters dissertation she did write the history of X County and that this was approximately ten years ago. She has written nothing since that time nor anything prior. They state that she is currently exaggerating her association with the historical museum and has little to no contact with them....Mrs. V. reports enjoying [her] apartment very much and having made the acquaintance of a woman across the hall. She also reports being very active with numerous phone calls back and forth from with her friends, and also noted two people in the X area that she has had contact with. Her sons doubt that she has had any contact with anyone in the X area and that the phone calls from the historical society and other people in X are not as frequent as she states. They report that the patient tends to describe her activity of eight to ten years ago as current." [137]

The discrepancies between Mrs. VanDyke's description of her own situation and her family's perception of it are also reflected in the physician's notes in her clinic record.

> "Decreased interest in activities and memory loss. From the patient's standpoint she does not complain of either of these and feels that her memory is quite good for someone her age (86). The family members,

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[137] E.V., Social History, p. 2

> particularly the daughter-in-law, report some confusion about days and having to use a calendar to keep track of appointments, which she will occasionally miss....There is some difference about how much contact she has had continued by phone with people in X. She apparently indicates that this is fairly frequent, whereas the children believe that it is not a very frequent event or does not occur at all."

Faced with these discrepancies in patient and family accounts, the clinic staff refrained from making any judgments regarding the accuracy of either version of the story. In making their recommendations they based their decisions on Mrs. VanDyke's performance on the mental status examination and on their observations of her in the clinic setting and on a home visit made by the clinic nurse. Based on these criteria, staff found that Mrs. VanDyke was competent to live independently and to make decisions about her own life. The assessment portion of Mrs. VanDyke' history and physical exam reads, in part, as follows:

> ASSESSMENT: 1. Possible memory loss and decreased social interaction. There is no real indication this woman has any significant cognitive deficit. She may have some benign senile forgetfulness, but if she does it is pretty minimal. The lack of interaction may in part relate to having moved from X to X, where she has fewer contacts. How significant a problem this is is not clear. She seems to be getting along reasonably well in her current living circumstance, although in the future she may need to have some more help. She does not appear to need it at the moment. [138]

In similar fashion, the social history portion of Mrs. VanDyke's clinic record contains the following assessment:

> ASSESSMENT: Patient presented with a very neat and well cared for appearance. Her speech was appropriate. Her affect and mood were not impaired, neither was her

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[138] E.V., History and Physical, p. 2

> memory. She scored 2/15 on the Geriatric Depression Scale. She was alert and oriented. She did monopolize the conversation and was very descriptive in any answer, however, her answers were appropriate to the questions asked. Comparing interviews with patient and family, she did tend to present herself as very active, involved, and adjusting well to her move to X and making social contacts. Her sons report that this would be more descriptive of her lifestyle eight to ten years ago.[139]

One of the themes which was evident in my interviews of Mrs. VanDyke was her pride in her intellectual abilities. As she spoke of her experience in the assessment clinic, Mrs. VanDyke referred to the visit in terms of her proficiency in answering questions posed by the clinic staff. She prided herself on her performance and had little else to say about the experience. If she understood her children's reasons for initiating the assessment clinic visit, Mrs. VanDyke gave no indication of that to me. Her response to clinic recommendations was consistent with her construction of her situation. The clinic's assessment confirmed Mrs. VanDyke's ability to live independently. Since this had never been a question for Mrs. VanDyke, she made no comment about it. On the other hand, the recommendations for participation in volunteer or social activities were rejected by Mrs. VanDyke on the basis of what she viewed as an already busy schedule.

On the other hand, Mrs. VanDyke's son and daughter-in-law were frustrated by the clinic's recommendations and believed that Mrs. VanDyke had succeeded in deceiving the clinic about her competency. They described how Mrs. VanDyke went shopping prior to the home visit made by the clinic nurse so that her cupboards would be stocked with

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[139] E.V., Social History, p. 1

appropriate foods. To her children, Mrs. VanDyke's referral to the clinic was a waste of time.

MV Yeah. We had that family conference thing and oh, it was just a farce. It was a charade. She was playing them like you can't imagine

SMC You mean,that everything was fine

MV Oh, yeah, and then she said that, they started to make some suggestions on things, she said I haven't got time for that she says I have people that I meet with every day and engagements, you know, just as if she was just one big mad social whirl

SMC And actually

MV Anything ... but that. [140]

DV One of the things, like she knew you know that the social worker from the geriatric center was going to come out so she went to the grocery store and she bought all the foods that she knew, she has a good mind () and had it on her shelves so that when they opened the cupboard, she knew they were going to do that ()

SMC She's sharp

DV Oh, she's sharp. She still has a slice of bread and a glass of milk for supper but ()....It went down on her record that her cupboards were well stocked with the proper foods. And they're still out there if you want to look at her cupboards (laugh). [141]

The tenacity with which all participants adhered to their constructions of "trouble" in this case was illustrated in the response of some of the clinic staff when I asked them about the possibility that Mrs. VanDyke may have stocked her food cupboards for the sole purpose of "passing" her clinic evaluation. The staff did not appear surprised by this and

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[140] M & D.V., Interview # 1, p. 32

[141] M. & D. V., Interview # 1, p. 36

the social worker used this possibility - if indeed it were accurate - as further evidence that Mrs. VanDyke was indeed capable of managing her life in such a way as to meet her own needs and "outwit" those who might attempt to find her incapable of living independently.

> S.W. It's interesting that she would do that. And that shows how intact she is really that she could go out and stock her grocery shelves and know what people are going to be looking for.[142]

The clinic's interactions with the VanDyke family demonstrate with remarkable clarity the power of each individual's construction to resist the force of opposing constructions. Mrs. VanDyke, her son and daughter-in-law, and the clinic staff each finished the assessment process adhering to their original views of what Mrs. VanDyke's situation was.

MRS. THOMPSON AND GRACE

Mrs. Thompson came to the assessment clinic at the urging of her daughter and her physician. She understood their insistence that she be evaluated in the clinic as their desire that she have available to her the most complete resources in order to foster her rehabilitation. When she realized that the clinic was not only not offering her any information she did not already have but, was, in fact, threatening her fiercely held independence by recommending that she take a drivers' test before resuming her driving, Mrs. Thompson was incensed and bitterly regretted her agreement to participate in the assessment.

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[142] Interview with GAC nurse and social worker, P. 12

ET If I would have done this, if we heard about this (clinic), um all the things that I went through, I went through all these (physical therapy evaluation activities). You see with my therapist when I came up here. And that's why it didn't help me with, 'cause I knew all those things and I was just doing things over again. Where it helps people who heard about it and they never had a therapist to show them all these things. And um, that's why, it was like you did them before and why go through it again when you have to pay all this money out. That's why I didn't want it. And Grace said, Oh, it'll help. Don't you want to know? They can help you and get more help for you.

SMC That's why, and that's why you thought you were

ET That's why I would do it. Otherwise I wouldn't have done it. And I didn't see where it helped at all, except for the doctor of course with the, but I could have went to the other doctor and had all that stuff done, you know. So I felt that it didn't help me. Where like, if someone was just getting over a stroke and they had to do all, 'cause I had to do all this at Grace's you see, the therapist all the time. And I thought, Oh, here I went through all this and it didn't help me. It made more of a problem.

SMC It made more of a problem...'Cause you thought you were going, basically you went because Grace wanted you to go?

ET Yea, and the doctor said, well you know, you can, they can give you more help and you deserve that, don't you think? And I said, oh yea, if they can help me. But of course you don't know that until you go through it. And I thought he shouldn't have said that either if he, uh, knew more about it. I don't know if he knew that much about it either. [143]

The clinic records indicate that the primary concern of Mrs. Thompson's daughter, Grace, in bringing her mother to the assessment clinic was a concern for Mrs. Thompson's emotional stability. In Grace's view, Mrs. Thompson was becoming increasingly depressed over the limitations caused by her stroke as well as the other stresses she had been

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[143] E. T., Interview # 3, p. 38

experiencing because of the poor state of her husband's health. Grace was emphatic in her belief that Mrs. Thompson's behavior was becoming increasingly difficult to handle.

