

"CHI LO, MAI LO"

I am old enough to show off my old age wisdom.

THE EXPERIENCE OF AGING AND CHRONIC ILLNESS

IN

OLDER WOMEN OF CHINESE ETHNICITY:

A PHENOMENOLOGICAL, FEMINIST STUDY

By

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ABSTRACT

Conceptualization for the study was formulated from the researcher's professional practice experience in nursing and from theoretical perspectives of personhood, aging, chronic illness, ethnicity, feminist sociology, black feminism and nursing. The subjective, personal experience of aging and chronic illness in older, migrant women is a poorly understood phenomenon within nursing. When such knowledge is lacking, the delivery of culturally relevant care to elderly, ethnic minority populations is compromised.

The study sought an understanding of older migrant women's personal experience of aging and chronic illness. The study explored two themes of knowledge: what meaning ethnicity brings to the older, migrant woman's experience of aging and chronic illness and how personhood is manifested within the aging and chronic illness experience.

All six study participants lived independently in the community and their ages ranged from 60 to 78 years. Data collection and analysis occurred concurrently. Data were collected through nine unstructured interviews. Each interview was audio recorded and transcribed. The transcripts were individually then collectively analyzed for emergent themes. Themes were validated and clarified with the participants.

A final framework titled the Dialectic of Control was constructed from synthesis of the participants' narratives. Control was characterized as the process of balancing adversity (loss) and prosperity (gain) associated with the experience of aging and chronic illness. Adversity referred to lowered Activities

of Daily Living (ADL) and Role performance accompanied by discomfort or pain. Prosperity referred to the freedom from responsibilities, optimizing independence in and accepting limitations of ADL and role performance, and remaining pain free.

Three phases informed the participants' experience of aging and chronic illness: Noticing the Changes, Reflecting on the Meaning and Optimizing Control. Noticing the Changes described alterations in the participants' ADL and role performance, the notion of usefulness and fears regarding anticipated ADL and role performance changes in the future. Reflecting on the Meaning followed the participants' exploration of relationships, culture, significant life events and self-perception as sources of insight into their experiences of aging. Finally, Optimizing Control revealed strategies for balancing the changes associated with aging and chronic illness. Wisdom, the culmination of life long knowledge, formed the central referent point through which the experiences of aging and chronic illness were understood.

Findings were discussed in relation to the current literature and the organizing framework. Although the notion of personhood was not explicitly defined in the data, several themes and subconcepts relevant to the literature and to the study's orienting definition were identified. Conclusions on the experience of aging were drawn from the participants' stories of their experiences. Assertions regarding the relationship of the data to Feminist thought were presented. Finally, the implications for nursing education, research and practice arising from the data were identified.

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CHAPTER ONE

The Rationale for the Study

Impetus for this study of aging in older, migrant women arose from discussions held with groups of senior Chinese and Indo-Canadian women regarding their perspectives of health. With each group that met, the women spoke of their financial worries and social concerns, their sadnesses, their joys, their strengths and involvements. In spite of their struggle, humor was a constant companion to our talk. Indeed, their obvious affection for one another and the careful attention they gave to my questions affected my thinking profoundly. Their stories moved me to reflect more deeply upon the experiences of aging in older, migrant women and to question nursing's standpoint in coordinating their care. The following excerpt from a meeting with senior Chinese women will illustrate.

During a discussion about exercise, a woman described her daily routine of attending early morning Tai Chi sessions at a nearby shopping mall. I asked if the classes were well attended, attempting to determine the number of Chinese seniors who would be participating. The woman responded that there were only "a few foreigners that attended." Intrigued by this answer, I asked the interpreter to clarify with the woman who the foreigners were. The answer came back quickly. Pointing and smiling at me as she answered the interpreter's question, the woman explained, "Why you. People like you attend the classes." There was a slight pause and then the women encouraged, "You too should come."

My initial response was of stunned silence, momentary confusion. To consider myself as foreigner in my own country, my own city, indeed, in my

"territory" as a professional was somewhat disquieting. Yet, as I thought about her words, they made perfect sense. Spoken from a personal perspective, they were verbal pictures that informed her world of reality. In a group of Chinese, Cantonese speaking seniors, gracefully practicing the art of Tai Chi, I and others like me would most certainly be viewed as "foreigner."

I was struck by how deftly, in a matter of mere moments, the presumptions of majority had shifted. Although unconsciously claimed, my assumed place of authority representing the dominant culture, the majority in the outside 'macro' world of society, was tipped - turned upside down. I was now the minority, the person who was "outside" the group 'norm', representing color, customs, cultural beliefs, and behaviors different from and strange to their own. That experience of "nurse as foreigner" led me to consider more fully the complexities of ethnicity and migration.

Issues of poverty, sexism, ageism, and cultural bias extant within the dominant, white, patriarchal society took on new and troubled meanings, both professionally and personally, as I continued to reflect on our discussions over the next several months. Unhappily, I found that I was both a product of and participant in this socially constructed reality of oppression. I needed to "interrogate" my "whiteness", attempt to "determine what forces of denial, fear, and competition are responsible for creating fundamental gaps between professed political commitment to eradicating racism and the participation in the construction of a discourse on race that perpetuates racial domination." (hooks, 1990, p.54). Insight into the socio-economic and political realities of aging in older women of ethnicity will provide direction in ending oppression. As the background to the problem will show, it is a phenomenon about which little is known.

Background to the Problem

Ethnicity and aging are timely issues for health care planners and service providers. It is projected that by the year 2021, Canada's senior population (those 65 years and over) will more than double, rising to reach over 20% of the total population. Moreover, within the past two decades Canada has witnessed a rapid rise in the number of ethnic minority seniors. Approximately six thousand seniors of differing ethnic minorities immigrate to Canada each year. Delivery of health services to this group deserves careful attention (Canadian Public Health Association, 1988).

Seniors represent 24% of all those in Canada who do not speak either English or French. Among this group, twice as many women as men are unable to speak either English or French (Statistics Canada, 1986). Inability to speak the language severely disadvantages access to resources contributing to health. Poverty, inadequate social supports, poor housing, and lack of culturally appropriate health and social programs lead to ill health in ethnic minority seniors. (CPHA, 1988). It is useful to consider current understandings of the health risks in aging, migrant women.

Little is known about the differences in class and ethnicity in aging women (Gee & Kimball, 1987). Some studies have explored the ability of migrant women to gain access to services. For example, it has been shown that older migrant women carry a higher risk of developing health problems and experience more difficulty in obtaining services than older women from mainstream white society (Anderson, 1986). Although poverty and social isolation are more evident among aging women overall (Gee & Kimball, 1987), there is some evidence that the situation among older migrant women is more extreme (Lin-Fu, 1987; Louie, 1985). Elder abuse appears to occur more

frequently among ethnic minority women (as abuser and as abused elderly) than among white elderly women (Steinmetz & Pelliciaro, 1986). Clearly, life is marginal for many if not most of these women. It seems imperative then, that nursing seek to empower the voices of older, migrant women.

Nursing is guided by the words of black feminist, bell hooks (1990). If nursing is to empower, if it is to truly hear the concerns of older, migrant women, nursing must seek the voices of older, migrant women and listen to their stories by "entering that space where our words would be if we were speaking, if there were silence, if we were there." (p. 151). Understanding of the aging, migrant women's experiences of marginalization in society - free from subjective distortions and cultural biases - is paramount to effective and humanistic nursing care (Sands & Hale, 1987).

While patriarchal society's marginalization of women is well documented (Fraser, 1987; Smith, 1990), it is important to consider in greater detail, how migrant women's experience of marginalization may be further exacerbated. That is, while older, migrant women may suffer the "triple" socio-economic jeopardy of age, ethnicity and gender (Havens & Chappell, 1983) or "multiple" socio-economic jeopardy of age, gender, and "ethnic variations" (Penning, 1983, p. 82), they are also vulnerable to oppression by members of their own gender. A brief examination of recent developments within feminist epistemology will illuminate.

Within contemporary feminist thought, where equality may seem unequivocal, "white" feminism stands accused of hegemony. Gains made by the women's movement against patriarchal oppression have for the most part benefited white, middle class women. For instance, presuming to speak for all women's experience, white feminism has excluded not only Black feminist thought, but indeed, many "other" ethnic perspectives from its discourse on

women's oppression (Collins, 1990; hooks, 1990). Almquist (1986) relates why racial- ethnic minority women have avoided participation in white feminist women's organizations. Through social policy development termed "internal colonialism", ethnic minority groups are treated as "colonies" within the dominant society (p.114). While the social policy set for "conquered" territories is practiced with the "unwitting" participation of its white workers, they are nonetheless "willing" participants, thus complicit in the ongoing economic and political oppression of ethnic minority women (p.114-115).

So, on the one hand, not only are migrant women marginalized by the policies and practices of patriarchal society, but within the dominant culture, they are vulnerable to further marginalization by members of their own gender, in this instance, white, middle class women. An example of this kind of ethnocentric thinking is evidenced within nursing as well. The realization that care plans formulated for the "dominant white American group" could possibly be viewed as unacceptable, or even as threatening to other cultures is a disquieting notion to many nurses (Morse, 1987, p.129).

The voices of senior, migrant women speak from and to the personal, forming the ethno-cultural histories of personhood. They are subjective accounts of experience, insight and reflection that inform their lives as women, as wives and mothers, as grandparents, as sisters and daughters.

Women of and from a culture different than the dominant Anglo-European-Canadian culture are women whose life histories "propose an alternate understanding of ethnicity", where ethnicity is viewed "as part of our personal history" (Disman, 1983). By issue of their gender, advancing age and cultural placement within white patriarchal society senior, ethnic minority women are vulnerable to profound silencing. Their ability to voice to their cultural sense of health and well being is diminished (Disman, 1983; Penning, 1983). Disman

(1987) warns of the social justice inherent in the term ethnicity where it is used as a term for 'otherness', inferring that ethnicity is seen "as a social stigma." (p.74).

Conceptualization of the Problem

Conceptualization for the study was formulated from the researcher's professional practice experience in nursing and from theoretical perspectives of personhood, aging, chronic illness, ethnicity, feminist sociology, black feminism and nursing.

Personhood is the conceptual core of the study around which perspectives of aging, chronic illness and ethnicity were organized. The notion of personhood directs awareness of how personal meaning of life experiences is shaped by the social, economic and cultural context of people's lives. Through words and images, the voice of personhood provides a conceptual passageway (Taylor, 1978), through which one may come to know the lived experience of older, migrant women's lives.

There is no explicit theoretical framework directing research exploring the life course of women. Because of women's marginality in social science research, the studies of women tend to be "issue related, descriptive work" (Gee & Kimball, 1987, p. 10). Issues uniquely related to the life course of women are aging, health, poverty, work life, family life and sexuality. These issues were explored within the parameters of this research study and guided the formulation of the interview questions for the study.

Chronic illness is common in the elderly. Adjustment to chronic illness is difficult for most people, but can be especially difficult for the elderly (Chenitz, Stone, & Salisbury, 1991). Accordingly, the phenomenon of chronic illness as it manifests itself within the aging experience was considered.

The voices of senior, ethnic minority women are embedded within the day to day experiences that shape their lives as women. Their voices speak of and to the personal and the cultural, subjective accounts of experience, insight and reflection that inform their lives as older women (Disman, 1987) - the "talk" of personhood. Because of their gender, advancing age and cultural placement within white, patriarchal society, older, ethnic minority women are vulnerable to profound silencing. Articulation of their cultural sense of health and well being is often diminished (Disman, 1983; Penning, 1983). Social justice must be vanguard in defending ethnicity from inferences of social stigma (Disman, 1987). Older, migrant women's stories and narratives are at risk, subject to cultural editing, their words filtered and altered by belief systems dominated by a male, Cartesian view of science - a culture different from and dominant to their own (Crisman, 1977; Smith, 1990).

Feminism represents a major philosophical standpoint in selection of the study's methodology. The male perspective holds authority over women (Smith, 1990). Smith explains the "actualities of people's lives and experiences" are governed from the standpoint of administrative relevancy, not for the significance of "the people that live them." (p.87). To investigate the "directly experienced world as a problem", as a means of determining society from inside the experience is proposed as an alternative perspective. Thus, knowledge of ways in which the experienced world is socially organized and the determinants of its character and dynamics are realized. The researcher is directed to explore knowledge beyond what is already known and is grounded in the experience of how that knowledge is manifested. Anderson (1987) asserts that understanding of women's experiences must arise from the "context of the larger social organization and the ideological structures generated from outside their experiences." (p.413).

Although the paucity of knowledge in the study of ethnicity and aging in women has been noted earlier, further consideration of the approach to the study of ethnicity is warranted. I return briefly to the writings of hooks (1990) to show how conceptualization for the study of ethnicity and aging in women was informed. The Black feminist scholar creates a dialectic where the voices of both the oppressor and the oppressed are heard,

Often this speech about the "Other" is also a mask, an oppressive talk hiding gaps, absences, that space where our words would be if we were speaking, if there were silence, if we were there. This "we" is that "us" in the margins, that "we" who inhabit marginal space that is not a site of domination but a place of resistance. Enter that space. Often this speech about the "Other" annihilates, erases: "No need to hear your voice when I can talk about you better than you can speak about yourself. No need to hear your voice. Only tell me about your pain. I want to know your story. And then I will tell it back to you in a new way. Tell it back to you in such a way that it has become mine, my own. Re-writing you, I write myself anew. I am still author, authority. I am still the colonizer, the speaking subject, and you are at the center of my talk.(hooks, 1990, p.151-152)

hooks' perspective challenges nursing to reflect upon its complicity in the hegemony of white, patriarchal society. Nursing, as a mirror image of white society, must openly examine our profession for "masks" of bias, for however subtle examples of domination and oppression hidden behind words like ethnicity or otherness. hooks urges self-interrogation by those who would study "oppression, dominance and exploitation" by asking, "What does it mean when primarily white men and women are producing the discourse around Otherness ?" (p.53). Although nursing must seek the voices of older, migrant women so that they may inform our practice, so we must listen with equal care to the voices of culture, political and class bias within our selves, indeed our profession. For they are the voices that shape the way from which we learn to

hear the voices of other. Researcher self-interrogation is explored in a discussion of feminist methodology in Chapter Three of the study.

Finally, Although it is axiomatic that nursing is founded on the concept of care, (Benner & Wrubel, 1989; Leininger, 1988; Watson, 1985), the work of these noted nursing theorists holds particular relevance for this study of older, migrant women's experiences of aging and chronic illness. For instance, Benner & Wrubel (1989) propose that conceptualizations of caring are central to nursing's discourse on issues of coping and coping strategies. The authors argue that the concept of caring reflects three dynamics which grant its primacy in nursing: first, caring validates that events, relationships, and materials have significance for people; second, caring reflects the condition of enablement, facilitating the expression of connectedness and concern; and third, caring creates an arena for the provision and acceptance of help. Leininger's (1988) conceptualization of caring directs nursing to deepen its consideration of the cultural, social and environmental contexts of biophysical and psychological care. Watson (1985) emphasizes the humanistic approach, proposing the notion of interpersonal phenomenology, the coming together of nurse and patient in the creation of a new understanding and awareness of a phenomenon. Therefore it follows that if nursing is to practice caring as proposed by the preceding nursing theorists, nursing must indeed know the person cared for and understand the cultural texture of their lives.