The discrepancy in the reasons which Mrs. Thompson and Grace had for coming to the assessment clinic are clearly indicated in Mrs. Thompson's clinic records.

> Mrs. T. stated that her daughter had thought the Assessment Center could help her to function better and that was her primary reason for coming today. She states that she would "do anything to make things easier"...Grace (Mrs. Thompson's daughter) states that her primary concern is her mother's emotional stability. She states that her mother is extremely frustrated since her stroke.[144]

The reason Mrs. Thompson had for coming to the clinic was consistent with her desire to regain as full a range of independence as was possible for her. She had fought consistently from the time of her stroke to regain her ability to walk and to live independently. The following excerpt from the case conference where Mrs. Thompson's assessment results were discussed reflect the staff's awareness of her determination as a pivotal factor in her recovery from her stroke.

> Dr. ...She had a very dense left hemiplegia and then had some gradual return of function in her left leg. Um, and she worked very hard to do, to get that going again. She had some facial involvement at that time as well with slurred speech, according to the uh. Apparently the family was given a rather poor prognosis of her recovering significantly because of the extensive degree of damage but she was bound and

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[144] E.T., Social History, p. 1

determined so she did. [145]

The clinic's recommendation that Mrs. Thompson be retested before she resume driving was a tremendous blow to her confidence in her abilities. As was the clinic's standard procedure, the recommendation was not delivered until the time of the family conference which was held several weeks after Mrs. Thompson's evaluation. During the waiting period, Mrs. Thompson was agitated about what the decision was going to be and came to regret having agreed to attend the clinic.

> SMC What's going to happen if (the clinic) recommendation says that you would be okay to drive?
>
> ET Well, then I'll be able to drive....
>
> SMC Suppose we say you can't?
>
> ET Then they (her children) won't let me. They'll put up a big fight. And I will put up a big fight and there will be a family feud. Then I'd have to take a driver's test then I guess...I don't know what they'll put me through but they'll put me through more. So I don't know. I says if that's the case I'm sorry I started this. [146]

The clinic staff was aware of the fact that their recommendation about Mrs. Thompson's driving was going to be difficult for her. Interestingly, staff members were ambivalent about suggesting that Mrs. Thompson needed to have her ability to drive evaluated. While agreeing in the staff conference that this was a step that needed to be taken, some staff privately spoke of their reservations about the recommendations and their hope that Mrs. Thompson would pass the test

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[145] E.T., Case Conference, p. 5

[146] E. T. , Interview # 5, p. 22

and resume driving.

> Dr. She's champing at the bit now because of some restrictions that have been placed on her particularly the driving concern uh, because that would interfere with her degree of independence. Uh, whether a younger person with a stroke would have been, whether it would have been recommended that that person not drive like it was for this older woman I don't know. I had some real reservations about pushing for her not to drive.[147]

Neither Mrs. Thompson nor Grace were pleased with the clinic's recommendation that Mrs. Thompson's driving be re-tested. Their displeasure stemmed from their constructions of what Mrs. Thompson's trouble was. Mrs. Thompson herself was desperately trying to maintain and increase her independence. Not being able to drive until she had passed a road test was both a delay in her progress and, more importantly, a blow to her pride in her own abilities.

On the other hand, Grace was convinced that her mother should not drive again. She was angry that the clinic did not recommend that Mrs. Thompson never resume driving and considered the recommendation that her driving be re-evaluated as "passing the buck".

As did the other older participants in this study, Mrs. Thompson retained her own construction of her situation and did not agree with the clinic's recommendations either that she take a driver's test or that she begin a counseling program. As had Mr. Brown and Mrs. VanDyke, Mrs. Thompson expressed her rejection of the recommendation that she begin counseling by an outright refusal to participate in such a

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[147] T.B., Interview # 1, p. 8

program. Rather than refuse outright to follow the recommendation that her driving be re-evaluated before she resume driving, however, Mrs. Thompson compromised. She agreed to appear for a driver's test but prior to taking it she confided to me that she had begun to drive again for the first time since her stroke.

ET I'm not driving yet. Well, I'm driving but the kids don't know it (laugh)...It's, I'm taking a road test the 22nd.

SMC Oh, it is scheduled? 'Cause

ET Oh, yea.

SMC The last I knew it hadn't been.

ET Oh it was, we were supposed to go the, earlier than that but, um, but I looked at my insurance and here that had, it was lapsed ...And I said I couldn't drive the car. Er, my daughter, Jean, she didn't want to drive it either. So we had to postpone it till the 22nd.

SMC But it is scheduled?

ET Yea, right. I'm going through with the darn thing. And with this kind of weather coming up I knew it would happen. But, like I say, when it's nice I've been driving. They don't know it but, running a few errands here and there...what have you. And they think I'm just going around the parking lot. [148]

Grace's response to the clinic recommendation about her mother's driving was total rejection. She made her objections known and then withdrew completely from participation in arranging her Mrs. Thompson's driving test.

SMC Will she drive again, do you think?

G That's another issue... I don't even want to deal with it. I absolutely don't. I can't live with it...So if

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[148] E.T., Interview # 4, p. 14

> the state passes her, I couldn't even, I could, I could not. I oppose it totally. I took her practice driving in the parking lot and it scared me to death. And I've already said I oppose it. My sister... wanted to take her for the drivers' test. That's fine, then that's up to her. I said what I had to say....If the State...passes her I guess there's nothing more that I can do. but I have said what I had to say and I have, in my power, tried to prevent that. [149]

Both Mrs. Thompson and Grace interpreted their visit to the assessment clinic in the context of themes that permeated their life stories. Mrs. Thompson thought she was coming to the assessment clinic in order to receive suggestions to increase her level of independence as she recovered from her stroke. She was frustrated and disappointed when the clinic offered the same suggestions which she had already received from the physical therapist who had been working with her at home. In addition, Mrs. Thompson's drive to be independent was severely, although temporarily, undermined by the clinic's recommendation that her driving ability be evaluated. Any questioning of her abilities would probably have been disturbing to a woman as determined as Mrs. Thompson to prove her independence. The fact that her ability to drive, which was a pivotal aspect of her independence, was being questioned only compounded the difficulty.

The difficulties Grace had had with her mother over issues of control and autonomy were also highlighted by their visit to the clinic. Grace's concern about her mother's emotional state and her concern that Mrs. Thompson was no longer able to drive safely touched on the central question in their relationship - who decides? Mrs. Thompson believed

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[149] G.E., Interview # 3, p. 16

that the clinic was "siding" with her daughter when they recommended she have a driver's test; Grace believed the clinic "passed the buck" by not recommending that Mrs. Thompson stop driving completely. Neither were satisfied with the clinic's interventions but both interpreted them in the light of their own constructions of what constituted Mrs. Thompson's "trouble".

THE CLINIC STAFF'S VIEW OF THE ASSESSMENT PROCESS

As noted in previous chapters, older participants and their children articulated their constructions of age and trouble in large part through the use of richly detailed and uniquely articulated "life stories." In contrast, clinic staff used a highly standardized format to record the information they received from patients and their families. In addition, the interviews with clinic staff revealed that they spoke of older participants and their families in similarly standardized categories. The interviews revealed both distance from, and highly focused articulation with, the phenomenon of troubled aging which was distinctively different from the immediacy and pervasiveness of other participants' involvement with the process.

The difference in the staff's perspective from that of the other participants is understandable both because of the distance from the phenomenon of the individual participant's experience of aging as well as because of the specificity of focus within which clinic staff functioned. For older participants, the experience of their own aging was a pervasive but largely unconscious aspect of their being. For their children, the phenomenon of their parent's aging was intimately

witnessed over time and, as we have seen, often a profoundly emotionally charged experience. For clinic staff, however, the experience of the older participants' aging was viewed through the filter of their particular professional focus. Since this focus involved evaluating the "normalcy" of the older participant's performance at a particular point in time according to established criteria, the staff's experience was necessarily both more specific and more limited in time than that of either the older individuals or their children.