Knowledge and understanding are found in the language of narration, of personal meaning where, "a particular self is constituted through these narratives, occasioned by the presence of a listener, her questions and comments." (Riessman, 1990). Narratives are the voices of personal meaning (Kleinman, Eisenberg & Good, 1978; Richardson, 1990; Sandelowski, 1991; Smith, 1990).

Conceptualization of the problem then, seeks to understand through the voices of older, migrant women what meaning these issues of aging, health, poverty, work life, family life and sexuality hold for them and how these issues are manifested within the concept of personhood.

Statement of the Problem

The subjective, personal experience of aging and chronic illness in older, migrant women is a poorly understood phenomenon within nursing. There is a paucity of study directing nursing knowledge to understanding the meaning of personhood within older, migrant women. When such knowledge is lacking, planning and providing culturally relevant care to foster an optimal state of health for elderly, ethnic minority populations is compromised.

Purpose of the Study

The purpose of this study was to seek an understanding of older migrant women's personal experience of aging and chronic illness. The study searched for two themes of knowledge: what meaning ethnicity brings to the older, migrant woman's experience of aging and chronic illness and how personhood is manifested within the aging and chronic illness experience.

Significance of Study

The demand for both community based and institutional care of the elderly is increasing (RCHCC, 1990). For instance, by the year 2020, the numbers of 75-84 year old elderly living in institutionalized care will increase by 36 percent while the 85 year old and over group will increase by 51 percent. These statistics coupled with projections of seniors (65 years and over) more than doubling their numbers within the same time frame, underscores the major

role services for the older adult will play over the next several decades.

Moreover, as women increasingly outnumber men in the senior population and projections indicate this trend to continue well into the next century (McPherson, 1983; Gee & Kimball, 1987), the demand for knowledgeable, effective and equitable health care services for women will also increase. The rapid rise in the number of ethnic minority seniors immigrating to Canada each year reflects Canada's cultural mosaic in transition. It emphasizes the concomitant need for increased knowledge in providing effective, culturally relevant and humanistic care for elderly people from differing ethno-cultural communities.

Nursing continually seeks ways to improve the effectiveness and quality of nursing care interventions. Indeed, as alluded to earlier, the profession of nursing prides itself on its founding principles of care and caring (Benner & Wrubel, 1989). Understanding the cultural shaping of the experiences of older, ethnic minority women in aging and chronic illness precedes practice credence in this mission of care. Knowledge of cross-cultural caring will challenge nursing to examine theory and practice for evidence of ethnocentric perspectives that comprise care (hooks, 1990). Exploring personhood from the perspective of older women from differing ethnicity's provides a context whereby nursing may learn ways to more effectively listen, hear and respond to those who must live their lives in the margins of society. Nursing knowledge will be informed through consideration of the "lived experience" of older, ethnic minority women. Finally, cross-cultural interpretation of aging provides conceptual "food for thought" that will help shape future developments in nursing education, research and administration as well as practice.

Research Question

The research question sought an understanding of the experience of aging and chronic illness in older, migrant women and an understanding of the manifestation of personhood within the older, migrant woman's experience of aging and chronic illness.

Two questions were formulated. What is the experience of aging in older, migrant women who are chronically ill ? What is the experience of personhood in older, migrant women who are chronically ill ?

Introduction to the Methodology

A qualitative, naturalist approach was taken in this study. A qualitative paradigm is applicable when the researcher is seeking emergent knowledge from the subjective perspective of human experience (Sandelowski, Davis, & Harris, 1989). Qualitative and more naturalistic methodologies are appropriate in studying women and aging, in that women may place more emphasis on the nature of their interpersonal relationships in describing their "social worlds", a perspective that is frequently disregarded in quantitative studies (Gee & Kimball, 1987, p. 14).

As the purpose of the study was to understand the experience of aging and chronic illness in older migrant women of Chinese origin a phenomenological methodology was employed. The phenomenological approach seeks the subjective interpretation of a given lived experience and the effect that perspective has on the experience (Oiler, 1982; Omery, 1983, p.50). A feminist perspective was applied to the phenomenological method in order to gain a deeper understanding of the socio-economic, political and cultural context of older, ethnic minority women's lives. Narratives bear witness to the oppression and domination of women (Anderson, 1991; Oakley, 1981). A comprehensive

description of each of these methodologies and their application in research is provided in Chapter Three.

Definition of Terms

CHRONIC ILLNESS

The irreversible presence, accumulation, or latency of disease states or impairments that involve the total human environment for supportive care, maintenance of function and prevention of further disability (Curtin & Lubkin, 1986).

CULTURE

The system of information that codes the manner in which the people in an organized group, society or nation interact with their social and physical environment. The customs, beliefs and values, and sets of rules, regulations, mores and methods of interaction within the group.

ETHNICITY

Attributes of common ancestral origin and culture (customs, beliefs, and values), race or physical characteristics and language that create a sense of group identity.

ETHNIC IDENTITY

Refers to a subjective perspective of one's own heritage and to a sense of belonging to a group that identifies itself and is identified by others as distinguishable from other groups (Lipson & Meleis, 1985).

OLDER CHINESE WOMEN

Women who are immigrants to Canada, are 65 years of age or over, whose first language is not English and whose primary ethnic identity is to the culture and customs of their country of origin.

MIGRANT

A person who seeks lawful permission to come to Canada to establish permanent residence, or has completed the immigration process and has established permanent residence in Canada.

MIGRATION

The act and/or process of moving one's residence from one country, region or location to another country, region or location with the intent to establish permanent residency.

PERSONHOOD

The human capacity for awareness of self; the realization of a personal past, present and future and the manifestation of a system of beliefs reflecting personal values and choices. It is the capacity to be a self-interpreting human being within the context of the personal, familial, social, cultural and spiritual traditions and, the concomitant capacity to act with agency, to articulate these aspects of self through language and action.

Assumptions

This proposal was based on the assumptions that:

- 1) The women who participated in this study are independent and autonomous human beings capable of articulating the meaning of personhood.
- 2) The women who participated in the study have ethno-cultural pasts that inform their past, present and future.
- 3) The women who participated in the study provided authentic narratives that are auditable and confirmable.
- 4) The women who participated in this study may express their experience of aging, chronic illness and personhood in different ways.

Limitations

The findings of this study will not be generalizeable to the larger population. This is in keeping with the phenomenological paradigm. Phenomenology is not intended to produce results that are applicable to the larger population. Rather, the aim of phenomenology is to provide comprehensive knowledge and understanding of a phenomena particular to an identified group of persons. Thus, what is learned from this study will be relevant and generalizeable to people in situations similar to the Chinese women who participated in this research study.

Summary

In this chapter, I report the rationale, background, conceptualization, problem, and significance of the study. Research questions asked in the study are provided and the purpose of the study, to seek an understanding of the experience of aging and chronic illness on older women of Chinese ethnicity is outlined. An introduction to and rationale for the phenomenological and feminist methodologies selected for the study is given. Definition of terms employed throughout the study are identified and the assumptions and limitations for the study are outlined.

In Chapter two, I provide a critical review of selected literature identifying the current state of nursing knowledge of ethnicity, aging and chronic illness in general and of the experience of aging and chronic illness in older, migrant women in particular. The concept of personhood is analyzed and the literature addressing Chinese culture as it relates to this study is examined.

CHAPTER TWO

Review of Selected Literature

The purpose of the literature review is to acquire a wide perspective of current knowledge relevant to the area of research study. It directs the researcher to carefully reflect upon preceding work and employ methodologies that will expand understanding (Burns & Grove, 1987) .

The literature is presented in three parts. Part One, examines the literature from the perspective of the topics central to this study: women, ethnicity, aging and chronic illness. In Part Two, studies addressing Chinese culture and the illness and aging experiences of older Chinese women are explored. Part Three considers the concept of personhood. Theoretical variations are explored for those that most effectively articulate the structure and processes of personhood. This is followed by an evaluation of personhood for its relevancy and conceptual link to Corbin and Strauss's (1987) notion of "biography" in the experience of chronic illness (p.253).

A summary concludes the chapter with acknowledgment of the strengths and limitations of the current state of knowledge of the experience of aging in older, migrant women. Gaps in knowledge are identified and recommendations for future study are provided.

Women, Ethnicity, Aging and Chronic Illness

This section begins with an analysis of the lack of women's perspectives in health and social science literature. Then studies of ethnicity, aging and chronic illness are explored.

Women's Marginalization in Health and Social Science Literature

While aging is a multi-faceted phenomenon, one important aspect of aging is the degree to which it is tied to women's issues. At the level of the individual, women are more likely than men to reach old age, particularly extreme old age. At the societal level, the aged population is increasingly composed of women and will become even more so in the future years. (Gee & Kimball, 1987)

Male bias in studies of health and illness places health and social service providers at risk of not only being insufficiently informed of the health care perspectives of women generally, but of aging women (Gee & Kimball, 1987) and of women of differing ethnicities (Anderson, 1990; Lin-Fu, 1987) particularly. The consequences of this phenomenon within social science thought is worthy of further consideration.

Sociological thought - conceptual frameworks and methodologies - is premised upon a "universe grounded in men's experience and relationships", formulating a social knowledge that determines, names, and orders the relevancy of social issues extant within society (Smith, 1990, p.13). Because of this bias in the social organization of knowledge, women's experiences and perceptions of the world are repressed, disjointed from those generally accepted and understood by society. Rather than remaking women's issues into sociological issues, remaining subject to the filtering and interpretive processes of the dominant male perspective, Smith proposes an alternate sociology that would begin from the standpoint of women, a sociological perspective situated within the direct experiences of women. This perspective would in turn interpret and name "the social organization and determinations of the properties and events of our directly experienced world." (p.22). Until the argument for a sociological understanding of women is secured, effective recognition of women's perspectives in health and social science literature

remains doubtful. Moreover, without this perspective of women, the opportunity to effect change within social and health care practice is also limited (Smith, 1990). A brief overview of the state of women's studies in health and social science will perhaps illuminate.

Women's perspectives are subsumed under those of the male in most social science studies across the life span (Gee & Kimball, 1987; Smith, 1990). A review of the health science literature showed a similar bias. For example, in the following studies, there is no acknowledgment of possible differences between female and male experiences of the phenomena: **aging and ethnicity** (Canadian Association of Public Health, 1988; Disman, 1987; Eliopoulos, 1990; Gelfand & Barresi, 1987; Ujimoto, 1987), **chronic illness** (Charmaz, 1983; Connelly, 1987; Corbin & Strauss, 1987; Lambert, 1987; Lubkin, 1990), **culture** (Chrisman, 1977; Eisenberg, 1977, 1978; Kleinman, 1978, 1980, Weller, 1984), **social inequality** (Cox, 1987; Li, 1988; Harel, McKinney & Williams, 1987; MacLean & Bonar, 1983). Likewise, in clinical studies examining the cultural relevancy of existing health care services, consideration that women's socio-economic placement in society represents health needs different than those of men was not raised as an issue (Bernal & Froman, 1987; Dyck, 1989; Fong, 1985; Jones & van Amelsvoort Jones, 1986; Louie, 1985; McCormack, 1987; McDonald, 1987; Rothenburger, 1990; Skawski, 1987).

While it is not the focus of this study to examine the inequities confronting women living within patriarchal society (Fraser, 1987; Smith, 1990), it is clear that knowledge of women socially constructed from the male praxis perspective carries significant implications in the allocation of resources for and in the planning and delivery of health services. And while it has been argued successfully that much can be learned from studying the differences between

the two sexes in the application of theories, for example theories of aging (Gee and Kimball, 1987), studies that produce knowledge of women from a feminist perspective, particularly in the domain of aging are in urgent demand (Nett, 1982).

Gee & Kimball (1987) shed light upon the lack of women's perspective in the literature, " The general failure to incorporate women into the mainstream theoretical perspectives on aging is a reflection of our resistance to incorporate women into society and, hence, into sociological and psychological research. " (p. 10). Smith (1990) expands,

...the worlds opened up by speaking from the standpoint of women have not been and are not on a basis of equality with the objectified bodies of knowledge that have constituted and expressed the standpoints of men. (p.13).

Women's standpoint remains subject to the authorization of men because it is the objectified knowledge of men that shape the world of social governance. The discussion next turns to a review of the literature on aging, ethnicity and chronic illness.

Studies of Ethnicity, Aging and Chronic Illness

Ethnicity. The need to expand our current level of knowledge of the complex role played by ethnicity in health and illness is widely reported in the literature (Anderson, 1986; Baumgart & Larsen, 1988; Kleinman, Eisenberg, & Good, 1978; Lynam, 1992; Mattson, 1987; Royal Commission on Health Care and Costs, 1991). What is known about ethnicity and aging is nascent knowledge. Disman (1988) comments, "Canadian research on ethnicity and aging is in its infancy. We need a good deal of research so that we can build a data base which can be translated into services and programs." (p.29). As ethnicity's entry into the social science literature spans a brief 20 year period, several

conceptual and methodological issues continue to be problematic (Gelfand & Baressi, 1987).

First, examples of methodological difficulties are assumptions of homogeneity within ethnic minority groups and effective sampling strategies (difficulty in gaining access to individuals within groups). In the former instance, age has been used as "leveler", creating a false sense of homogeneous groups by nullifying differences that exist between ethnic groups. Second, ethnicity has tended to be viewed as a static variable. An "emergent" view of ethnicity is recommended. This approach allows for recognition of the adaptive changes that occur over an individual's or ethnic group's natural life. Third, while there is general acknowledgment of the positive effects of a strong ethnic identity, recognition must be given to the potential negative effects of ethnicity on the older person. For example, many ethnic minority families living with seniors, experience inter-generational conflict where traditional belief systems clash with the modern views of family life (Gelfand & Baressi, 1987).

Ujimoto (1987) underscores the conceptualization problems of ethnicity particularly as it relates to creating an understanding of relationships within the family. Rosenthal (cited in Ujimoto) notes that ethnicity is viewed from at least two perspectives: 1) as primarily an "immigrant culture" where ethnic is equated with traditional and non-ethnic with modern views of the world and 2) as a indicator of social inequity related to social class and conflict. Both are seen to be too broad in approach, overlooking the consideration of intergenerational or cross-generational variance among ethnic groups.

Beyond methodological and conceptualization problems, the lack of consensus on the continuing relevancy of ethnicity as a primary health care variable warrants concern. Noting the exception of newer immigrants, some argue ethnicity is a moot point in American society, while others exhort ethnicity

as crucial to any consideration of public service programming. Still, the practical reality of funding cuts in social programs has served to heighten the existing competition between ethnic service agencies in securing adequate program funding. Given that present day projections are bereft of assurances for a brighter economic future, the politico-economic roots of the debate over the relevancy of ethnicity are thus exposed (Gelfand & Barresi, 1987).