In addition to the specificity of their focus, staff members were "middle aged" and for them the experience of becoming "old" was not -and could not be - an experiential reality. Their understanding of older people was based upon intensive study of the phenomenon of aging and upon years of experience as health professionals working with older people. This wide range of knowledge and experience resulted in an expertise in dealing with components of the aging process, an expertise which was characterized by sensitivity to the potential needs of older patients but also by the distance born out of years of highly focused and often short term relationships with many older individuals.

The ways in which staff members constructed the meaning of geriatric assessment depended heavily upon their understanding of their professional roles. Staff members believed that providing geriatric assessment to patients accepted into the clinic was both a therapeutic intervention for individual older people and their families as well as a demonstration to the health care community of providing competent and compassionate health care for older adults. They viewed the older people who came to the clinic as representative of a particular type of

older adult,the "frail elderly". Staff members believed that they were in the forefront of clinical practice in providing the service of geriatric assessment and this belief lent an aura of commitment and zeal to their practice.

> NURSE The other thing for me as a clinician and as a scholar is the challenges in assessing and interviewing to help older people are just so exciting and stimulating. I mean to me the field of gerontology and geriatrics needs the best and the brightest people because the problems are so intriguing, they're so complex, they're so challenging that it takes an excellent diagnostician, an excellent clinician to really figure things out and to help and to me that part of it is very exciting...When I first started there were so few advocates for the elderly at least that were known and that any time a person, in my thinking, had an opportunity to do something that made a difference or to speak up on behalf of the older population, someone who can be articulate and can see what needs to be done then it's almost that person's mission to do that.[150]

The staff's belief in the value of geriatric assessment is shared by many in the health care field (Williams, 1983; Rubenstein, 1983; Blumenfield et al., 1982). Geriatric assessment units are seen as valuable in preventing unnecessary hospitalizations and premature placement of older people in nursing homes as well as encouraging older people to maintain maximum levels of independence and providing direction and support to families caring for older members. (Williams et al., 1982; Rubenstein et al, 1984; Lefton et al., 1983).

Members of the clinic staff believed that the process of evaluation they

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[150] E. H., Interview # 1, p. 18

offered to older people and their families was therapeutic. They emphasized the importance they attached to listening to older patients and families as a means of validating the experience of these patients and helping them to clarify the nature of their difficulties.

> NURSE: Just the pieces that are concomitant parts of the assessment, you're listening, you're reacting to what's being said, just that whole caring and interest process that goes with assessment I think is a very significant intervention. The home visit, the experience that I had doing the home visits, was the piece that really set the stage for the caregivers and the patients to know that this was a place that was really going to listen and that really validated what was being said. And the majority of caregivers would say this is the first time anybody ever asked us this, this is the first time anybody took the time to find this out.[151]

Staff were aware that the process of being evaluated was a difficult, and often frightening experience for older people and their families.

> SOCIAL WORKER: It's very frightening...I think that that fear, that anxiety, is what patients and families, certainly the ones that are a little bit more cognitively intact...We all have anxiety when we go to the doctor about, you know, what are they going to tell us we have. It's more pronounced in some than in others. There's that and also, for others, they're looking at what changes and the larger picture of what changes this diagnosis or whatever other conditions, or what it's going to mean in their lives. What is that going to mean, how it's going to affect their future and that has great significance for people I think.[152]

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[151] E. H., Interview # 2, p. 13

[152] S. W., Interview # 1, p. 20

At the same time that they acknowledged the stress that patients and families were under when they came to the clinic, staff believed that their ability to listen "objectively" to the stories these people told them was a critical aspect of their ability to help. In the following excerpt, the clinic psychiatrist explains his views on the staff's objectivity.

> P. Now where we come into this as health professionals I think we do have more objectivity even though, as I said, we come in bringing our own bags of experience. I think that to this situation we are more objective because we don't have that much of an involvement...We are more objective I think than the family who, which can have tremendous emotions involved in the situation and the stress of the situation. I'm talking about the real stress for the person, say the caregiver, nights that they cannot sleep at all because of the old person walking around and not sleeping. I mean the real stress, the pressure of making a decision and so on only may probably accentuate or, the old conflicts or the old problems. Make them more vivid and bring them back with more, with more intensity so that they interfere with the final decision.[153]

Clinic staff expended a good deal of effort in remaining "objective" when relating to patients and families. They experimented with multiple forms of gathering information from patients and with record keeping which would assure that they were collecting relevant information which was useful in developing recommendations for patients and their families. Their experience with large numbers of older people who were experiencing difficulties associated with the aging process, as well as their familiarity with research in geriatric medicine and gerontology, led the clinic staff to develop standardized methods of assessment. Staff believed that these methods, which included gathering

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[153] W. P., Interview # 1, p. 23

information according to uniform categories, were most likely to provide them with the information they needed to diagnose the causes of problems the older participants were experiencing and to recommend approaches to their solution. By applying the same procedures of assessment to each patient, staff sought to provide each patient and family with as objective and comprehensive an evaluation as possible. At the same time they tried to recognize the uniqueness of each older person and family as they participated in the assessment process. Their attempts to individualize patients however, did not diminish the overwhelming power which the categories they had established exercised in the clinic's construction of older participants' old age and trouble. The power of these categories was evident in the uniformity of style of patients records which reflected the staff's desire to record, effectively and efficiently, the problems for which the older participants were referred to the clinic and the results of the clinic staff's assessments. The style of the records had the effect of blurring for staff the distinctiveness of their experience of individual patients. The difficulty remembering individual patients and the impossibility of identifying them from the information contained in their charts led the clinic staff eventually to institute a policy of taking a picture of each patient at the time they first came to the clinic.

DISCUSSION

The impact of the assessment process on the participants in this study varied widely. Older people, adult children, and clinic staff had significantly different perceptions of the purpose of the clinic as well as very different views of the clinic's effect.

To all appearances, Mrs. Hamilton and Mrs. VanDyke were largely unaffected by their participation. Neither woman accepted the fundamental message about the clinic's purpose, that it was designed to evaluate the performance of old people. As we have seen, Mrs. Hamilton thought she went to the clinic because she was having trouble with her legs and she remembered little of her visits there. Mrs. VanDyke concentrated on her ability to answer the clinic staff's questions accurately and quickly and spoke of her pride in her performance in much the same way as she spoke of her academic achievements.

For the rest of the older people, however, the clinic's impact was less benign. Mrs. Thompson was profoundly upset both by the fact that she was being evaluated and by the fact that her competency to drive was called into question. Some of the evaluation procedures made her feel "like a child again" and she resented what she saw as the clinic's agreement with her daughter that her ability to drive was questionable. Mrs. Thompson's negative feelings about the assessment process were compounded by the fact that she was not aware of the clinic's function when she agreed to participate. She went because she believed the clinic would offer suggestions which would help her regain her independence. Instead she felt that the process undermined her self-confidence and added to her struggle for independence.

Of all of the participants, Mr. Hauser was perhaps most profoundly affected by the process of geriatric assessment. To a greater degree than the other older people, he emerged from the clinic having been named as a member of the troubled aged. His memory deficits and confusion, as we have seen, were pointed out to him in the presence of family and friends and he was asked to surrender his driver's license

because he was not competent to drive safely. While Mr. Hauser disagreed vehemently with the clinic's assessment of his driving ability, he did surrender his license. Although he had resisted his daughter's warnings about his driving in the past, the power of the clinic's authority expressed in the public forum of the family conference was apparently too great a force for him to resist.

Although Mr. Brown was not as drastically affected by the clinic as Mrs. Thompson or Mr. Hauser, the process confronted him once again with the fact that his disease was incurable. Since his primary reason for agreeing to participate in the clinic was to find a cure for his Parkinson's disease, he also did not relate to the clinic's purpose of geriatric assessment. Because of this and his failure to think of himself as old, he did not appear affected by the clinic's evaluation of his "oldness." However, he was deeply disappointed that the clinic was unable to cure his Parkinson's. After thirty years of looking for a remedy, he was still willing to try again and when his efforts were unsuccessful he was profoundly disappointed.