Still, statistical evidence demonstrates that the lowered life expectancy among ethnic minority groups in general (as measured against the dominant White majority) represents a failure to mitigate the effects of poverty, malnutrition and poor health extant among ethnic minority seniors (Gelfand & Barresi, 1987). Clearly, these data are not reflected in social policy. Questionably, services continue to be directed toward the rural poor, frail elderly over 75 years of age and most often members of the predominant White majority. Although this analysis speaks to the American perspective, it does not seem untenable to apply this perspective to Canada's growing ethno-culturally diverse aging population. Indeed, Ujimoto (1987) points out that many older ethnic minority persons not only have had to endure extreme adversity within their own life spans but as well, they have continually been denied the same access to resources (health, education, social, economic and political) enjoyed by the dominant White society.

While nursing's study of ethnicity has made progress towards the development of an assessment framework for cross-cultural nursing (Leininger, 1991; Morse, 1987; Spector, 1989; Tripp-Reimer, Brink & Saunders, 1984; Waxler-Morrison, Anderson, & Richardson, 1990), understanding of older women's (of differing ethnicity's) experiences of aging is scarce. Indeed, knowledge of migrant women's illness experiences is only recently developing (Anderson, 1987). Most studies of migrant women's experiences of health and

illness are concerned with women of child-bearing age (Anderson, 1986, 1989, 1991; Lynam, 1985; Thompson, 1987; Woods, Laffrey, Duffy, Lentz, Mitchell, Taylor, & Cowan, 1988).

Aging. Three major theories of psycho-social aspects of aging emerge from the literature: disengagement theory, the inevitable, self-initiated withdrawal from social roles and activities as one ages; activity theory, the perspective that multiple social roles leads to satisfaction in old age; and personality or continuity theory, the interplay of personality, lifestyle, social status and coping behaviors in successful adjustment to aging (Burbank, 1986; McConnell & Matteson, 1988; Ujimoto, 1987).

Cross culture application of both disengagement and activity theories of aging is problematic because of cultural biases in the underlying assumptions particularly in regards to social status, life style and the development of coping behaviors. Of the three, continuity or personality theory is seen to hold more promise. Additionally, aging as a sub-culture (based on age and ethnicity) or as a stratification process (a hierarchy of social role, chronological age and developmental tasks) provide useful direction in understanding the influence socio-ethno-cultural backgrounds in the adjustment to aging (Ujimoto, 1987).

Hochschild (cited in Burbank, 1986) calls upon researchers to seek understanding of the aging experience by asking what personal meaning the experience of aging holds for the older adult. In an analysis of disengagement theory, Hochschild informs us that personal meaning is the ultimate broker of legitimacy. The author stresses, "To study behavior and ignore its personal meaning is to miss the most profound dimension of aging." (p.84). It seems appropriate that the cross-cultural relevancy of the current theories of aging be examined from this perspective of personal meaning.

In sum, several areas in need of further exploration in the study of ethnicity and aging are presented in the literature. Those relevant to this study are: the similarities and differences in later life stages (Luborsky & Rubenstein, 1987); differences in the meaning of the "ethnic self", that is, perception and individualism (Disman, 1983; Luborsky & Rubenstein, 1987); a definition of the multiple ethnic meanings of aging (Disman, 1987); and research into the Chinese culture experience of aging, family and friendships (Louie, 1985; Lubben & Becera, 1983). Clearly, as noted earlier, the paucity of women's experiences and perspectives in the literature, must be addressed as well.

Studies which have contributed to an understanding of chronic illness in the elderly will be examined next.

Aging and chronic illness. Advanced technology in the Western world has extended the natural life span of its members. As life expectancy has increased, the prevalence of illness in the elderly has risen (Eliopoulos, 1990; Matteson & McConnell, 1988; Royal Commission of Health Care and Costs, 1991). Major illnesses that trouble the elderly are more often chronic than acute in nature (Chenitz, Stone, & Salisbury, 1991). Cardiovascular disease, chronic obstructive pulmonary disease (COPD), Alzheimers disease, Parkinson's disease, arthritis, osteoporosis, and diabetes are chronic illnesses most commonly affecting the elderly (Chenitz, Stone, & Salisbury, 1991; Murray & Zentner, 1985). Normal aging processes such as reduced cardio-vascular and pulmonary function, muscle wasting and altered sensory processes heighten both the impact and consequence of chronic illness in the elderly. Chronically ill elderly are at higher risk both physiologically and psycho-socially, particularly when immobility is pronounced (Monicken, 1991).

The impact and consequence of chronic illness is often not fully appreciated by health care providers (Lambert, 1987). Chronically ill individuals frequently

experience a profound loss of self arising from living a more restricted life style than in the past, increasing social isolation, a sense of stigma or discreditation from change or loss in past roles and fear of being a burden in the future.

Dependency on others for validation of self is increased (Charmaz, 1983).

Adaptation to chronic illness requires that the individual perceive that the output of effort required in the rehabilitation phase is worth the outcome, an improved quality of life (Curtin & Lubkin, 1986).

Corbin and Strauss (1987) construct a thematic understanding of chronic illness that speaks of a "failed body, biography, conceptions of self and biographical time." (p.249). Dependent upon the degree of assault upon the body, there is always some realization that the structural self as whole has been fundamentally broken or altered in some way. Consequently, past, present and future notions of self are profoundly shaken. Biography refers to the three dimensions that constitute the notion of self; body, biographical time, and self conception. It is from this sense of biography that self or self identity is reconstructed and reconstituted. The reconstitution of identity involves several overlapping steps that culminate in the rebuilding of self as a whole again which provides the capacity to perceive self in the future.

The applicability of chronic illness adjustment theories to the elderly seems reasonable. Salisbury (1991) reports that depression in the elderly is not uncommon. It is associated with multiple losses experienced by the elderly as they move through the aging process. Certainly, it is well documented that the correlation of depression with chronic illness is high. Bereavement (losses of spouse and life time friends) can accentuate the losses associated with chronic illnesses. Acknowledgment of depression is often denied by the elderly. Depression is not seen as a treatable condition. Rather, it is accepted with resignation that it is part of the natural progress of life and moreover,

nothing can be done about it. Salisbury provides this example of an elderly patient recovering from a stroke,

I am not *depressed*, that's a head sickness. I got *real troubles*. I can't walk, my wife is sick and she has to put me in a home. Naturally I can't sleep and I don't care for nothing, but I have misery, not depression. (p.436, original emphasis)

The clinical picture of depression in the elderly does not markedly differ from that of the younger adult. Finally, it is noted that the recognition of depression in the elderly, particularly in response to chronic illness may be confounded by symptom overlap of the two conditions namely, fatigue, low concentration, and insomnia (Salisbury, 1991). The relationship of culture to the experience of chronic illness and aging will next be considered.

The manifestation of culture within the chronic illness experiences of elderly ethnic minority populations is less well known (Gelfand & Baressi, 1987; Marshall, 1987). As there is a paucity of studies directed toward older, migrant women's illness experiences, the effects of chronic illness on younger, adult migrant women is explored for direction. The context of age clearly suggests several potential socio-economic differences between the child-bearing, parenting roles and responsibilities of younger women and those of older women whose child-bearing and parenting tasks are essentially behind them; still, the assumption is made that there will be some similarity in their illness experiences. For instance, two areas presumed to hold opportunity for comparison between younger and older migrant women are the personal experience of adjusting to a chronic illness and gaining access to health care services alluded to earlier. The following will perhaps shed further light on this position.

Illness as culturally bound. Understanding of illness as a culturally bound phenomenon have been drawn from the seminal work of several theorists.

Although first published in the mid to late seventies, their work continues to pervade the literature.

Understanding of the impact of culture upon the illness experience has been provided by Kleinman, Eisenberg and Good (1978) who instruct,

Illness is culturally shaped in the sense that how we perceive, experience, and cope with disease is based on our explanations of sickness, explanations specific to the social positions we occupy and systems of meaning we employ. (p.252)

The authors conceptualized a "cultural construction clinical reality" where health care providers in collaboration with patients, created medical diagnoses and therapeutic regimes that named particular disease and related treatment modalities.

Eisenberg's previous work (1977) provides additional insight into the notion of systems of meanings, "All belief systems (and we must acknowledge that this includes our own) are culturally bound. They make little sense out of context despite their persuasiveness to those brought up to share the same frame of reference" (p.14). In the theorist view, the study of cultural differences in perceptions of illness - belief systems informing responses and practices - decreases the likelihood of fostering an ethnocentric approach to health care delivery.

Chrisman (1977) reinforces the notion of the cultural shaping of health behaviors and its relationship to what is termed the "lay health system", the systematic organization of health beliefs and practices found within heterogeneous society (p.360). A conceptual framework, the "health seeking model" describes the process by which help seeking behaviors (as responses to health and illness) are shaped by socio-cultural factors. Chrisman takes the position that when health behaviors are contextualized within the rubric of culture, greater understanding of the role played by lay health systems, and of

the larger medical system is facilitated. Five elements of health-seeking behaviors are identified; symptom identification, shifts in role behavior, lay consultation and referral, treatment actions and adherence (p.353).

Adherence is suggested as a replacement term for compliance as the final elements of help-seeking process. Adherence is seen to represent a more egalitarian view of the client-advisor relationship. Chrisman urges, "...we must recognize and document the heterogeneity of health beliefs in order to avoid cultural stereotyping and to better understand the condition under which people choose health practitioners." (p.358).

Chronic illness and ethnicity. Cross-cultural tension often arises from differences between the system of health beliefs and practices traditionally held by differing ethnicities and those prescribed by the larger, dominant health care system (Anderson, 1985). The social organization and delivery of health and social service programs may impact dramatically on the lives of migrant families caring for a chronically ill child, where the personal meaning of the illness experience may be profound (Anderson, 1986). For example, Chinese-Canadian families caring for chronically ill children experienced dissonance between their traditional approaches to illness and that of the dominant health care system. The health care system's "ideology of normalization" creates a paradoxical experience for the migrant families (Anderson, 1989, p.253). That is, while the health care system's urges the migrant family caregivers to create a 'normal' lifestyle for their diabetic child, the lived reality for both the parent and child is a constant reminder of what is not normal about their lives as they struggle to comply with dietary restrictions and insulin regimes.

Yet, the issue of noncompliance in differing ethnic communities must be considered beyond the notion of clashes in cross-culture belief systems. Closer examination of ethnic minority women's experiences shows that the

impact of chronic illness embodies multiple risk factors in the women's lives. In a phenomenological study by Anderson (1991), the self-reported noncompliance of diabetic Cantonese speaking women revealed that several factors intensified their response to chronic illness. Embedded in the dailiness of their lives, within the context of family and social roles, expressions of a devalued self in response to chronic illness were noted. These feelings of devaluation were heightened by their feelings of loss and isolation associated with their migration experience. Indeed, their experience of marginalization occurred through the process of migration. Dyck (1989) emphasizes, "Studies need to consider the space beyond the clinic which forms the every-day conditions shaping our clients life experiences." (p.253, emphasis added)

Several studies have explored the importance of cross-culture communication in the provision of services. Variations among ethnic groups in both the manner and cultural appropriateness of communicating personal feelings in response to illness requires further investigation (Jones & Van Amelsvoort Jones, 1986; McGoldrick & Rohrbaugh, 1987). While sensitivity to cultural differences comes only through reflecting upon the life patterns of differing cultures (Fong, 1985), communication between cultures may be restricted by variances in communication patterns and approaches (Dyck, 1989). Understanding of one's own cultural system of beliefs and practices as a service provider is imperative. Care providers who do not reflect upon their own knowledge of and attitudes towards ethno-cultural groups risk dehumanizing care and/or experiencing conflict within the care setting (Fong, 1985; MacDonald, 1987; Sands, & Hale, 1987). Finally, vigilance in looking beyond the structured familiarity of practice guidelines is recommended. For instance, standard care plans devised to promote quality

care may extort the price of blocked cross-cultural communication (Rothenberger, 1990).

One of the major challenges in working with women of differing ethnicity is to devise clinical interventions that are culturally relevant and at the same time confront inequities in gender relationships. Women of differing ethnicity vary widely in the realization of women's role in society and often experience conflict when pressed to accept conventions of the dominant society (McGoldrick, Garcia-Preto, Hines & Lee, 1989). The traditional culture of Chinese people and the aging and illness experiences of older Chinese women is next examined.

Studies of Chinese Culture: Women, Aging and Chronic Illness

There is a paucity of information on the experience of aging and illness in older Chinese women. Orientation to Chinese culture, is useful in the data analysis phase of the study. Topics selected for review are the cultural characteristics that inform character traits of the people, Confucian perspective of the individual, family structure and relationships, and aging and self- identity in elderly Chinese women. Concepts such as filial piety, duty, honor, obedience, achievement and success as they relate to the Chinese character and family life are examined. The dynamic nature of culture is noted.

Chinese Culture and Personality Traits

Wu & Tseng (1985) note the influence of Chinese cultural tradition on concepts such as self-perception and coping behaviors, social relationships (familial, marital, friends), and help-seeking behaviors. Family and a "collective" approach to responsibility, child socialization processes, social network systems, emotional restraint and control, and valuing of education and

achievement comprise essential aspects of Chinese culture. The following sheds more light on these notions.

Personality traits particular to Chinese people are introversion, emotional reservement, a preference for tranquillity, a tendency to be over considerate of others, and habitual self-restraint (Weihzen,1985). Confucian thought is identified as a significant factor in the appearance of these traits. Confucianism has dominated the Chinese culture as social theory for over 2,000 years, profoundly affecting the behaviors and thoughts of Chinese people. Weizhen elaborates,

Confucianism advocates mildness, goodness, courtesy, thrift and modesty. It demands that a woman be obedient to her father, husband, and son and to cultivate chastity, speech, artistry and demeanor. ...Thus, the Chinese people are expected to become sober-minded, reasonable, and prudent; but the development of their nature has, as a result, been restrained, which has inhibited the full display of their feelings, intellect and initiative.

The recent emancipation of women in socialist China , over the past several decades, represents a shift away from the negative attitudes of women reflected in much of traditional Confucian thought. Weizhen advises that the character traits reported in the study apply to the Han nationality in China, which forms 94% of the total population of China .

Confucianism and Individualism. King and Bond (1985), in a review of the sociological literature, propose that Confucianism's notion of individualism has been misunderstood by Western society. The dependent perspective of Chinese behavior has been over emphasized, disregarding Confucist notions of self-direction in "constructing a social world." (p.30). Individualism is a relational conception that espouses development of the individual life (fulfilling creative potentials) through the richness of the individual's social nexus. Friendship itself is understood in the context of family, or kinship. Indeed, this

family or kinship aspect is the distinguishing feature of Chinese friendship. However, in Confucist thought, as the family is preordained, it has primacy. Friendship, because it is entirely self-initiated, does not carry the same familial responsibilities of honor and obedience.