With the exception of Mrs. VanDyke's son and daughter-in-law, the adult children who participated in this study were in general agreement that engaging in the process of having their parents assessed was a valuable experience. In all cases the children were the ones who contacted the clinic and made arrangements for their parents' evaluations. Some families regarded the clinic as an expert resource to help them determine what was wrong with their parents and to recommend what, if anything, they should do. As we have seen, the children of Mr. Brown, Mrs. Hamilton, and Mr. Hauser were troubled by what they regarded as the

confusing, contradictory or inadequate health care which their parents had been receiving. Since their construction of their parents' trouble involved confusion about what was happening, the significance of the assessment clinic as an expert resource was particularly strong. Since these families approached the clinic staff as a team of experts, they tended to regard the diagnosis offered by clinic staff at the conclusion of the assessment process as definitive.

Other participant families came to the assessment clinic with a fairly well established construction of what was wrong with their parent. In these instances, when the clinic's diagnosis differed from the family's, the family adhered to their construction of the problem. For example, prior to bringing her to the clinic, Mrs. VanDyke's son and daughter-in-law had been told by a physician that Mrs. VanDyke showed all the symptoms of "clever senility". To some extent, Mrs. VanDyke's family had used this explanation as a framework within which to understand her changed behavior. When the clinic diagnosed Mrs. VanDyke as being "cognitively intact", her family refused to accept this construction and were exasperated because, in their view, Mrs. VanDyke had been able to deceive the clinic staff about her mental competence.

All participant families, whether or not they had a clear construction of what was wrong with their parent, appeared to have some notion of what needed to happen. In some instances this construction was very definite. For example, Mrs. Thompson's daughter was convinced that her mother's driving ability had been irrevocably damaged by her stroke and that she should never drive again. When the clinic recommended that Mrs. Thompson take a driver's test before she resumed driving, Grace

refused to participate in helping her to do this and withdrew from any further involvement with the driving issue. Other families were less definitive but were leaning toward a particular course of action. Mr. Brown's daughter and son-in-law had determined that any decision regarding Mr. Brown's future would be up to him to decide. While they themselves favored the idea that he move from the nursing home into a supervised apartment situation, which is what the clinic staff recommended, they did not try to dissuade Mr. Brown from his decision to remain in the nursing home.

In contrast to the highly individualized experiences of the geriatric assessment process expressed by older participants and their children, clinic staff spoke more broadly of their commitment to caring for the health of older people and their families and saw the process of geriatric assessment as a valuable expression of that caring. Staff expressed a belief that many of the patients and families coming to the clinic were stressed and apprehensive about the clinic's procedures and eventual findings. They were aware that patients and their families often had different perceptions of the nature and extent of trouble in the older person's life and that the clinic's recommendations had the potential of being a source of conflict to the family. However, they understood their role to be the evaluation of the older patient's physical, emotional, mental, and social condition by objective criteria and the formulation of recommendations for continued treatment based on their assessment. If their evaluation conflicted with that of the older person or the family, they saw the conflict in most instances as an understandable result of the patient's or family's difficulty in facing the effects of the aging process.

The results of the visits by older participants and their children to the assessment clinic resulted, in all cases, in a confrontation between the participants' constructions of what constituted trouble in their lives with the clinic's construction expressed in diagnoses and recommendations. The confrontation varied across participants but in every case the constructions of trouble held by participants prior to their visit to the clinic remained essentially unchanged. The older people who were evaluated as being cognitively intact (Mr. Brown, Mrs. VanDyke, and Mrs. Thompson) rejected those clinic recommendations which were not consistent with their own constructions of their situation. They did this, in some instances, despite the fact that their children agreed with the clinic recommendations (e.g., Mrs. VanDyke's children believed she should have more social involvement than she currently had; Mrs. Thompson's daughter believed she should not drive).

The remaining two participants, Mrs. Hamilton and Mr. Hauser, had problems with memory loss and confusion and their children took primary responsibility for responding to the clinic recommendations. Despite the fact that Mr. Hauser vehemently disagreed with the clinic's recommendation that he not drive, he surrendered his license. Mrs. Hamilton's lack of awareness of the impact which the clinic's interventions had on her and her high level of satisfaction with the social activities which had been one of the clinic's recommendations made her situation very different from Mr. Hauser's. Further study of the relationship of the constructions of trouble held by confused patients and the impact which the assessment clinic has on these would be useful.

Before they came to the assessment clinic, all of the children participating in this study had already defined, however vaguely, a sense of what needed to happen for their parents. For those families whose construction matched that of the clinic staff's, the visit to the assessment clinic served to legitimate the family's construction about what was wrong with their parents and what needed to be done about it. Families were given a good deal of information about causes of the behaviors they were concerned about in their parents. This information served as a framework within which they could now formulate explanations about their parents' behavior.

The adherence of the older people and their children to their own constructions of age, trouble, and "what to do", even in face of a differing construction by the assessment clinic, raises questions about the significance of assessment to the participants in this study. [154] On the one hand, when the clinic verified the family's construction about what was wrong and about what to do, families adhered to clinic recommendations and expressed gratitude about the clinic's usefulness to them. On the other hand, however, when there was a serious discrepancy between family and clinic constructions, families adhered to their own constructions and, in some instances, expressed disappointment in the clinic's inability to understand their parent's situation as they did.

The power of participants' to retain their original understandings, to

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[154] The robustness of cognitive models has been recognized in fields as diverse as psychology (Schoenfeld, et.al., forthcoming) and physics. See, for example, diSessa (1987) where he discusses the power of intuitive physics to resist change despite years of formal instruction in physics.

incorporate information which was congruent, and to modify or reject what was incongruent supports the work of other researchers who have investigated peoples' beliefs about illness. For example, Hunt et al. have conducted a diachronic study of the illness experiences of a group of women before and after they saw a physician. Their findings show that the women developed their understandings about their illnesses based on their prior histories and their ongoing life experiences. The physicians' diagnoses and treatment recommendations were incorporated into the women's constructions of their illnesses insofar as they fit with their experiences and the demands of their day to day lives (Hunt et al., 1989).

GERIATRIC ASSESSMENT AS A RITUAL PROCESS

In many respects the clinic's process of assessing older persons participates in both the phases of a ritual of passage as these have been outlined by van Gennep (1966) as well as in many of the primary characteristics of ritual behavior. Davis-Floyd has used the work of van Gennep, Turner, Douglas and other classical analyses of ritual behavior to examine the procedures used in American hospital births (Davis-Floyd, 1988). In this section, I use a similar framework in conjunction with Garfinkel's analysis of status degradation ceremonies to investigate the procedures used in the geriatric assessment clinic. I first analyze the assessment process in light of the three ritual phases of separation, liminality and incorporation. Following this, I use Davis-Floyd's framework applying those characteristics of ritual which are designed to produce or enhance its transformational effect as they can be seen in the clinic's process of geriatric assessment. I

argue that Davis-Floyd's paradigm, while particularly salient in analyzing hospital birthing procedures, is less satisfactory when applied to the process of geriatric assessment. A major obvious reason for this is that the event of birth as well as the period of pregnancy which serves as a lengthy period of preparation for the transformation occasioned by birth, have no analogues in the process of geriatric assessment. As noted earlier, the older participants did not consider themselves old so that their visits to the clinic to have their "oldness" assessed were not only not preceded by a period of preparation but were most often occasions for the new and unwelcome characteristic of "old age" to be attributed to them formally for the first time. The findings of this study show that the power of participants' constructions of themselves and their situations, their own self assessments if you will, prevented the transformative power of the clinic's ritual process from having its effect.

The classical phases of a rite of passage as outlined by van Gennep include a phase of separation when initiates are withdrawn from their previous status; a liminal or transition state when they are suspended, as it were, and are neither what they once were nor yet what they will be at the completion of the ritual; and finally, a phase of incorporation when initiates are integrated into their new status.

Once patients are referred to the geriatric assessment clinic, they can be considered as having entered into the separation phase of the ritual process. Very really, they no longer have the same status they did before they were presented to the clinic as an older person "in trouble." Regardless of the individual's sense of self, the larger

society (be it family, neighbors, community) has identified him or her as both old and troubled.