King & Bond (1985) further postulate that the slow erosion of the Chinese family since the early 20th century (due to increasing industrialization and urbanization as well as exposure to Western individualism), locates the individual outside the traditional family setting for relationship construction. As Confucianism makes no reference to relationships with strangers, the Chinese feel uneasy in such social situations. Thus, Chinese often turn to mediators to provide a bridging role in establishing a social relationship. In both pre and post socialist China, in the absence of an effective system of civil law and in the presence of rampant bureaucratic corruption, the driving force behind the social construction of a "reliable friendship network", is protection of "one's personal and family interests." (p.41). The authors summarize,

This kind of highly personal relation construction constitutes an important cultural strategy for securing social resources towards self-advancement. To be sure, it is not merely a rational, calculative process; such "engineering" is conditioned by Confucian norms of *bao* or reciprocity (King, 1980; Yang, 1957). What we argue is that the Chinese individual is entirely capable of asserting a self-directed role in constructing vast relational networks outside his family. (p.42)

In studying self-identity in older women, Chan (1983) found a strong commitment to maintain self-worth and personal autonomy in elderly widowed Chinese women who immigrated some 40 years earlier and were living alone. Despite or perhaps because of years of hardship in forced separation from their husbands (due to the Chinese Immigration Act of 1923 which deterred most men from sending for their families in China), the women exhibited a

strong sense of self identity and dignity evidenced in their choice to live independently from their families. Commitment to matriarchal family obligations was met by offering both financial and social support to their family members as best that they could, given their own circumstances.

Family Structure, Beliefs and Values

The family is the fundamental unit of Chinese society (Chang, 1981; Louie, 1985; Wu & Tseng, 1985). The traditional Chinese family is hierarchical based on generation, age and gender and reflects a strong patriarchal bias (Chang, 1981). For example, the parent-child relationship ranks above the spousal relationship and the eldest male is the usual family decision maker (Hsu, 1985).

Honor, respect and obedience to one's parents are deeply entrenched family values, particularly in regard to the elderly (Chang, 1982; Lai & Yue, 1990; Louie, 1985; Wu & Tseng, 1985). For example, the notion of filial piety, the respect for and care of one's aging parent's, is emphasized in traditional Chinese culture (Chang, 1981; Hsu, 1985; Lai & Yue, 1990). Achievement and success are attributes strongly encouraged across the life span in order to bring honor and praise to the family (Chang, 1981; Louie, 1985; Wu & Tseng, 1985). Thus, one's obligation and duty to bring a good name to the family is stressed (Chang, 1981). Children's performance in society is seen as a direct reflection on the family (Louie, 1985). Children are raised to keep their emotions in check and instructed to avoid any disruption of the balance and harmony of family life. Family harmony is achieved and supported through obedience (King & Bond, 1985). Accepting praise in recognition of individual or family accomplishments is considered poor manners. Denial of praise is socially appropriate behavior (Chang, 1981). Sacrifice of individual or personal

goals for the common good of the family is expected in traditional Chinese culture (Hsu, 1985; Louie, 1980).

A woman's duty and obligation to obey her parents, particularly her father, is given to her husband when she enters marriage. On the death of her husband, her duty of obedience transfers to her eldest son (Hsu, 1985). The Chinese wife's duty is to ensure her husband's happiness by following his wishes. A traditional Asian woman would feel shame and be self-blaming if her husband was unhappy or her children misbehaved (Chang, 1981).

Differences in health beliefs and practices are noted between generations of Chinese based on the number of years of immigration (recent, 20 years, 40-50 years) as well as those of Chinese ethnic origins who are first, second or third generation Americans (Louie, 1985). Acculturation is generally more evident among those who have settled for longer periods of time. The contemporary life style and behaviors of adult children are often a source of conflict for the more traditionally inclined parents (Louie, 1985).

The discussion now turns to Part Two, the concept of personhood and its relevancy to Corbin and Strauss's (1987) notion of biography.

Personhood

The literature is explored for theoretical variations on the concept of personhood including descriptors, conceptualizations, definitions and interpretations of personhood. An orienting definition for personhood is presented and cross-cultural relevancy of the concept is considered.

Corbin and Strauss's (1987) conceptualization of the chronic illness experience is examined for its relevancy to personhood. Arguments are developed for articulation of Corbin and Strauss's notion of biography with that of personhood and for the universality of the concept of personhood.

Theoretical Variations of Personhood

Cassell's (1983) descriptors for person are: personality and character, the person's past and family life, associations and relationships with others, personal work, cultural and societal roles, body image, the hidden (private, inner) life, hopes for the future and spiritual meaning of life. Personhood embodies the emotional, social, physical, familial, private and spiritual aspects of an individual.

Leonard (1989) addresses the current debate in nursing research regarding two different conceptualizations of the person. In the Cartesian view, the individual is seen as an "assemblage of traits or variables such as anxiety, control, and self-esteem" with the self seen as subject and the environment as "object". (p.41). Leonard explains that the Heideggerian or phenomenological perspective asks the question, "What does it mean to be a person ?" (p.42). Here person and environment are seen to be constituted by one another. The phenomenological view centers on this relationship of the person to the world (environment). It is not a causal relationship, rather it is the gradual weaving of meaning, language, culture and family tradition into the fabric of the individual that creates the person, and by which the person's self is known. Thus, Leonard postulates, that in order to understand a person's experience of a situation, it is necessary to study the person in the context of their world as a self interpreting being.

Taylor (1985) describes the person or personhood as agency. It is through agency that the person is capable of making evaluations that form the self or self identity. Taylor expands,

Much of our motivation - our desires, aspirations, evaluation - is not simply given. We give a formulation in words or images. Indeed, by the fact that we are linguistic animals our desires and aspirations cannot but be articulated in one way or another. (p.36)

Taylor argues that acceptance of this position advances the proposition that a person cannot be known as simply an "object among objects" but rather as a life that "incorporates an interpretation." It is a life that cannot exist without expression because the person that is to be interpreted is essentially a "being who self-interprets" - the manifestation of agency (p. 75).

Orienting Definition of Personhood

Personhood is defined as the human capacity for an awareness of self; the realization of a personal past, present and future, a system of personal beliefs reflecting values and choices. It is the capacity to be a self-interpreting human being within the context of the personal, familial, social, cultural and spiritual traditions and the concomitant capacity to act with agency, to articulate these aspects of the self through language and action.

Cross-cultural Relevancy of Personhood

It has been noted earlier that further research into cross-cultural differences in aging, chronic illness, and health belief practices is needed. It has been emphasized that investigation is needed into the concepts of self and individualism and the personal meaning aging brings in ethnic cultures. While the occurrence of cultural differences in interpretation and manifestation of personhood within ethnic communities is acknowledged, it is argued that elements forming the conceptual basis of personhood are universal, namely; selfhood, time (past, present, and future), personal belief system (values and choices), capacity for self-interpretation and articulation, and lastly the contexts of personal, familial, social, cultural, and spiritual traditions. For example, Anderson (1991) states "...the diagnosis of diabetes meant a major restructuring of life...and a major redefinition of self - who one is and what one is able to do. This restructuring of life transcends ethno-cultural boundaries." (p.712). Anderson goes on to emphasize that while the act of restructuring is

not culturally bound, the process of restructuring (the how of restructuring) must be understood from where the experience is situated. That is, within the socio-political and ethno-cultural context of the person's life.

Biography and Personhood

It has been proposed earlier that personhood serve as the conceptual window from which to seek an understanding of older, migrant women and their experiences of aging. The impact of and adjustment to chronic illness can be exceedingly difficult, particularly for the elderly. It is imperative then that appreciation of the experience be realized as fully as possible. Accordingly, it is argued that Corbin and Strauss's (1987) notion of biography provides an understanding of personhood manifest within the chronic illness experience. The criterion of intersubjectivity of meaning (Burbank, 1986) is employed to determine the relevancy of the concept of biography to the concept of personhood.

Biography. Biography is a conceptualization by Corbin and Strauss (1987) to capture the three perceptual dimensions of self; identity, the physical body, and perceived biographical time where conceptions of the self's past, present and future are embedded. It is through the three dimension of biography that self begins the "biographical work" that needs to be done in the reconstruction and reconstitution of a "whole" self within the illness experience (p. 264).

Biographical body conception. The biographical body conception is employed by Corbin and Strauss's (1987) to figuratively articulate the three dimension of biography. It provides a diagrammatic representation of the impact of chronic illness on the interactive processes of the body, self and biographical time. The following depiction offered by the author's illuminates,

...when chronic illness comes crashing into someone's life, it cannot help but *separate* the person of the *present* from the person of the *past*, and affect and shatter any *images of self* held for the *future*....the

who I was in the past and the who I hoped to be in the future, in whole or in part, are rendered discontinuous with me in the present. *New conceptions* of who and what I am, past, present and future must *arise out* of what remains.(p.249, emphasis added)

Intersubjectivity of meaning: Biography and Personhood

Shared agreement on the theoretical definitions of concepts and on the relationship between the concepts must occur for intersubjectivity of meaning to be reached (Burbank, 1986). It is argued that Corbin and Strauss's (1987) biography and the essence of personhood share several conceptual elements and as such meet the criteria of intersubjectivity of meaning.

For example, in the above quote describing the impact of chronic illness, elements within the concept of biography namely, past, present and future, and the notion of the 'new' conceptualization (of who and what I am) correspond with the conceptual elements of personhood. That is, the self, as a self-interpreting, self-articulating being with a past, present and future employs these attributes to reconstruct the new self. Indeed, it is through the agency of personhood that the restructuring occurs in response to chronic illness.

Although Corbin and Strauss (1987) do not explicitly identify the five contexts of personhood namely personal, familial, social, cultural and spiritual, it is argued that these contexts are implicit in the conceptual language of their theory. For instance, Corbin and Strauss's (1987) notion of biography is presented in the context of environment and situation which corresponds to the personhood contexts of the personal, familial, social, cultural and spiritual. Further, the concepts of reflection and transcendence as manifested within the notion of biography relate to the spiritual context of personhood.

Finally, the concepts of reconstruction and reconstitution may be seen as the agency of personhood where the notion of self as a self-interpreting being is articulated through language and action. Thus, the element of self within the

concept of personhood is in agreement with self of biography. That is, both concepts present the individual or person as a self interpreting, self-articulating being, manifesting a personal past, present and future through language and action within the contexts of personal, familial, social, cultural and spiritual traditions.

Summary

This Chapter reveals a strong gender and ethnocentric bias in health and social science literature and a need to generate further studies of ethnicity and aging.

Selected areas noted as in need of further study are differences in perceptions of later life stages, differences in the meaning of an ethnic self and definitions of the various ethnic meanings of the aging experience. Cross-cultural relevancy of theories of aging is limited. Emphasis is placed on studies investigating the personal meaning of the aging experience.

Chronic illness, common in the elderly, carries significant physiological and psycho-social implications for the aged. Nursing studies of chronic illness in women of differing ethnicities have primarily centered on child-bearing women. While much is known about the cultural shaping of the illness experience, knowledge of aging, ethnicity and chronic illness in migrant women is lacking.

Confucianism's influence in traditional Chinese culture is profound. Confucist individualism is relational in context and fosters a self-directed role in formulating social networks. The family is the central unit in traditional Chinese culture. In the traditional perspective, family relationships are hierarchical based on generation, age, and gender. Success and achievement, considered important attributes, bring esteem and honor to the family. Duty, obedience and respect for authority, especially towards one parents is highly valued. For example, filial piety, the respect for and care of one's aging parents is

considered an important virtue. Women's traditional marital role is to bring happiness to the marriage through obedience to her husband and through raising obedient children. There is a need to understand the ways in which such traditions shape the experience of aging and personhood in older, migrant women of Chinese ethnicity who are chronically ill.

Because personhood formed the conceptual core of this study, an orienting definition of personhood is provided. As chronic illness formed another aspect of the experience of aging for this study, arguments proposing the conceptual congruence of personhood with Corbin & Strauss's (1987), notion of biography are stated.

In sum, the literature review revealed significant gaps in knowledge of the experiences of aging in older women of ethnicity. Marginalization of older ethnic minority women and the concomitant risks for and consequences of poverty, sexism, ageism and racism was reported in the literature. As feminist methodology of empowerment of the oppressed is congruent with nursing's principle of humanistic caring, a feminist perspective is recommended for exploration of these issues.

In the next chapter I describe the research design, participant selection process, and procedures for the collection and analysis of data in the study

CHAPTER THREE: METHODOLOGY

As the purpose of this study was to gain an understanding of the experience of aging and chronic illness in older women of Chinese origin, phenomenology was selected as the research methodology. Qualitative research is used in studies where the researcher wishes to expose the essence of a person's experience of a phenomenon or understand the underlying circumstances of a poorly understood phenomenon (Struass & Corbin, 1990). Further, the literature revealed that older, migrant women by nature of their age, gender and ethnic origins carry a higher risk of experiencing socio-economic and political oppression. Accordingly, a feminist approach was considered in the research design.

In this Chapter, I describe phenomenology and feminist thought. The relationship of phenomenology to feminist thought is articulated and the nexus formed by feminism, phenomenology and nursing is illuminated. This is followed by a report of participant selection procedures. Then, ethical considerations of the study participants and procedures for data collection and analysis are identified. The issue of rigor is considered as it relates to phenomenological and feminist methodologies

Research Design

Phenomenology

Phenomenology has a strong philosophical base and tradition (Cohen, 1987; Giorgi, 1975). From a phenomenological perspective, meaning is socially constructed, informed by situation and context. Phenomenology provides a way of accessing that meaning by studying the "lived-experience". (Mishler, 1979).

Phenomenology is defined as the study of the appearance of things (Omery, 1983) and an approach to viewing and researching lived- experiences within a world (Wilkes, 1990). The purpose of phenomenology is to develop a richer understanding of the multi-faceted and complex nature of a phenomenon through describing and reflecting upon the meaning embedded within the situation, object or action (Wilkes, 1990). It strives for exactness, a type of rigor that goes to the "roots" or genesis of things in order to understand the original meaning of the phenomenon (Cohen,1987).

Participants' stories, life histories, oral and written historical accounts and interviews form the substance of phenomenological research. They occur as narratives, revealing the cultural and societal, the language and behaviors, the individual complexities of human thought and action experienced throughout and within the contexts of time and space. As knowledge is socially constructed, narratives are central to developing understanding of the social world (Richardson, 1990). Rich data can be gathered through the narrative process of story telling (Sandelowski, 1991).

In the phenomenological method the investigator does not seek validation of a selected conceptual model or framework. Rather, the researcher gathers data and gains understanding of the phenomena from the subjective interpretation of meaning that the participants have of the experience and the effect of that experience on the perspective or behavior of the participant (Omery,1983).

The researcher practices holistically, approaching the question to be investigated by going to the people in their situation where they are "involved in the world." (Oiler,1982, p.179). The researcher is encouraged to be aware of their own presence in the world and to use empathy and intuition in their involvement with the experience. Oiler identifies four steps to the

phenomenological approach: 1) bracketing (suspending or laying aside what is known about a subject 2) intuiting (looking at the experience with "wide open eyes", with knowledge, facts and theories held back and becoming engaged in the phenomenon without being controlled by it) 3) analyzing (as descriptions are considered, recurring themes are recognized) 4) describing (guiding another along the same path taken by the researcher so that the experience becomes his/her own (p.180).

Phenomenology is congruent with nursing practice (Allen, Benner & Diekelman, 1986; Emery, 1983 ; Oiler,1982; Phillips, 1989; Watson, 1989). The notion of human beings as narrators and of their "products as texts" reflects a particularly significant time for nursing researchers. It offers solutions for research problems that have previously been obscured by conventional "theory and methodology debates" (Sandelowski, 1991, p.161). Finally, as nursing professes to value the quality of life, the authenticity of a client's life experience, the sanctity in the nature of the client-nurse relationship, and a holistic approach to client care (Benner & Wrubel, 1989; Chin, 1985, 1989; Watson, 1985), a qualitative approach in research is appropriate (Oiler, 1982; Wilkes, 1990). Given the preceding analysis of phenomenology and the purposes of this study a phenomenological approach was selected.