The liminal phase of the ritual process lasts from the time the clinic nurse visits the older person (now called a patient) at home, until they have completed all of the phases of evaluation by physicians, nurses, social workers, and physical therapists. While they are in this phase, which lasts several weeks, the individual's performance is tested by several professional strangers. Questions are asked about how he or she performs such intimate tasks as bathing, dressing and going to the bathroom and whether or not they know what the current day and season is. Such questions are ordinarily asked only of or about very young children, or adults who are deemed incompetent. While the questions have a basis in the theory of geriatric medicine (Katz et al., 1963; Folstein et al., 1975), their systematic presentation through a series of tasks in which the older person's performance is evaluated clearly highlights the marginal status the older person occupies during this period. The individual's status as a competent, normally functioning adult is no longer taken for granted and, instead, his or her performance is closely scrutinized.

Since the purpose of the evaluation is to find out how the older person performs the activities in question, a priori judgments on the part of staff about a patient's competence are discouraged. Nonetheless, the very act of assessment has the potential to undermine, however briefly, the self concept of the older person who is the object of the evaluation. In Mrs. Thompson's case, an unintended consequence of the assessment process was her experience of being reduced to the status of

a child.

ET But I tell you that last day was a rough day for me. the therapist put me on that table you know, and she made me turn on my stomach and I suffered my back for about 4 or 5 days. THe pain wouldn't go away. And I told her I can't do it. And she wanted me to get on my knees and show her if I could get up if I fell. I says, no I won't. I says, that's one thing I won't do...Oh I was worn out that day, three hours...

SMC From the evaluation you mean?

ET Umhm, right. I now I don't know how I came out of all that either.

SMC How do you think you did?

ET Well, I guess I did pretty good. I don't know. Some of the things I didn't. The first, putting that kindergarten stuff I call it but it really wasn't, putting the different shapes to fit in, you know. Why that one part I didn't do and, 'cause they look so different on the paper you know. So, and then the money they wanted me to work on that. And I hate when anybody, when I'm adding or subtracting, I did that on the paper, but I hate anybody over my shoulder.

SMC Watching?

ET Yeah, right. My husband used to do that before he took sick and I'd say, just go away and let me handle this, I have my own way of doing it. And we each had our own way of course. So, and he never liked either if I did that to him. So I used to kid him and tell him, no I don't like it either. So anyway I don't know. So anyway I hope I came out pretty good. I don't know, its hard to say.

SMC Yeah, you know I'm curious. Because not having been on the other end of it. I mean, I know what it's like being on my end of it...but it almost sounds like this is some kind of an examination of you or some kind of test that you, is that what it feels like to you?

ET Yeah, that's what it feels to me, uhhuh. Right. Yeah, like I'm the child again. And I brought up six children (laugh). I don't need all this. Oh dear.[155]

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[155] E.T., Interview # 3, pp. 7-8

Mrs. Thompson's experience is reminiscent in some respects of Garfinkle's description of a status degradation ceremony in which an individual's total identity is transformed into a socially inferior identity (Garfinkel, 1961). Garfinkel considers that an individual's identity is comprised not only of his or her behavior but also includes the reasons which account for the behavior. In the case of the geriatric assessment clinic, staff evaluate the behavior of the patient being assessed in light of what they know about his or her diagnoses and past history. The final results of the evaluation are expressed in terms of an understanding of the older person's condition or disease state as the grounds for his or her behavior. In Mrs. Thompson's case, the staff were evaluating her performance in light of the stroke she had suffered several months earlier and the results of their evaluation incorporated her diagnosis as the grounds for her behavior in the tasks she had been given to complete. Thus her total identity (the sum of behavior and the reasons which make the behavior explicable) was expressed, as a result of the evaluation, as that of a disabled adult. Simultaneously, Mrs. Thompson herself experienced a reduction in her status from that of competent adult to that of a child.

The actual assessment period of the clinic process has many of the elements characteristic of the liminal phase. A prime characteristic of this phase is the de-structuring of the individual's belief system so as to make him or her vulnerable to learning the rules of the new state toward which he or she is moving. The systematic repetition of questions and tasks which test their mental, physical, emotional, and social status send a potent message that the patients' abilities to perform normally in these areas is under question. In addition, during

this phase, the older person does not know the results of the tests he or she is undergoing. Having been singled out as an old person thought to be in trouble, the individual is not yet eligible to be incorporated officially into the ranks of the troubled aged. This will come only if and when the older person's evaluation results fall in the range generally accepted as characteristic of people belonging to this category.

The phase of incorporation begins at the time of the family conference when the results of the assessment are "revealed" to the patient. They are told how their performance compared with the normal range of performances in adults their age and the significance of deviations from the normal are explained. By being compared in this way to an "objective standard," the older person is effectively cast as a member of a uniform category. Either he or she is 'normally old' or he or she belongs to a category of 'abnormally old.' Interestingly this conference is almost always attended by family or friends. Because of their presence, the older person's status is effectively announced not just to him or her but simultaneously to the larger community as well. In this way the individual's new status is publicly declared. [156] Either they have entered the ranks of the troubled aged or they are declared to have successfully manifested that they are functioning competently. In either case, however, an incorporation of sorts is designed to occur. Even those patients evaluated as being competent

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[156] These elements of the family conference can also be understood in the light of Garfinkel's work on status degradation ceremonies. See Garfinkel (1961) for an explanation of the need for an individual and his behavior to be defined as "instances of a uniformity" and also for the need of witnesses in order to have a successful degradation ceremony.

have had their "oldness" called into question. If they are deemed to be competent at the conclusion of the geriatric assessment process it is precisely that they are judged to be competent as "old" people.

Primary Characteristics of Ritual Inherent in the Geriatric Assessment Process

Some of the ritual characteristics which Davis-Floyd identifies as being particularly critical in fostering the transformative effect of ritual include redundancy and intensification, order and formality, a cognitive matrix, the production of an affective state, transformation, and preservation of the status quo (Davis-Floyd, 1988). Each of these characteristics can be seen to a greater or lesser extent in the process of geriatric assessment as it was carried out by the clinic.

Redundancy and Intensification

In a maximally effective ritual, a basic set of messages is repeated over time in many different ways and with a gradually increasing intensity. As mentioned earlier, a prime focus of the assessment process was the evaluation of the older person's ability to perform basic functions learned in early childhood as well as to determine his or her mental status. During the clinic nurse's visit to the older person at home, a family member was routinely asked to be present during her interview with the patient to assure that the information gathered was accurate. [157] Patients were asked how they performed tasks such as

[157] This procedure was established when the clinic began to receive several referrals to see patients who were noticeably confused.

bathing, dressing, getting in and out of the bathroom, and if they were able to control their bowel and bladder functioning, and their answers were checked with family members for accuracy. Their mental state was determined by asking, among other things, if they knew what year and season it was and if they could name familiar objects. As patients progressed through the assessment clinic the same questions were asked by different members of the clinic staff. They were combined with questions designed to evaluate the older person's state of depression, whether they could handle money, prepare a simple meal, and get up off the floor should they fall. The clear message communicated repeatedly throughout this evaluation process was that the older person's basic competence as an adult was in question.

A Cognitive Matrix

Ritual is embedded in the belief systems of a culture and expresses those beliefs. An analysis of the geriatric assessment process provides a useful insight into the belief system of the clinic and, since the clinic's procedures are similar to geriatric assessment units throughout the country, to the cultural beliefs of the wider health care community. The notion of geriatric assessment rests on the belief that some older people have needs that are different enough from those of younger people to merit evaluation by a specialized team of health professionals. Implicit in this belief is the additional premise that the needs which these older people experience are essentially health related. Finally, the assessment process enacts the belief that knowledge is the key to alleviating the problems which these older people and their families experience. The clinic staff developed highly

sophisticated assessment questionnaires and procedures to assure that they were getting the most effective information on which to base their diagnosis of the older person's problem and from which to develop recommendations for dealing with the problem. Implicit in this development was the belief that the problems of the assessment clinic patients were best served by a technologically advanced evaluation which would help to resolve present difficulties and prevent future ones from occurring. The use of highly sophisticated assessment procedures in the context of a medical setting also reinforced the notion that problems associated with aging are best met through a process of medical intervention. Despite the fact that a large number of the problems which surfaced in the assessment of patients had to do with social rather than health issues, the clinic was still seen as the appropriate medium for recommending solutions to these problems.

Production of an Affective State

Ritual processes are designed to produce an emotional context in which participants are more open to the meaning of the ritual experience. The patients and families who came to the geriatric assessment clinic are already in a particularly vulnerable state. Whether patients agreed or not, they had been defined as being in trouble and were brought to a team of professional strangers to have their physical, mental and emotional functioning evaluated. They and their family members were confronted with old age as a characteristic which they must now face, however they chose to respond to it. The clinic's process of intensive and repetitive evaluation consistently emphasized both the patient's status as old and as potentially incompetent, a status with enormous

implications both for patients and their families.

Preservation of the Status Quo

The enactment of ritual is a powerful force in the preservation and transmittal of a culture's belief system. As such it plays an important part in preserving the status quo. As Davis-Floyd points out, however, ritual must work to renew the belief system that underlies it. In the geriatric assessment clinic, the belief in the power of sophisticated assessment to alleviate the troubles of older patients and their families was a powerful incentive for the staff to continually seek to refine the procedures they used in the clinic. Staff spent time and energy in an ongoing effort to develop more efficient, more comprehensive, and more uniformly objective assessment tools. They continued to augment and enhance their assessment procedures and to share the skills they had developed with other health professionals in the community and the state.

Transformation

In Davis-Floyd's paradigm of hospital birthing as a transformative ritual, the moment of transformation occurs when the "reality as presented by obstetrical procedures and reality as perceived by the birthing woman become one and the same." (1988: 156) The analogous moment of transformation in the geriatric assessment process would occur when there was a fusion of the older person's sense of self and the clinic's view of him or her as being, at least provisionally, old and troubled. Despite the profound impact which the clinic had on some of

the older participants, the findings of this study indicate that this moment of transformation did not occur for any of them. Even for those older people for whom the impact of the clinic was profound, it is fair to say that the transformative function of the ritual process was never fully successful in their regard. None emerged believing that they were old. Even Mr. Hauser, who was devastated and angry about the clinic's assertions that he was not fully competent, did not change his conviction that he was not old. Mrs. Thompson's experience with the clinic temporarily altered her confidence in herself and for a time she felt that she had lost control over her fight for independence. The experience, however, did not have a lasting effect on her self-confidence. On the contrary, after a time it galvanized her anger and determination as she demonstrated by deciding to drive before taking a driver's test.

While the assessment process was not completely successful as a ritual of transformation for the older participants, it served that purpose more effectively for some of the adult children in their identification of their parents as old. With the exception of the Browns, who identified Mr. Brown's Parkinson's Disease rather than his age as the source of his difficulties, the adult children who participated in this project had already identified their parents as old some time before contacting the assessment clinic. For the adult children the period beginning with their identification of their parent as old and extending through their initial visits to the clinic, was analogous in some respects to the period of pregnancy in Davis-Floyd's analysis of hospital birthing procedures. The adult children were coming to terms during this time with the recognition of their parents as old people and

were more apt than were their parents to acquiesce to the transformative power of the assessment process to legitimize this identification. Perhaps this period of preparation and the expectations which the children had that the clinic would, in fact, affirm their construction of their parents as old accounted for the difficulties which the adult children experienced when the clinic did not identify the older person either as old or as dependent.

CHAPTER 7

CONCLUSION

I began this research expecting to discover reasons why older people who participated in this study experienced trouble in aging. What I discovered was that most of the older participants did not view their own aging as a major cause of distress. Instead, the deepest source of trouble for most older participants resulted, paradoxically, from efforts to help them which were initiated first by their children and subsequently by the assessment clinic. Families and health professionals unwittingly created a significant part of the trouble which these older people experienced during the course of the study. Understanding the central role which conflicting views of age and of trouble played for all of the study participants allows a better appreciation of aging in our society. In this chapter I review the major differences in perspective held by the three groups and discuss the implications of the conflicting views for older people, their families, and for professionals working with them. The findings of the study are also discussed in the light of pertinent anthropological and gerontological literature and in relation to the medicalization of aging.

We have seen that the construction of age was intimately connected to the ways in which trouble was defined by each of the participants. The definition of trouble was significantly different, however, for each

type of participant. Older people viewed as troublesome those circumstances which threatened specific skills which they valued highly and which had allowed them to develop a particular stance toward the world throughout their lives. These skills, for example Mr. Hauser's mental acuity or Mrs. Thompson's independence, had been a central component in how these older people understood themselves and their world. When the skills were undermined or interfered with in some way, the older participants defined the loss not only as troublesome but as the cause of their feeling temporarily old.

When the older people experienced a loss of some degree of competence in a particular skill which was of great importance to them, they compensated for the loss by engaging in activities which allowed them to use the same skill differently. To cite but two examples: Mr. Brown lost his freedom to travel at will and to initiate a wide range of social activities. Accepting his physical limitations, he chose to live in what, to his family and the clinic staff, appeared the unnecessarily restricted environment of a nursing home. For Mr. Brown, however, the protected environment allowed him to continue to move about at will (now within a narrower range) without the worry of falling in a place where help would not be available. Choosing to remain in a nursing home in his old neighborhood also allowed him to maintain contact with his old friends and neighbors. Although he no longer was in a position to initiate the contacts by physically reaching out to these people when he chose, Mr. Brown made himself available to their visits and continued to maintain telephone contact with them.

Mr. Hauser's memory loss severely impeded his ability to control his

life through acquiring and using information. However, even though he was no longer able to process information in his customary fashion, Mr. Hauser continued to use his mind to control the effects which his loss of memory had on his day to day living. He developed elaborate systems of recalling dates, appointments, and peoples' names and used these to good effect for a long period after his memory began to deteriorate.

The older participants' ability to compensate for the loss of highly valued skills arose in part from their recognition that the skills in question were not an essential part of their self-identity. Important as they were, the skills were simply abilities which they had used to express themselves throughout life and did not constitute the core reality of who they were. When they experienced a change in their ability to relate to the world through using these skills the older people defined the change as troublesome and as triggering a sense of feeling old. They did not, however, experience themselves as irrevocably different people. They confronted the changes they experienced as they grew older in ways which had been characteristic for them throughout their lives and continued to use their distinctive skills in ways that they saw as appropriate to their changed circumstances.

While older participants defined trouble as the result of a threat to a highly valued personal skill, their children labeled as troublesome the events which threatened their perception of their parent <u>as parent</u>. Even though the children's perceptions revolved around changes in the same highly valued skills which constituted the older peoples' definition of trouble, the meaning of the changes and, consequently,

their impact was essentially different for parents and children. For example, Mr. Hauser's daughters interpreted his memory loss and confusion not just as a difficulty for him. It was also a continual reminder to them that this was, in their view, "not the same man" they had known all their lives. It was this latter perception that made their definition of Mr. Hauser's trouble so painful to them.