I now proceed to a discussion of the relevance of feminism and feminist methodology in nursing research.

Feminism and Feminist Methodology

In this discussion of feminist methodology, I briefly review the somewhat tenuous history of feminism and nursing. Then, feminism, inclusive of Black feminist thought is explored. This is followed by a consideration of feminist research methodology. Rationale for selection of the feminist perspective for this study concludes this part of the discussion.

Before I proceed to discuss feminism and nursing, it is useful to provide an initial explanation of what is meant by the term feminism. Feminism is seen as both a commitment to change women's place of oppression in society (Speedy, 1991) and as a world view that not only values women but also confronts all systemic injustices based on gender (Chinn, 1985).

Feminism is not a recent social movement, it has been part of the our social fabric for at least three centuries. Notions of feminist thought are reflected in the literature of seventeenth century Britain. Many consider Nightingale's (1890-1910) work as strongly supportive of women and exemplary of feminist work (Chinn, 1985; Kerr, 1991). As well, the suffragette movement of the late 19th and early 20th century witnessed a significant shift in society's view of women. Legislation requiring nurse registration represented a major accomplishment for the status of women generally and for nursing specifically. Nursing was viewed as leader in advancing the rights of women (Kerr, 1991).

Until the turn of the century, feminism and nursing traveled a common road in advancing the welfare of the urban poor. However, two significant socio-economic events of the time, the establishment of medicine as a dominant profession in society and the shift from home to hospital based nursing care plumbed the divergent paths that feminism and nursing were to follow over the next seven or eight decades. Feminism developed an increasingly militant voice in its demand for gender equity in the social order of things such as education, family life, economics, health and politics. By the early sixties, feminism had essentially denounced the traditional role of women (wives and homemakers, teaching, nursing) and in so doing, alienated many of the women living these roles. Nevertheless, nursing, caught up in a burgeoning patriarchal medical system that demanded obedience and deference,

continued its struggle during this time to develop its own philosophical stance, theoretical perspective and standards of education and practice (Shea, 1990).

In the early eighties, theories of oppression were applied to nursing to explain the profession's ongoing problems of low self-image and lack of autonomy (Roberts, 1983). This created an opportunity for nursing to reflect upon the potential benefits that feminism offers in advancing the goals of nursing practice (Chinn, 1985; Shea, 1990). Likewise feminism, through advances in academia - the development of women's studies and concomitant formation of feminist theories of the cultural shaping of women's experiences - witnessed the shift to an increasingly inclusive rather than exclusive perspective of women. Today, convergence of nursing and feminism seems more likely.

There are four major philosophical understandings of feminism: 1) liberal feminism (roots in 19th century feminism, espouses socio-economic and political rights for women equal to those of men) 2) Marxist feminism (ties oppression of women to the socio-economics of capitalism and promotes social revolution to end a sexist, exploitive society) 3) social feminism (class analysis of women's roles within the cultural institutions of patriarchal society, child rearing, housework and consumerism, it particularizes the socio-economic concerns of working class women and woman of color) and 4) radical feminism (fundamental belief that all women are oppressed, it seeks an understanding of women's experience language and knowledge separate and apart from the dominant male ideology). This position distinguishes radical feminism from the previous three perspectives that define women in relation to men. While these four perspectives differ theoretically in naming the socio-economic cause of and in identifying solutions to ending the oppression

of women, they share a deep concern for the value of women and a common commitment to ending gender based oppression (Chinn, 1985).

Feminist and nursing theories share several beliefs and values. Both view the environment as integral in shaping the experiences of health and the wholeness of life experience is seen as greater than its component parts (Chinn, 1985, 1989). The commitment to caring and nurturing, and recognition of the individual worth and unique contribution of each person is central to feminism and nursing practice (1985). The role feminism proffers within nursing practice is one of "personal, philosophic and political means for analyzing the realities of women's lives as lived in patriarchal systems." (Chinn, 1985, p.77). The notion of 'the personal is the political' is a conceptual imperative for nursing in understanding that the socio-economic and political traditions of oppression are power and freedom (1989, p.73). Feminism is politically committed to change within - the change that arises from "where we live." and it is directed toward "peace, freedom and choice for all." (p .74).

MacPherson (1983) proposes that the women's movement and particularly the women's health movement were instrumental in the development of a new paradigm for nursing research. Traditional research is a mirror image of patriarchal society. It defends the status quo of existing power relationships and either ignores or discounts the oppression of women. Feminist centered research, on the other hand, attends to the values of right, truth and good. Feminist theories arise from feminism's concern for and study of the conditions of women's lives embedded in women's experience, that the dialectic of considering and promoting social change for women is the developmental source of a feminist epistemology. The following two theorists provide important contextual background to an understanding of feminist methodology.

Science tends to reflect dominant social values and perceptions of reality (Du Bois, 1983). The dominant androcentric theory of human beings is derived from male perceptions and a male belief system. That is, there is no knowledge of women. DuBois explains, "'person' has been considered to be male, woman (is) defined by what she is not. i.e. not male" (p.107). Women are seen as anomalies, deviants from the norm. This androcentric view of women has "rendered women not only unknown, but virtually unknowable" (p.107). Feminist methodology is circular, interactive and reflexive with the values and beliefs of the researcher informing the process. Naming is integral to feminist research. Naming confers power as it denotes value and quality to that which is named. Du Bois elaborates

That which has no name, that for which we have no words or concepts, is rendered mute invisible: powerless to inform or transform our consciousness of our experience, our understanding, our vision; powerless to claim its own existence. (p.108)

Feminism and feminist methodology can be likened to an archeological dig, a search for truth of women's experiences that lie hidden and obscured beneath the layers of misnamed, misinterpreted and misunderstood information purporting to impart meaning to women's lives. Researchers must learn to see anew, not to look for what we have been told is there, nor what we might like to find, "but what is" (p.110).

This is a "communal" task shared among feminist researchers (Du Bois, 1983). It is a need to generate concepts, a need to see and think *complexity* and *contextually* (sic) while rejecting dichotomy, duality, linearity, and fixity. There is a 'double consciousness' of women (p.111). An androcentric culture has formed our conscious reality, ways in which we think and perceive and

understand our particular realities. Within us as women, there is another language that speaks of another reality that has

...often been not only unnamed, but unnamable...We are observer and observed, subject and object, knower and known. When we take away the lenses of androcentrism and patriarchy, what we have left is our own eyes, ourselves and each other. (p.112).

Smith (1990) proposes that at the moment in time when women's experience separates from text-mediated discourses essential to notions of ruling in modern society, a fault line is formed and from this, a critical standpoint arises. New insights are realized and new knowledge is created. Smith expands, "We make a new language that gives us speech, ways of knowing, ways of working politically. At the moment of separation from established discourses, the objectified forms of knowledge they embody become critically visible. " (p.11).

It is only by entering into the material or social world of women that knowledge of women's world can be gained (Smith, 1987). Smith urges,

The only way of knowing a socially constructed world is knowing it from within. We can never stand outside it.
...Even to be a stranger is to enter a world constituted within as strange. The strangeness itself is the mode in which it is experienced. (p.92).

Knowledge then, emerges from the context of the developing relationship, the dialectic between observer and the observed. Smith cautions that the understanding and knowledge of researcher (observer) has capacity to subsume the knowledge and understanding of subject. As observers we must not use our privileged position to construct a version of reality which is then imposed on others as their reality. That is,

....rewrite the other's world or impose upon it a conceptual framework which extracts from it what fits with ours. Our conceptual procedures should be capable of explicating and

analyzing the properties of their experienced world rather than administering it. Their reality, their varieties of experience must be unconditional datum.(p.93)

Black feminist thought. At this juncture it is important to approach Smith's advisement in the context of Black feminism. As noted in an earlier discussion of ethnicity, white feminism is accused of hegemony, assuming to speak to the Black woman's experience. In doing so, white feminism ignores or worse, discounts the differences in political and socio-economic privilege between white women and women of color. hooks (1984) illuminates,

...white women who dominate feminist discourse today rarely question whether or not their perspective on women's reality is true to the lived experiences of women as a collective group. Nor are they aware of the extent to which their perspectives reflect race and class biases, although there has been a greater awareness of biases in recent years. (p.3)

Indeed, hooks warns, the racism evidenced in white feminist writing serves to reinforce notions of white supremacy, preventing women from crossing ethnic and racial boundaries to bond in political solidarity. The notion of a "common oppression" situated in the experience of essentially working class white women was usurped by middle class white women to advance their prerogatives of class and race, an "ideology of liberal individualism." (p.8). Exploring the consequences of white feminism's class and racial bias hooks informs, "These unacknowledged aspects of the social status of many white women prevent them from transcending racism and limit the scope of their understanding of women's overall social status in the United States." (p.14).

Conflict persists within feminist thought in the struggle to determine a clear understanding of what feminism is and stands for. Moreover, hooks (1984) argues, the long standing view of white feminism as a social movement committed to either gender equality or to the advancement of individual

freedom no longer obtains in a world rife with racial and class oppression. Feminism must look beyond the boundaries of sexism and individual freedoms to the examine the broader political perspectives of society indeed to global revolutionary politics. In this way, then, oppression by class and race would become as relevant to feminist thought as sexism now is. Shedding light on this diversity among women's social and political worlds lays bare the lived reality of all women, particularly those women "whose social conditions, have been least written about, studied, or changed by political movements." (p.25). Thus, feminism, defined "as a movement to end sexist oppression" forces advocates of the position to seek out "systems of domination", clearly seeing oppression as the inter-relationship of class, sex and race. (p.32).

Collins (1990) writes of similar difficulties in attempting to define the nature of Black feminist thought. That is, a definition that on the one hand effectively articulates the standpoint particular to African-American women's experience (oppression by gender, class and race); yet on the other hand, recognizes "the importance of coalitions with Black men, white women, people of colour and other groups with distinctive standpoints." (p. 33). Collins proposes that Black feminism constitutes a "recurring humanist vision". (p.37). Citing Walker's (1983) notion that the human species reflects a range of colors (brown, pink, yellow, white, beige and black) that denote membership of the "coloured race", Collins offers that Black feminism is a "process of self-conscious struggle that empowers women and men to actualize a humanistic vision of community." (p.39).

The preceding brief analysis does not pretend to address the complexities inherent to a discussion of Black feminist thought. Rather, the inclusion of Black feminist theory alerts the researcher and reader to thoughtfully consider the socio-economic, political and cultural biases inherent to standpoint. That is,

in the case of the researcher, a woman born of and socialized in the values and belief system of the white middle class. Further, the above analysis is limited in that it does not consider the full range of feminist perspectives in relation to differing ethnicities and cultural contexts. Limitations of this study preclude a comprehensive and complete analysis of feminist thought. Having examined the concepts of white and Black feminism, I now examine the characteristics and tenets of feminist methodology .

Feminist methodology. There is no one feminist methodology or indeed one philosophical standpoint from which a singular definition of feminism can be determined (DuBois, 1983; Chinn, 1985; Hall & Stevens, 1991; Harding, 1987; Speedy, 1991). Confusion about feminism and feminist methodology arises from the lack of clarity in the literature in the use of the terms, method, methodology and epistemology (Harding, 1987). Method is a technique for gathering evidence (e.g. listening to participants, observing behavior). Methodology is the theory and analysis of how research should proceed. Epistemology is a theory of knowledge which may be characterized as a series of strategies for justifying beliefs. The essential aspects of feminist methodology are revealed in the characteristics and principles of the approach.

Distinguishing characteristics of feminist research are: 1) the notion of plurality in women's experiences (Hall & Stevens, 1991; Harding, 1987; Klein, 1983) 2) the research is conceptualized as *for* women as opposed to *on* women (Duffy & Hedin, 1988; Harding, 1987; Klein, 1983, emphasis added) 3) the researcher-participant relationship is horizontal in nature, (Duffy & Hedin, 1988; Harding, 1987; Klein, 1983; Speedy, 1991) and 4) the researcher demonstrates self-awareness, and reflexivity by explicit expression of assumptions, beliefs, biases and the decision-making trail throughout the

research process (Anderson, 1990; Christman, 1988; Duffy & Hedin, 1988; Hall & Stevens, 1991). Finally, three principles are basic to feminist inquiry:

- 1) women represent the central value (experiences, thoughts and needs)
- 2) ideological and socio-economic factors oppress women and 3) feminism is committed to social change through social action (Hall & Stevens, 1991).

Concepts cited in the literature as guiding the application of feminist research methodology are reflexivity (Anderson, 1991), justice and authenticity (Connors, 1988), gender equity (Sampsel, 1990), dialectical paradigm (Duffy & Hedin, 1988) and ethics and reciprocity (Christman, 1988). Of these reflexivity and authenticity will be briefly examined.

Reflexivity refers to the dialogue between the researcher and the participant. It is used for empowerment and social action, "empowering the disadvantaged and the oppressed". Providing answers to questions that facilitate the participants' ability to obtain greater control over their lives is an example of reflexivity in action (Anderson, 1991).

Feminist methodology, part of "new paradigm", is similar to participatory or social action research in that it strives for authenticity and justice in the researcher-participant relationship (Connors, 1988, p. 32). Authenticity is measured by the researcher's ability to engage in the research process totally, rather than masking themselves behind the role of researcher. It requires ongoing exploration (reflexivity) of one's own expectations, biases, perspectives and experiences. The nature of the researcher-participant relationship is likened to Martin Buber's concept of I-Thou, where each is fully present to the other. That is, the researcher and participant construct or "cocreate" together, the experience that is being considered (p. 34). Dialogue is used to inspire an environment of balance between researcher and the participant in the exchange of information.

Nexus: the Link Between Feminism, Phenomenology and Nursing

The preceding analysis of phenomenology and feminist thought shows a strong link between the two views. Both methodologies propose that knowledge arises from understanding a phenomenon from inside the experience where it is lived. Phenomenology and feminism recognize that the diversity that exists in people's life experiences is the essence of meaning that leads to knowledge. Feminism is politically committed to empower all people in the struggle against all forms of oppression and domination.

Nursing values the quality of life, the validity of people's life experiences, the privileged nature of the client-nurse relationship, and the significance of holism and humanistic approach in client care. Nursing understands that socio-economic and political oppression is a consequence of inequitable access to power and loss of freedom. Nursing, phenomenology and feminist methodology then, share the view that the "lived experience", as the center of meaning and understanding leads to knowledge. Phenomenology provides the means by which to enter the "every day" world as it is known" while feminism and Black feminist thought advocate that humanism replace systems of oppression. Nursing, grounded in a philosophy of caring links these two perspectives. Indeed, it is this nexus of perspectives that provided the rationale for the approach taken in this study. Selection of participants is now considered.

Selection of Participants

Small sample size and the concentrated time and attention demanded in both data collection and analysis in qualitative research requires knowledgeable and receptive participants. Participants were selected on the basis of their ability to meet the needs and direction of the study (Morse, 1986).