To the children, their parents' loss of ability to function in ways which had been distinctive markers of their identity as parent was not a peripheral or temporary loss but rather a definitive one. In a very basic sense these adult children actually experienced the loss of their parents as parents. This experience had implications for the children about their own adulthood as Grace expressed in her response to the radical change in her mother after Mrs. Thompson suffered her stroke. "I lost my mother, meaning her vitality, her independence, her strength...it was very difficult, very ( ), and it was time for me to grow up."[158]

The adult children's realization of the implications for themselves of their parents becoming old - and in some way no longer acting like parents - may account for their sense of needing to "do something" about the changes which they identified as being troublesome. The older people themselves were engaged in developing alternate strategies to cope with their loss of physical or mental abilities and did not identify the need for additional help in dealing with these difficulties. Their children, on the other hand, defined the

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[158] G.E., Interview # 1, pp. 7-8

difficulties as indicative of a radical change in their parents' identities and contacted the assessment clinic for assistance in diagnosing what was wrong with their parents and for recommendations about treating what was wrong. [159]

The assessment clinic was brought into a highly conflicted situation with regard to each of the participant families (with the exception of Mr. Brown and his daughter and son-in-law). The older people did not identify themselves as old and did not recognize any need for assistance. Their children both identified them as old and believed that they needed help. Given the opposing constructions of troubled aging held by these families, it is obvious that the clinic's diagnoses and recommendations would disagree either with the older peoples' perceptions or with those of their children. Even though the clinic held its own unique perspective on the situation of each older participant and family, aspects of the clinic's construction frequently coincided with those of either the older person or his or her children. As we have seen, when the clinic's view was presented to the participant

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[159] The one family who appeared to be an exception in this regard also did not identify their parent as old. Mr. Brown's daughter and son-in-law, as we have seen, continued to use Parkinson's Disease rather than age as the explanation for his frailty. They had become accustomed over a thirty year period to the disease being the source of his physical limitations and as his limitations progressed they continued to use the disease as the explanation for his condition. Joan and Bob were the only adult children in the study who did not identify either a marked personality change in their parent or their own sense of loss of a parent. They also did not contact the clinic primarily out of a sense of needing to do something about Mr. Brown's behavior. Rather they contacted the assessment clinic primarily because they were concerned about the medical care Mr. Brown had received during the time he was hospitalized and subsequently discharged to a nursing home.

families, whichever member was in disagreement with it retained their original definition of the problem and modified or rejected the clinic's recommendations. In the process, however, particularly for the older participants, the conflict between their definition of their situation and the clinic's generated a significant amount of difficulty.

The significant differences in the constructions of troubled aging fashioned by older participants, their children, and the assessment clinic have implications for families with older members and for professionals working with older people. An obvious implication is the need to recognize potential, and probable, differences in how each of these groups defines trouble. A logical corollary of this implication is that optimal solutions to troublesome situations may also differ among older people, their children and health professionals. We have seen in this study that a difficulty which arose for several participants stemmed from the assessment clinic's recommendations regarding the treatment of a problem which was not recognized by the individuals to whom the recommendations were addressed. For example, neither Mr. Hauser nor Mrs. Thompson thought that their driving was unsafe. Mr. Brown did not experience life in a nursing home as particularly troublesome and Mrs. VanDyke did not see herself as being socially isolated. In each of these cases, the problem was one which had been identified by the adult children and not by the older person. Most of the clinic's recommendations, however, were focused on - and demanded changes in behavior from - the older person. Given this scenario, it is relatively easy to understand why the recommendations were rejected by those older participants who were in a position to reject them.

The involvement of the geriatric assessment clinic in the troubles which these families experienced underscores the issue of the medicalization of aging which has been raised by Arluke and Petersen and numerous other researchers (Arluke and Petersen, 1981; Veatch, 1973; Cassel, 1972). Citing the perspective of authors who have studied the medicalization of both normal and deviant behavior in western society, Arluke and Petersen note the gradual dominance that medicine has assumed over other forms of institutional control of these behaviors (e.g. supplanting religion and law as the primary institutional form of social control for drug addiction and alcoholism). Noting the increasing medicalization of aging that is occurring in our society, these authors note that medicine has now assumed a major role in decisions (e.g. institutionalization of older patients) which were formally the sole responsibility of families.

The findings of this study highlight some of the complications which can occur with the involvement of the health care institution in family concerns about an aging member. Only two of the four older participants whose children brought them to the assessment clinic because they were concerned about their behavior had undiagnosed health problems which needed treatment. Mrs. Hamilton's confusion was due, at least in part, to undiagnosed hypothyroidism and her condition improved after she began taking the medication which the clinic prescribed. Mr. Hauser's memory problems and confusion were aggravated by some of the medications he was taking when he first came to the clinic and his condition also improved after he stopped taking these medications. These participants derived significant benefit from specific health related interventions by the clinic and the appropriateness of their involvement with the clinic seems clear. The clinic's effectiveness with the other participants,

particularly Mrs. Thompson and Mrs. VanDyke, seems far less clear. In these instances, the older person's children were distressed over their parent's behavior and that behavior was labeled by the children as having a health related component. The clinic's acceptance of these participants as patients and the subsequent series of events underscores the consequences of treating "the whole patient." As Arluke and Petersen note, "From this perspective (seeing the older patient as presenting unique symptomatic responses to multiple physical and social problems), the role of the physician vis a vis the older patient is not only to assess his clinical status but to appraise his social life" (1981: 279).

There is a fine line between the acceptance of aging as being frequently accompanied by health related problems and the perception of aging as a disease, which is a perception that has numerous advocates (Losch, 1977; Kurtzman and Gordon, 1976; Gladue, 1975). The findings of this study indicate some of the complications that can arise from the unintended effects of involving the older person in a health assessment which extends beyond the boundaries of physical and mental health.

The results of this study indicate the need for those involved in providing health services to older adults and their families to recognize the existence of three views of what the family situation is rather than focusing on the older person as "patient." While the dynamics involved in negotiating three potentially conflicting views of troubled aging are indeed complex, my findings indicate that failure to recognize and negotiate the differences may well serve only to generate additional conflicts. Conversely, a clear identification of the source

of a particular definition of troubled aging (i.e., older person, children, or health professional) would be an effective point of departure in defining the reasons why the situation is troublesome and for formulating potential solutions.

In this regard, a question which this study did not address but which would expand our understanding of the interrelationship among constructions of troubled aging, is why adult children chose a particular point in time to "decide" that their parent needed help. My data suggest that many of the adult children were engaged in other stressful situations unrelated to the older participants at the time that they determined something needed to be done about their parents' situations.[160] It was also clear in several instances that the older person's "trouble" as defined by their children had been going on for some time before the children contacted the clinic. The possibility of external and unrelated stressors as a contributing factor in precipitating the adult children' decision to intervene in their parents' lives is an area which needs further research. My data at least suggest that the timing of adult children' interventions with their aging parents may be unrelated to the actual status of the parents.

Adult children's definitions of their parents' troubled aging as meaning that their parents were engaged in an irreversible decline were significantly different from their parents who viewed troubled aging as

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[160] These situations included simultaneous illnesses of several family members, discovery of a child's drug problems, and the illness of one of the adult children participants.

temporary and reversible. Children's perceptions may well have stemmed from their realization that their status as children, albeit adult children, was being threatened by the loss of their parents. Services for older people and their families could expand their focus from the older person as the object of help to the needs which adult children may be expressing by referring their parent for help. Adult children may benefit from additional support and education to understand their responses to their own shifting roles and responsibilities as their parents age. Recognizing that troubled aging is a phenomenon that extends well beyond the aging parent and impacts, perhaps most severely, the aging child would be a helpful orientation for those involved in working with older individuals and their families.

As we have seen, the older people in this study were actively engaged in confronting the difficulties which accompanied their growing older. The approaches they developed were, not surprisingly, consistent with the approaches they had developed to challenges over a lifetime. This finding supports those of Myerhoff (1978), Myerhoff and Simic (1978) and Kaufman (1986) who found that older people respond to changing life situations in their later years in patterns which are consistent with their approaches to life as younger people. This study adds the additional dimension of exploring the implications of older peoples' life views as they come into relationship with the life views of their children. In this study I have shown that conflict in these views has profound implications for precipitating transitions in the life course not only of older people but of their children as well.

The study also demonstrated that the constructions of troubled aging

held by all of the participants, including the health professionals, were resistant to external influence. As has been mentioned, this finding supports those of other researchers in medical anthropology as well as other fields. [161] It does, however, call into question the more classical concepts of cognitive anthropology as well as the explanatory model framework frequently used in the investigation of patients' illness beliefs. Far from being a static framework of beliefs about their own or their parents' aging, the constructions of troubled aging held by the families who participated in this study were fashioned dynamically out of their unique understandings of their experiences of growing older.

The older peoples' understandings were built on the foundation of their perceptions of themselves which had been developed over a lifetime of interaction with the world around them and which continued to be fashioned in ongoing relationship with that world. Their children's constructions rested heavily on the relationships they had built up over a lifetime with their parents. The health professionals views of troubled aging, as we have seen, were formed largely in the development of their professional careers and were based on their knowledge and experience in treating the health related problems of older adults. When these views confronted each other in the geriatric assessment clinic, there was considerable exchange of information. However, there was relatively little exchange of perceptions and no significant change in the constructions of troubled aging held by any of the participants, including those of the clinic staff. Awareness of the power of older

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[161] See pp. 206-207

people's constructions of themselves and the resiliency which those constructions can provide, as well as the impact which changing abilities in aging parents may have on their children could provide the basis for a more effective approach to the difficulties which older people and their children experience.

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Appendix A

Appendix A

GERIATRIC ASSESSMENT CLINIC PROTOCOL

The Geriatric Assessment Clinic operates two half-days per week and services are reimbursed by a combination of third-party payers and out-of-pocket fees charged to the patient. The clinic operates as an assessment, referral, and follow-up unit. Primary care and emergency services are not provided. The clinic sees patients 65 years of age and older who are functionally limited and have multiple medical problems. A multidisciplinary team assesses the patient and makes recommendations according to the following process:

1. Referrals are screened for eligibility via an intake phone call by the administrative assistant. When patients are not eligible for services they are referred to appropriate community resources. When the patient is admitted, the following process is initiated.

2. Each patient is assigned to a clinical nurse specialist who coordinates the patient's care while the individual is in the assessment process.

3. Within 48 hours of intake the patient's primary physician is notified of his/her referral to the clinic and informed regarding the process.

4. Each patient receives a comprehensive assessment by a team consisting of a clinical nurse specialist, social worker, geriatrician, occupational therapist, and physical therapist. A geropsychiatrist is used on a consultation basis and for selected patients.

5. Other backup resources are available and consulted as appropriate (e.g. pharmacist, dietician).

6. A core data base is completed on each patient and includes information in the following domains: 1) sociodemographics; 2) physical assessment (medical history, physical exam, diagnostic studies); 3) level of functions in basic and instrumental activities of daily living (i.e. bathing, dressing, toileting, transferring, bowel and bladder continence, eating, use of the telephone, managing transportation, shopping, housework, meal preparation, medication administration, and finances); 4) mobility; 5) mental assessment (cognition and affect); 6) social assessment (social support, patient/caregiver dynamics, caregiver burden); 7) economic (income, insurance information); 8) environment (living arrangements, safety of environment).

7. The core data base is collected and interpreted by means of the following process:

a) Within two weeks from admission to the clinic, a home visit is performed for all patients living within a 25 mile radius of the clinic. data collected on the home visit includes all of the core data with the exception of the physical exam and the diagnostic studies. For those patients living beyond the 25 mile radius these data are collected on their first visit to the clinic and for these patients the environmental assessment is gathered by patient/family report rather than by observation.

b) The remainder of the core data base (i.e. physical exam and diagnostic studies) is done on a subsequent visit to the clinic.

c) A team conference is held at the beginning of each clinic day to review data on patients being seen in that clinic.

d) A weekly case conference, in which the entire assessment team participates, is held for the purpose of a final comprehensive evaluation and to formulate recommendations for long-term care for those patients who have completed the assessment process.

e) A conference with each patient and the family caregiver is held at the clinic and is attended by appropriate team members. Each patient and family caregiver is provided with written recommendations for the patient's long-term care which are discussed and explained. Referrals to appropriate agencies are initiated by the clinic team as needed.

f) A written summary of the clinic team's findings and recommendations is sent to the patient's primary care physician within two weeks of the family conference.

g) A follow-up visit to the clinic is scheduled every three months for continued assessment and evaluation.

Appendix B

TOTAL SCORE _____

Patient Name _____
Date _____
Examiner _____

MINI-MENTAL STATE EXAMINATION

ORIENTATION	Record Answers	Right	
What is the...			
Year?		1	
Season?		1	
Month?		1	
Date?		1	
Day of the Week?		1	
	Total	_____	(5)

Can you tell me where we are right now? For instance, what state are we in?	1	
What city are we in?	1	
What are two main streets nearby?	1	
What floor of the building are we on?	1	
What is this address or what is the name of this place?	1	
Total	_____	(5)

REGISTRATION

I am going to name three objects. After I have said them, I want you to repeat them. Remember what they are because I am going to ask you to name them again in a few minutes.	Apple:	1	
	Table:	1	
	Penny:	1	
Please repeat the three items for me. "Apple"..."Table"..."Penny"...			
Score first try. Repeat objects until all are learned.	Total	_____	(3)

continued...

Patient Name_____

Date_____

ATTENTION/CALCULATION

Can you subtract 7 from 100, and then subtract 7 from the answer you get and keep subtracting 7 until I tell you to stop?

Court 1 error when difference between numbers is not 7.

Record:

(93) (86) (79) (72) (65)

Number of correct responses: 0 1 2 3 4 5

*OR: If patient cannot or will not perform serial 7's, ask him/her to spell W-O-R-L-D backwards and score accordingly.

Now I am going to spell a word forwards and I want you to spell it backwards.

The word is WORLD, W-O-R-L-D. Spell "world" backwards.

Repeat if necessary, but not after spelling starts.

Print

letter: _ _ _ _ _ _ _ _ _ _

Number of correct responses: 0 1 2 3 4 5
(Score is number of letters in correct order)

Total _____ (5)

RECALL

Now what were the three objects I asked you to remember?

Apple: 1

Table: 1

Penny: 1

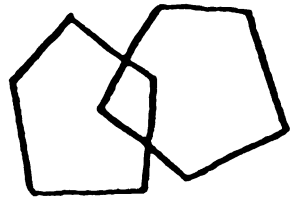
Total _____ (3)

continued...

Name_____

Date_____

LANGUAGE

Show wristwatch What is this called?	Watch:	1
Show pencil. What is this called?	Pencil:	1
I'd like you to repeat a phrase after me: "No ifs, ands, or buts" Allow only one trial.		1
Read full statement and then hand over the paper: I'm going to give you a piece of paper. When I do, take the paper in your right hand, fold the paper in half with both hands, and put the paper down on your lap.	Right hand: Folds: In lap:	1 1 1
Hand "close your eyes" sheet. Read the words on this page and then do what it says. Code 1 if respondent closes eyes.		1
Write any complete sentence on this piece of paper for me. Sentence should have a subject and a verb, and make sense. Spelling and grammar errors are okay.		1
Here is a drawing. Please copy the drawing on the same paper. Correct if the two five-sided figures intersect so that their juncture forms a four-sided figure and if all angles in the five-sided figures are preserved.		1

Total Score _____ (9)

MMSE.txt

CLOSE YOUR EYES

Appendix C

APPENDIX C

INTERVIEW SCHEDULE

FOR OLDER PERSON:

1. Do you think of yourself as old?
2. How did it happen that you came to think of yourself as old?
3. What has it been like for you to become older?
4. Are there things you like about becoming older?
5. Are there things you don't like about becoming older?
6. Do your children think of you as old? How can you tell?
7. Has anything changed in the way you relate with your children as you have become older?

FOR ADULT CHILDREN:

1. Do you think of your (mother/father) as old?
2. How did it happen that you came to think of (him/her) as old?
3. What has it been like for you to have your (mother/father) become old?
4. Are there things you like about your (mother/father) becoming older?
5. Are there things you dislike about your (mother/father) becoming older?
6. Does your (mother/father) think of (her/him self) as old? How can you tell?
7. Has anything changed in the way you relate to your (mother/father) because (he/she) has gotten old?

Appendix D

APPENDIX D

TABLE 1

NUMBER OF INTERVIEWS BY PARTICIPANT

PARTICIPANT	NUMBER OF INTERVIEWS
Mr. Brown	2
Joan & Bob	1
Mr. Hauser	10 + Case Conference + Family Conference + Follow-up visit to clinic
Frances & Betty	3
Mrs. Hamilton	2
Jim	2
Mrs. VanDyke	2
Mel & Diane	1
Mrs. Thompson	6 + Case Conference + Family Conference
Grace	3
Clinic Physicians	4
Clinic Nurse	4
Clinic Social Worker	3