Because the point of data saturation is difficult to predict in phenomenology, stating the exact number of participants required for a study is avoided (Emery, 1983). The literature estimates that six to eight participants are required. The data collection process ends when no new themes are developed, no gaps in the data are evident and the existing data makes sense and is confirmed (Morse, 1986). A total of six participants were interviewed in the study.

Process for Selection of Participants

Participants were selected from a computer generated list of women who participated in a study by Anderson (1991). The women had given permission to participate in follow-up interviews. Participants were initially contacted by telephone by Dr. Anderson's research assistant who provided the participants with a brief introduction to me as a graduate student in the school of nursing. The research assistant then briefly explained the purpose of the study and asked the participants' permission to send written information about the study. A covering letter from Dr. Anderson, introducing me as a graduate student under her supervision and a form authorizing the release of their names and phone numbers to me was mailed to the participants. I was contacted by Dr. Anderson and advised of participants who had agreed to be interviewed.

As the study progressed, it became evident that additional participants would be required. A request for assistance in recruitment of additional participants was made to a social worker known to the researcher at an agency providing services to Chinese immigrants. Two participants were identified and on approval from the University of British Columbia Behavioral Science Screening Committee for Research Involving Human Subjects, the two additional participants were interviewed. Participants were selected on the basis of their ability to meet the following criteria.

Inclusion criteria.

- 1) Participants selected were Chinese-Canadian females, age 60 years or over and participants of a study by Anderson (1991) titled, "Chronic illness, illness management and patterns of help seeking; A comparative study of Chinese and Anglo-Canadian women with diabetes (Quantitative phase)
- 2) Participants identified their primary ethno-cultural association is within the Chinese community,
- 3) Participants were sufficiently competent in hearing and speaking ability to express themselves in English.
- 4) Participants were willing to and capable of participating in the study (able to reflect upon and express their experience)
- 5) Participants were capable of understanding the purpose of the study
- 6) Participants were capable of understanding and signing a consent form.

Data Collection

Ethical Considerations

Each participant received a consent form (Appendix A) detailing the purpose, process and potential benefits of the study as well as identifying their rights as study participants. Prior to signing the consent form, the form was verbally reviewed with each participant. Signing of the form indicated informed consent of each woman to participate in the study and her acknowledgment that the interviews would be audio recorded.

Participants were informed that their involvement in the study was entirely voluntary and they would be free to refuse to answer any questions or withdraw from the study at any time without fear of any kind of reprisal to themselves or their significant others. In addition, the participants' right to request erasure of the audio taped interviews or of any portion of the tape during or after the interview process was explained. One participant exercised this right during the

first interview by requesting that the researcher turn the recorder off while the participant expressed feelings and thoughts she did not want recorded. Finally, participants were assured that any information leading to their identification occurring during the research interview would be erased from the tape.

The researcher answered questions during the selection process and during the data collection and analysis phases of the study. Requests for information, expression of concern, or observed signs of physical distress in need of attention beyond that which was achieved during the interview process were referred to an appropriate source. A recommendation to contact the Diabetic Association was made to a participant who requested further information about food preparation.

Confidentiality of the participants was maintained throughout the research process. Collected data (audio tapes and transcripts) were coded by the researcher to protect the confidentiality the study participants. Use of the collected data was restricted to the researcher and faculty members of the Thesis committee. Participants were informed that names would not be revealed during the course of the study nor in any published or unpublished reports on completion of study. The participants were also informed that should a paper for publication arise from the study, the data would be destroyed by erasure of the audio tapes and by shredding of the field notes after the manuscripts had been published.

The research commenced following approval by the University of British Columbia Behavioral Science Screening Committee for Research Involving Human Subjects.

Data Collection Procedures

Data were collected through an audio-taped interview process conducted by the researcher. Interviews were comprised of a series of unstructured, open

ended questions to facilitate reflective responses by the participants (see Appendix C). The interviews averaged one to one and one half hours and took place within the participants' homes. With the exception of two participants (one of whom left the country, the other declined a second interview) each of the total of six participants was interviewed twice. The purpose of the second interview was to clarify and confirm data collected in the first interview. Transcription of the tapes occurred following the interviews. Field notes made following the interview formed an additional part of the data. For instance, notes describing the situation of a participant distressed and upset about an unhappy marital relationship aided the researcher in interpreting the data arising from the recorded interview with the participant.

Each interview began by briefly reviewing the study with the participants and reminding them of their rights as a study participant. Open-ended questions were used to orient the participant to the topic under consideration. During the interviews, I employed the techniques of bracketing and intuiting, putting aside what I knew about aging, chronic illness, issues of ethnicity and feminism. I attempted to enter the experience as a newcomer, to hear the women's stories with "fresh" ears. Moreover, as I was sensitive to and respectful of the potential for my presence to be viewed as a visit from and conversation with a "foreigner.", I attended more closely to cues of the participants in the telling of their experiences.

In keeping with the notion of reflexivity and authenticity in feminist methodology, several of the participants asked questions about their illness and discussed their medication regimes. I responded to their questions, expressing interest in their medications and their accounting of the history of their chronic illness(es). Moreover, perhaps owing to the nature of the study, the participants and I would often engage in a mutual exploration of the existential

questions of life; the nature of relationships with oneself, family and friends; spiritual beliefs; accepting losses, etc.

At the end of each interview, the participants were asked if they had any further questions. Several of the participants asked for more information as to my own background (e.g. marital status and parenthood, future career plans etc.). They also wanted to know more about the reasons for my interest in their particular stories. This information was freely given. Two of the participants insisted on giving me gifts at the close of our interview time together: one participant signed in her name in Chinese characters to a painting she had done and the other gave me gifts of fresh vegetables and bedding plants from her garden. All of the participants answered in the affirmative when asked if they were interested in receiving a summary of the study.

Data Analysis

Analysis of the data proceeded from the interviews as they were completed and transcribed. The interviews were transcribed as immediate to the completion of the interview as was possible. Transcription of the interviews was conducted by the researcher. The lines of the transcribed text of each interview were numbered consecutively so that as elements and themes were identified they were easily coded and classified according to their location within the text.

The text of each transcript was read over once to get a general sense of the overall content of the interview. Review of the transcript several more times identified feeling or thought units within the participant's responses. With repeated readings and through reflection on the various units that were noted, sub-concepts were then identified and grouped together. From these findings, larger concepts and themes were developed which were validated with each participant of the study. These major themes were used to conceptualize an

organizing framework for interpretation and presentation of the findings. The organizing or conceptual framework was submitted for evaluation to members of the researcher's thesis committee experienced in qualitative research who concurred with the researcher's conceptualization of the data. The discussion next turns to consider the issue of rigor in qualitative research.

Rigor

Sandelowski's (1986), recommendations for adoption of four conventional scientific tests of rigor adapted by Guba and Lincoln (1985) were employed in this study. The tests of rigor are credibility, fittingness, auditability and confirmability. Each of these concepts will be considered.

Credibility, also referred to as truth value, refers to how well threats to the internal validity of the research design have been managed. In qualitative research, truth is considered to exist in the phenomenon as it is experienced or lived. Thus, truth is seen to be "subject oriented rather than researcher defined." (Sandelowski, 1986, p.30). Credibility is achieved when interpretation of the phenomenon triggers immediate recognition in persons experiencing that event. The closeness of the researcher-participant relationship is both a threat and an enhancement to the credibility of qualitative study. Closeness allows direct access to the participant's experience, but may also interfere with the researcher's ability to maintain sufficient distance from the experience to interpret the meaning in an effective way. When the researcher describes her own responses in relation to those of the participants, credibility of the study is enhanced.

Fittingness, known as applicability in quantitative research is a measurement of the external validity of the study. That is, the generalizability and representativeness of the research findings. In quantitative research this is most typically controlled through statistical sampling (random sampling and

large sample sizes among other techniques). In contrast, in qualitative research, sampling is often theoretical. Consequently, sample groups are small and purposive in order to collect and analyze the depth of data that are required to gain an understanding of the phenomenon. Participants who belong to a specified group are seen to represent the group. Threats to fittingness in qualitative research are: 1) over involvement in the participants' experiences and thus, difficulty in distancing from the experience (alluded to above) 2) overweighting the perspectives of the more articulate participants of a group 3) the tendency to present data as more "patterned, regular or congruent than they are." (Sandelowski, 1986, p.32). Fittingness is achieved when the findings are experientially understood (meaningful and applicable) by people outside the study and also fit the data from which they derived.

Strategies employed to achieve credibility and fittingness in this study were: 1) stating and reflecting upon the researcher's responses to the participants' behaviors and expressed feelings (the introduction of this study provides an example of this strategy) 2) testing the representativeness, coding categories and examples used to collapse and report the data 3) determining that data identify both typical and atypical elements 4) explicitly searching for factors that would disallow or invalidate conclusions arising from the data 5) seeking the participant's validation of the data and 6) consultation with other researchers (members of the researcher's thesis committee)

Auditability, referred to as reliability in quantitative research, addresses the consistency, stability and dependability of a test. Repeatability is central to the concept of reliability in quantitative research which emphasizes the regularity of human behavior. In contrast, qualitative research recognizes the variance and uniqueness of human experiences. Consistency is achieved in qualitative research through leaving a clear decision trail for another researcher to follow

by describing and accounting for the research process. Achievement of auditability in this study was determined by reporting in this and in earlier Chapters: 1) the trigger for the researcher's interest in the study 2) how the researcher sees the phenomena under study 3) the purpose of the study 4) subject recruitment and approach 5) impact of the researcher-participant interaction 6) method, setting(s) and length of time involved in data collection phases 7) and the data analysis process (reduction, transformation, weighting, interpretation, criteria for inclusive-exclusive categories formed to catalogue the data, and techniques employed to demonstrate the truth value of the data).

Confirmability, (termed objectivity in quantitative research), examines neutrality or freedom from bias in both the research process and in the outcome. Objectivity is integral to quantitative assessments of neutrality and is dependent upon the establishment of reliability and validity, ensuring distance from the subject to be studied. In contrast, qualitative research emphasizes subjectivity rather than objectivity as a criterion of neutrality. That is, truth about a phenomenon is revealed by increasing the closeness between the researcher and participant to facilitate a deeper understanding of the subjective experience of the phenomenon. Finally, in qualitative research, confirmability addresses the findings of the study, not the objective position of the researcher. In sum, when auditability, truth value, and applicability are demonstrated, confirmability is achieved.

Similarly, traditional empiricist standards of reliability and validity are inadequate measurements of rigor in feminist research (Hall & Stevens, 1991). Feminism also emphasizes the uniqueness and contextual nature of women's experiences. Standardization and repeatability are paradoxical to the feminist perspective. Dependability is recommended as a more appropriate

measurement and is determined by an audit of the inquiry. This is similar to the concept of auditability noted above.

The positivist science criterion of validity does not adequately encompass the complexities of women's experiences. Consequently, feminists turn to qualitative research methods. Here, validity and reliability in feminist research are conceptualized as "continuous" reflecting an "interconnectedness" as opposed to compartmentalization seen by empiricist researchers. What emerges is a standard of rigor termed adequacy. Hall and Stevens (1991) elaborate, "Adequacy implies that the research processes and outcomes are well grounded, cogent, justifiable, relevant and meaningful." (p.20). The concept of adequacy encompasses ten assessment criteria to be met in satisfying rigor: reflexivity, credibility, rapport, coherence, complexity, congruence, relevance, honesty and mutuality, naming and relationality. These criteria are similar to the notions of credibility and fittingness identified above. Of the ten, three are considered more fully for their added emphasis of the feminist approach complexity, relevance and naming.

Complexity refers to how effectively the study captures the socio-economic, historical, cultural, and political contexts of women's lives. Much of empiricist science has subsumed women's experience to male norms in conventional society. Thus, representation of the complex nature of women's lives situated within the context of the everyday, influenced by the culture of political and economic institutions and reflecting a historical background becomes imperative in feminist methodology (Hall & Stevens, 1991).

Relevance evaluates the applicability and significance of the research study in advancing the concerns of women's issues. Identification of the source and interest of the research and determining how the findings will be used are central issues for consideration. Naming is seeing beyond what one has been

socialized to see, challenging conventional assumptions of what is there to be seen in exploring the meaning of women's lives (Hall & Stevens, 1991).

Summary

In Chapter three, I provide a comprehensive discussion of phenomenological and feminist methodologies employed in the study. I show the link between phenomenology and feminist thought. The rationale for selecting these methodologies, based on a nexus of nursing, phenomenological and feminist perspectives is articulated. I conclude the chapter with a description of the participant selection procedure. Ethical consideration of the study participants is outlined and procedures for collection and analysis of the data documented.

Six women participated in the study. Of these, four women participated in second interviews and two women in third interviews. Following analysis of the data, an organizing framework was constructed based on the major themes arising from data. The organizing framework will be used in Chapter 4 to present the study findings.

CHAPTER FOUR: PRESENTATION OF THE FINDINGS

The presentation of the findings begins with a description of the study participants. Next, the organizing framework constructed from the central themes of the data is introduced. The framework is then used to present the findings. A summary of the participants' perspectives on the experiences of aging and chronic illness concludes the chapter.

A Description of the Participants

The ages of the six study participants ranged from 60 to 78 years. Four of the women were married, one was divorced and the other was widowed. Of the four married women, two women reported their marriages as happy, one described her marriage as conflictual, and the remaining woman implied an unhappy marital relationship. All the women had children and most women described their relationships with their adult children as fulfilling. Three of the women had experienced single parenthood.

The socio-economic status of the participants averaged mid-middle class. Life-span shifts in class standing was reported by four participants. Two women had maintained the high middle class standing of their families of origin. The educational background of the women ranged from 6th grade to a university undergraduate degree. The average was first year college. The majority of women had worked outside of the home for most of their married lives and were now retired. One woman had recently entered the work force at the age of 59.

Although all of the women were of Chinese ethnicity, one woman was Canadian born, second generation Chinese. Of the remaining five women, three had immigrated from Hong Kong, one from Malaysia and another from England. All five of the women who had migrated to Canada within the past 10 years had experienced migration several times in their lives.

All of the women had diabetes. One woman had Type I diabetes known as insulin dependent diabetes (IDD). Five of the women had Type II diabetes known as non-insulin dependent diabetes (NIDD). Although all of the women had at least one chronic illness in addition to diabetes, four women had two. Heart disease and hypertension were the most commonly occurring chronic illnesses followed by arthritis. Of the three women with heart disease, two women had coronary artery disease and one woman had valvular heart disease. All three of these women were on medication regimes and were regularly monitored by a cardiologist. Of the two women with hypertension, one woman had experienced a stroke. The two women with arthritis described themselves as having a "mild" form of the disease. All of the women were independent in their activities of daily living (ADL). As well, all of the women had been in contact with Canadian Diabetic Association and the woman who experienced a stroke was an active member of a community stroke club.

The Organizing Framework

In this study, participants were asked to describe their experiences of aging and chronic illness. Synthesis of the participants' responses showed that both adversity (loss) and prosperity (gain) are found within aging and chronic illness experiences. The wisdom of older age is sought to understand the events. Wisdom guides an inner dialogue about the experience of aging and chronic illness, by thinking through or "sorting out" previous times of adversity and prosperity in relation to the "new" losses and gains of aging and chronic illness. Finally, control, characterized as the need to accommodate times of adversity and prosperity, emerges as a central theme of the voice of wisdom. Accordingly, this dynamic inner dialogue, a process directed by and through the voice of wisdom is termed the Dialectic of Control.

Three phases emerge from the Dialectic of Control: Noticing the Changes, Reflecting on the Meaning, and Optimizing Control. Phase One, Noticing the

Changes describes observable changes in the participants' Activities of Daily Living (ADL) and role performance. Phase Two, Reflecting on the Meaning, reviews past times of adversity and prosperity for insight into the significance of change. Optimizing Control, the third and final phase, reveals strategies to accommodate the losses and gains associated with aging and chronic illness.

Two figures of the organizing framework are presented. In Figure 1 (page 66) aging and chronic illness are portrayed as spirals situated within the polarities of adversity (loss) and prosperity (gain). Adversity refers to lowered ADL and role performance accompanied by discomfort or pain. Prosperity, on the other hand, refers to the freedom from responsibilities that comes with older age, the optimizing of independence and limitations in ADL and role performance and, the good fortune of remaining pain free. Although not directly related to aging and chronic illness, war, poverty and culture as well as marital and family conflicts are included into the framework schematic to reflect the impact of these events on the participants' lives.

Wisdom is represented as an *inverted* triangle. Naiveté, the inverted tip of the triangle, represents the youthful limits of knowledge that over time evolves into the wisdom of older age; wisdom, the culmination of life long knowledge forms the base of the triangle through which the experience of aging and chronic illness is understood. As a participant instructed, "Chi lo, mai lo. That mean (sic) I am old enough to show off my old age knowledge."

In Figure 2 (page 67), the Dialectic of Control is shown as an inter-active dynamic; each of the three phases depicted as overlapping processes embedded in a circle of past, present and future. The outer aspect of the circle represents the contexts of social, cultural and economic circumstance. The figure emphasizes the shaping of the experiences of aging and chronic illness by each participant's socio-economic and cultural past, present and anticipated future.

Figure 1

ORGANIZING FRAMEWORK

Dialectic of Control (Adversity/Prosperity)

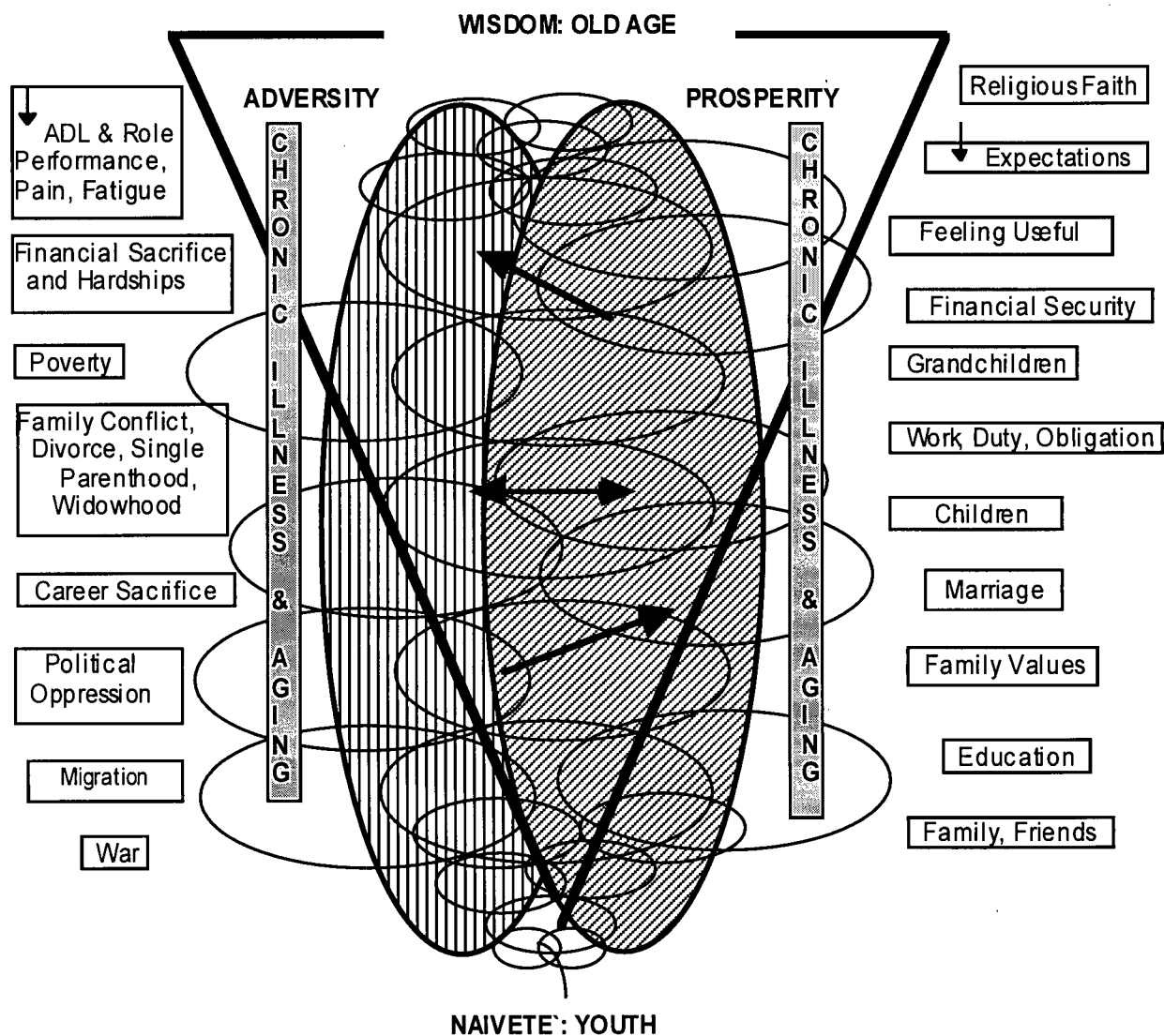
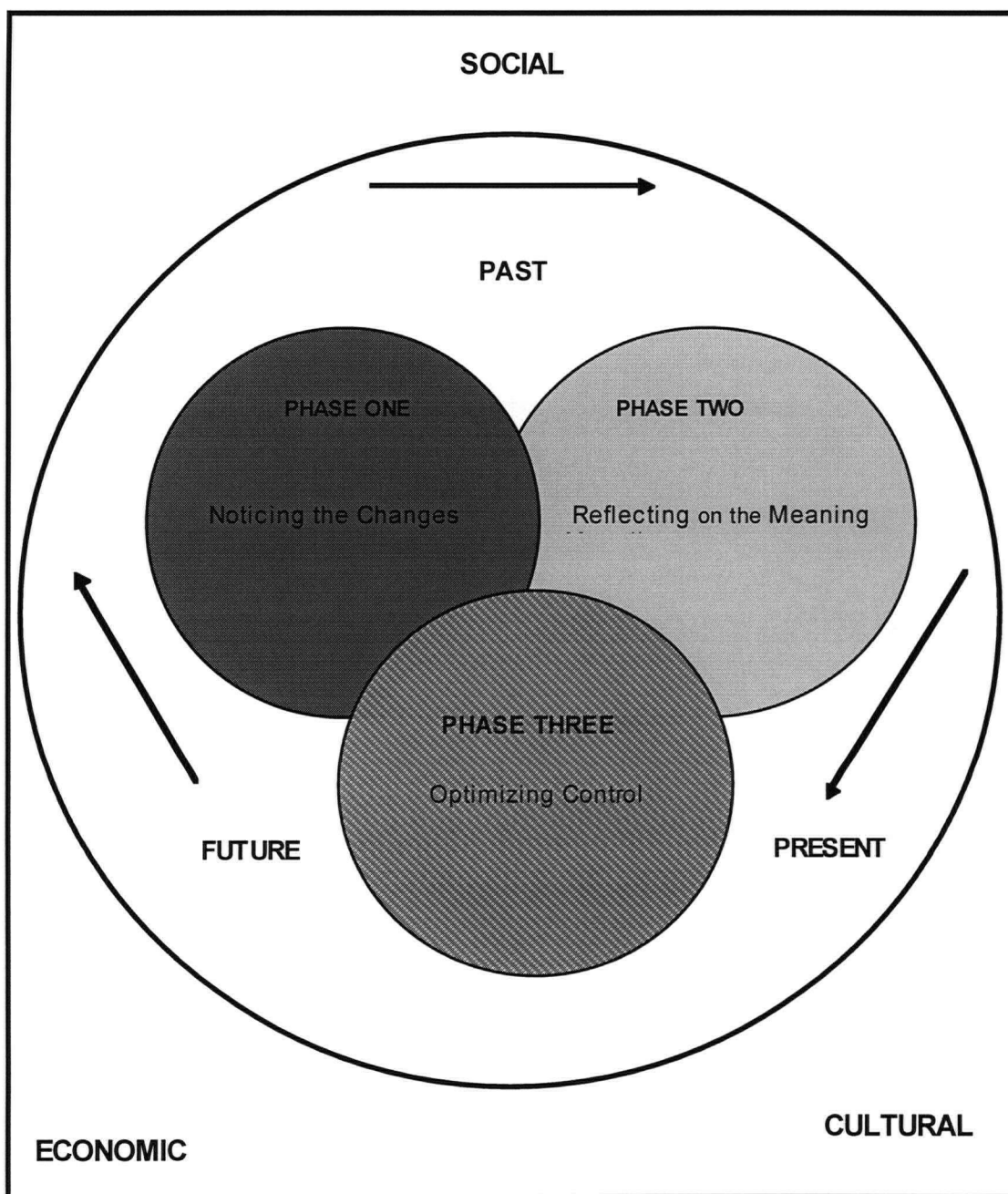


Figure 2

ORGANIZING FRAMEWORK**The Three Phases of the Dialectic of Control**

Noticing the Changes, Reflecting on the Meaning, and Optimizing Control
(The context of time and social, cultural and economic influences.)



Phase One: Noticing the Changes

Control over performance (independence) in ADL and the impact on relationships were the main themes of discussion in the participants descriptions of aging and chronic illness. Awareness of society's negative attitude towards aging was identified. This was evident in their expressed concerns about their performance in both their current situations and in the future. For example, a participant observed,

That's the part about I don't like about aging. People don't stop to think that just because you're old, you're not a person type of thing. I think that sometimes... there is feeling you get from people that as you get older, you somehow become less of a person, you know ?

Participants whose performance was less significantly altered by their illness, described the initial experience of aging as subtle, something that "just slowly creeps up on you." A participant related,

I've never thought about it. Its only quite recently on TV.....I say, 'Hey ! The announcer seems much younger !' But, I have never thought of aging myself, as myself. And, I still do not think of myself as an aging person. To me its creeping on so slowly that I'm not recognizing it. So, that when I look in the mirror I see the same face that I saw yesterday , and the day before..its gradual, my aging is gradual.

This woman denied any changes in her performance. Indeed, as will be noted below, she stated she felt she was more active as she aged.

Activities

Performance was strongly linked to the notion of being useful. That is, remaining active and productive in one's ADL and having the ability to contribute to the lives of family and friends in some way. Descriptions ranged from those who experienced significant changes to those who noticed little or no

differences in their performance. For example, the above participant commented,

Its (aging) creeping on so slowly, that I'm not recognizing it. So, I'm just going, you know. I'm still very active. As a matter of fact, more active than I've ever been, so I don't feel old. I do things that a 42 year old woman does. I don't feel that I'm in the old age.

Still another participant suggested that she is too busy to think about aging very much,

So, I don't think about it much really. Because I got so many things to do. You see all the junk I got here. So, I keep busy. And I read a lot. And I pick up a lot of information, you know, about it. On TV there is always some programs about seniors. And in the paper. There's even a piece here in today's paper, see, 'The right to die.' And, well heck, its one thing you can't stop !

However, a general slowing (lowered efficiency) and a drop in the overall quality of performance (effectiveness) was reported by most participants. Fatigue was a major issue in performance with the participants noticing a faster onset of and a slower recovery time from fatigue. For instance, a participant illustrated,

So, you see, its how long it takes you to thread a needle, to pick up pin, you see. You are slowed down. Like walking. Formerly very brisk, And not tired. If I'm tired, just sit down for 10-15 minutes, I get up and do a lot of things again. But now, you want to, but you can't, you see. So you have to sit and rest for awhile. Wastes time. So, that's how it goes more or less.

Another participant spoke to the gradual onset of the decline in performance, noting the change in energy from when she was young. She commented,

Gradually you feel you cannot do too much and then you get tired easily. You cannot do as much as you do when you are young. Like you don't have so much energy. You feel it, you know. Every year you feel it.

The following participant communicated her struggle to come to terms with quality of her performance,

Yes, sometimes, I feel everything not satisfied. (satisfactory). But, I say, Oh. I'm just getting old, don't be so selfish (so particular). Or just that I should take it easy. I just tell myself not to be so selfish. Keep it easy. (But) I want to do it much better, you see. But, now, I feel tired and everything is busy. I have no time to do it more better.

Participants noting more significant changes in their performance described their experiences of aging in relation to their chronic illnesses. For instance, the following participant describes aging in relation to the stroke she experienced 18 months earlier.

I don't feel it (aging) really. Except like with the stroke now, I feel it. But other than that I still feel I'm able to do a lot of stuff. I look after the house and I baby-sit my grandchildren. So, I don't know, maybe its something in side. I don't feel old. And I don't feel that I'm not useful. I still feel useful.

Gratitude for the absence of more severe physical limitations as well as freedom from pain and suffering was often expressed. A participant commented,

Well, sometimes I feel well, you know, like an old car ! All the parts are getting worn out. You inflate this part, the other part goes out ! But so far it hasn't given me a permanent problem. So, I am quite happy that I escape one after the other (serious illnesses and operations). I know many people have just one problem and they suffer so much. So, I have many problems yet...I mean the problem is there but the pain...I don't suffer. So, I am really grateful for what is happening to me.

Another woman added,

The change is gradual you know. You don't have to be sad about it. Actually I feel very happy because I have more than other people have. Because I can still walk. I'm 73 now. And so I can still walk. I can still eat. I can still sleep very well now.

The severity of limitations on the participants ADL shaped their accounts of their aging and chronic illness experience. A participant described her experience of aging and chronic illness this way,

I do get the occasional, you know, when you wake up in the morning and you feel a little stiff. But nothing that entrophes doesn't change. I'm a little stiff in the fingers here, but that's it. And, I have what they call diabetes. I have never been able to say, "I have diabetes." I say, "They tell me I have diabetes." Which is a control sugar thing. And, I control my sugar. I eat, I exercise and I take one tablet or half a tablet per night before my dinner. But it has not changed my lifestyle. OK So this is what I have and I control it.

Another participant, somewhat more restricted in her ADL described her understanding of the changes brought by chronic illness this way: "You see, I don't have any pain, or suffering from difficulties like some people have with their hands and their feet. I'm glad, so far I am still able. I don't need help or anything."

As all of the participants had diabetes, much of their discussion focused on adjusting to diet regimes. Expressions of frustration in cooking Chinese cuisine with markedly lower amounts of sodium and fat was a common concern. Indeed, cooking, once a pleasure, was often a source of frustration because of diet restrictions. Still, all of the women continue to experiment with ways to cook palatable Chinese food within the guidelines for sodium and fat content. Perceptions about the quality of performance are strongly linked to the participants' sense of their role performance within relationships.

Relationships

The inability to perform relationship roles as well as when they were younger or, more commonly, prior to the onset of chronic illness was a constant in the participants' stories. Negotiating a comfortable balance between independence (self sufficiency) and dependence (asking for and receiving help) with family members was identified as a challenge. Role performance in marital relationships was problematic for several participants.

The researcher identified unmet dependency and support needs reflected in this woman's statement who said,

I look after my husband. I have also to do the housework. Even cooking and put out and say, 'Its ready.' And, he come and he eat. After he finish his meal, go back to the seat, (points to the recliner chair in the living room) and look at TV. And then to sleep. Snoring, snoring , snoring. That's why we separate our rooms. And also my husband, he especially like to join the people and be happy (miming - raising a glass to her mouth several times). Like to the banquet. Everybody eat too much and everything. Not good for health.

Given that the woman appeared nervous, looking over her shoulder as she whispered this part of her narrative, the researcher queried the happiness of the marital relationship. Although alcohol abuse was not raised as an issue by the participant, the content of her story and the manner in which it was relayed was interpreted by the researcher that the relationship was less than satisfying. As the participant was unable to participate in a 4th interview the researcher was not able to confirm the plausibility of this interpretation.

Another participant, in spite of a loving relationship with her husband, expressed the inadequacy of her marital role because of fatigue. She related,

Its because of me. I sick. Why can't I go. Why can't I say yes, and then let him have a good time. Its because of me. I drag along and make him so miserable. Early morning I walk with him. Once. Then I cannot go. After lunch we would like to walk too. Every meal, after every meal we like to walk a little bit. We used to do that, you know, when we were young. Always. He always holds my hand. And now I cannot go. He go, one more time by himself. Isn't that awful ? I feel guilty like. Don't you think so ? When you have a husband, you want him to be happy too. Its because you (I) sit. Why can't I go with him ? Why can't I make him happy ? He's old too. And he cannot have this and he cannot have that...And even you know, sometimes when I cook, I cannot put salt in my food, so we have table salt all the time ! See, when you live with someone, you, you love him that much, you know what he think, he don't have to tell you.

Fatigue was a major factor affecting the role performance of the next participant also. The woman described,

I find I tire easy now. Like I say, it could be from the stroke too. I think its just a combination of everything. And, well, I don't have the patience like I used to. When I have the grandchildren-and I love having them- but when they make too much noise I just wish their parents would come and take them home. I find that I can't handle it as well.

Phase One, noticing the changes, highlighted the concept of control over an individual's performance in physical activities and in personal relationships. Participants identified fatigue as a major difficulty in adjusting to the impact of aging and chronic illness.

Phase Two: Reflecting on the Meaning

Participants explored their pasts and looked to the future to gain current understanding of their experience of aging and chronic illness.

Remembering the Past

Four sub - themes were synthesized from the participants' pasts: relationships, cultural influences, significant life events and self perception. Often practical strategies for adjusting to change and maintaining control were revealed. For instance, a participant recalled her early days of diabetes and her instruction of her grandchildren. She said,

But even my grandchildren, when I used to baby-sit them, I said, 'If grandma's out in the garden for too long a time, you look out and you see her lying on the sidewalk out there, you bring the sugar bowl and just open Grandma's mouth and put it on her cheek on both sides.' You know, to this day, my granddaughter remembers that.

Relationships. Participants recalled relationships with family members and friends who had influenced their lives in a significant way. A participant acknowledged, "I think that the way you are brought up have something to do

with your attitude to life. You know, your way of thinking." Receiving an education held particular significance for many of the participants. A woman stated,

We were lucky, you know, most Chinese, at my age, they don't go to school. Because you know, the Chinese family, they only want boys to study. The boys, their,you know, while the girls only marry out. So they don't give as much attention to them. But my father is different, because my grandfather is a diplomat, he is a very famous person in the Ching dynasty...So, although we have 11 children in the family, my father let us, all the girls can go to school. Like the boys. All put in a very famous and expensive school. That's why we're lucky.

Another woman said,

I am grateful to my father. My father was saying I leave nothing to my children except a good education. We were just lucky. When we started schooling, my father took care to send us to the best English school possible in Hong Kong and he had to pay a lot. Well, my father was a very learned man. He was an advisor in the Hong Kong university in the Chinese department. And he himself was educated in England.

Still another participant remembering what she learned from observing her blind grandmother reflected,

Like I see my grandmother grow old. And, see she was blind.. But she was quite smart to go around the house, without a problem. She can comb her hair and she can coil it neat as before without seeing. But like other things she can't do because she can't see. And sometimes she hears movement and she is trying to know what is happening. I find that, oh, its very exhausting. So, I was saying to myself, I hope one day when I grow old, I won't go blind. And then I said to myself, I will have to look after myself well so that I won't be a burden, you know to anybody when I grow older. And maybe it occurs to me, goes so deep in there. I try very hard to keep myself as active as possible, as long as necessary you see.

This participant recalled the wisdom imparted from her parents and her grandmother. She recounted ,

I listened to them when I was young. They would put us to sit down and they would talk to us. This is not a thing that the modern generation is having. And pearls of wisdom came out of their mouths. And I used to pray...Oh, my mother was a fantastic

woman. She was half Burmese and half white. And I used to pray to God, let me have that wisdom. And she told me that wisdom comes with age, my child.

And, I just loved my grandmother. I loved going to her house. And she would make us our favorite soup. She was very loving. She died at 92. She had all her faculties, walking, reading, she was doing everything for herself. She just died of old age, in her home, in her bed. She just fell asleep and that was it.

Still another woman recalled the kindness of a sister-in-law. The fourth of nine children in a family struggling to survive economic hardship, the participant remembered being beaten by her mother and treated cruelly by an older sister. The participant wept as she spoke of the kindness she had received from her sister-in law. She related,

And when I had the period, you know. Mother never explained. I didn't know what the hell was the matter. I thought I fell off the bike and hurt myself. And my brother's wife, she was kind. She used to put me on the bed and show me how to put on this cloth. You folded it like diaper, in a narrow band. And then when you used it, you have to wash it out. My sister should have been the one, but she didn't she was just nasty.. But my sister-in-law, she was good. Ahh, I missed her when she died. Because she was like a mother, you know what I mean. She was always there for me. That's why I help her daughter-in-law, its like I'm doing a little something back for her.

Her mother's lessons on how to be a thrifty provider evoked feelings of appreciation from this participant. She informed,

You see, I dress very...ugly, maybe you think. But I do this all by myself. I get a piece of material and then I measure it. I can make a coat or a pants or something. I just use it, every single piece. Yes. And I want to thank my mother. Really, she was so clever. She teach me to learn things. And in a useful way. A Chinese girl should learn how to keeping house, how to use everything very useful.

The participants explained how these individuals who exemplified wisdom and kindness as well as strength and practicality, taught them to cope with adversity.

Cultural context. Stories of women's role within the family and the changing nature of the family in relation to inter-generational differences gave steady testimony to the cultural context of the participants lives. Themes such as duty, honor, respect, obedience, obligation and thrift were constant throughout the participants narratives. A second generation Canadian Chinese woman who identified herself as a "half and halfer" described,

My mother died when I was 13, so I don't remember a lot of it. So, I feel that I am more Canadian than Chinese because I live around more Canadians and I do a lot of things that are Canadian. But there is still a wee bit of the Chinese that's left over from my Mom. I still have to respect my elders. Like we were always taught you don't talk back to your elders. So even if I don't agree with my step mother or sister-in-laws, or even my older sister, I would never say anything to anyone because I don't want to hurt their feelings by saying something they don't want me to say. You see, its Chinese custom that you show the elders respect.

Another participant provided this insight on family life. She reported,

You never talk back to your mother and father. Even if you are right you are not supposed to. And then, even when my father ask my opinion, then I have to wait till I see that he really means, sincerely mean he wants to hear the true thing. You know, sometimes he just wants you to please him. Say the things that he wants , you know. So you have to look carefully before you answer. ...You can tell by father's eyes. So you don't say anything deep down in your heart actually, what you want to say. But when he is happy and he's sincere and all that, then you can tell him about how you feel and what you want and what you don't want.

Woman's role was best characterized by a participant when she informed,

...some Chinese they still very conservative. They don't think girls are that important. As long as they become good wife. That would be OK . Chinese very seldom think of divorcing each other. No matter how hard it is you have to stick to that marriage to make it work. You are the one. You see ? Not the opposite one. Look at the mirror. What's wrong with me ? Why can't I make him love me ? Why can't I make him happy ? Its all my fault . See ? Not his fault !

Another participant used the teaching of Confucius to provide this life-span view on the role of women. She said,

Confucius say when you are young you accept your parents teaching and accept their advices and you please them, you see. Because they are your parents, you are dependent upon them. They are caring for you. When you come to marriage, you have to learn to know your husband and accept him and be in a good relationship, you see ? So that the marriage will be a good one. And then in time you grow older, the time when you come to be a mother-in-law or grandmother. That is the time that you learn to know the relationship between son and mother. Your son is no more a child. He's a man of the world. He knows what to do. He knows what is best for himself and his family. You learn to know this is a time for you to retreat. Chinese ladies are taught to be very tactful.

Thrift was characterized as an important lesson by this woman who observed,

I am in my Chinese way. A Chinese girl should do best at home. Don't be lazy. Try to learn some cooking, sewing and be peaceful with the neighbors. Many, many girls have lots of good education. But they don't use it. They use it on the wrong way. Some woman, think more money and more money. But they spend it, never use it the proper way or very sensible way. Like maybe help somebody, or maybe get more knowledge to learn from school, or get some savings. We don't know about our future. Maybe someday we cannot earn some money, so will have savings. This is very important.

A change in generation values was offered by a woman who related,

I remember my father said, "A woman must be educated, a woman must be cultured and a woman be this...." But in the end, she's going to end up looking after her children, taking care of children. So I never worked. I had to stay at home and look after the children traditional style. The young people today are not going to do that. I worry, I feel sorry for them. Because I feel they're missing out on things.

Changes to the traditional Chinese family were noted by this participant who remarked,

In Canada its not like China. In China, we usually get together. But in here, everybody have job and living far away. They have their

family to look after. Everybody is busy. I don't like it. But they are independent now. Too bad. Because the children do not stay with their grandparents. If they live with their grandparents, grandparents can look after them, you know ? Teach them not to go out to much with the other children. But now parents go to work. Leave them at home at summer time. That's what I'm thinking. No good. Its better to have mother stay at home and look after their children.

Participants talked about the differences between Canadian and Chinese (Hong Kong) social values and behaviors. A participant commented on her adoption of what she perceives to be a Canadian custom. Recalling her own childhood where the open display of affection was forbidden, she related,

Momma not happy. Momma, you know, not like you people here. You can hug your mother and all that. Oh no. You don't do that. Unless you're a good girl, or very good, you know. Then Momma would come in and pat you on the shoulder. And you feel very proud. Not like you people hug each other and all that. And even now I hug my granddaughter. Yeah. To show that I love her. I think hugging is a good thing.

Another participant reported a similar insight when she said,

And yet, in my day, when I had my babies, I was never as relaxed because I was inhibited. Very much inhibited. And I was not demonstrative and loving with my husband and my children the way people are today. I remember hugging my babies and so on. But I was born and brought up in England. They are not a very demonstrative people. And the Chinese people do not show any love and things like that. But I notice that the generation today, they do that in public. The young mothers really enjoy their children and their husbands in a way we never did.

This participant addressed the cultural differences in social values regarding sexuality, particularly in relation to young people. The participant advised,

Chinese are very important on this rule. Before you marry you cannot sleep with other boys. No such thing !. Never dream of such thing. Oh today is...You have condom in the schools ! Isn't that awful ! That is never heard of. Chinese never, never, never, even talk about these things in the house. No. But mother yes, maybe sometimes tell you. Don't do such a foolish thing. Don't let

the boy touch you. No,. That is very shameful. And, also, you see the movie. You only know the man for a few minutes, you know, and then the jump into bed. Isn't that an awful thing !

The cultural context of the participants lives provided a rich understanding of the experiences of aging and chronic illness. Traditional family values and beliefs were emphasized. Woman's role within the family was revealed. Themes of respect for one's elders as well as duty and obligation were noted. Inter-generational differences as well as cross-cultural comparisons of social values and behaviors were illuminated.

Significant life events. The issues of socio-economic and political hardship emerged as a themes from the participants review of significant life events . Several women had experienced single parenthood. A participant related the difficulty of attempting to balance the responsibilities of running a family grocery and parenting her children. Describing how she worried about leaving the children unattended after school she said,

So, I said, that's it. I gotta do something. Our next door neighbor was Mr. Doe, He was a real nice person. He used to watch out for us all the time. But I said, I can't be totally dependent on him, you know ? Just because he has a good heart, you can't use people. So, I made them (the children) come down to the store right after school. Well, I tell you that was hard. Because they would say, ' Mom, everybody gets to play baseball, we can't.' And I said, " Well, Jane is under age. If the welfare people know that I leave you guys alone, then they can take you away.' I had to threaten them with something. I don't know, a lot of people used to say to me,' Gee your terrible. Making your kids work for a few cents.' But that wasn't the idea. It was if they are there, they are under my care.

Another participant described the circumstances that led to her estrangement from her two eldest children living in communist China. Under government surveillance and seriously ill with TB, she had been denied permission to take her husband and children with her to look after her ailing father in Hong Kong. She fled the country taking only her youngest son. The participant related,

Well, I was under great suppression because I was teaching Americans in Wu Chow which is not far from Canton and because I spoke English and was from Hong Kong. And we had just had a struggle to have a new house built. And well, you know the communists, they had much against me. And they kept asking me questions about this and that. Well, I applied many, many times to come back to Hong Kong. My husband couldn't leave, he had to stay where he was. All my applications were not approved. Until one time, they just gave me permission. So, I left taking my youngest son. I meant to go away forever, but the rest of my family didn't know. Leaving my husband and my oldest son and daughter. She was 10, my son was 9. So the first thing I did was to write them a letter to say I was safe but I couldn't come back. I couldn't tell them before hand. There was too much responsibility on my husband. See, they would blame him for this. I was really suffering a lot. With 3 children and I couldn't do anything and the economy was getting worse and worse. I knew if I stayed on, I don't know, I don't think I would be here anymore. That was 1956. But they were very terrible years from 1957 to the time when I immigrated to here, to Vancouver, in 1975.

The next participant described how her husband's prolonged unemployment late in his career had dramatically altered the "sheltered" life she had previously enjoyed. Forced to enter the work force at a late age, she observed the following about women' struggle to cope with family responsibilities when she said,

Family difficulties. Oh yes, I think it's one of the worse things. That can age a woman and it can age a man too. But more so for women. They seem to deteriorate much more rapidly than men. I think its because they have nobody to share the strain with. If you have somebody to share the strain with, I don't think you age that rapidly. Because half the problem is solved already in having someone to share it with.

Careful saving resulted in another participant's eventual immigration to Canada. Although she felt that she and her husband were financially secure, she added the observation that she was now too old and ill to enjoy it. She stated, "Now is much better than before. The only trouble is old." The impact of those years of austerity was lasting. She said,

Everything cost lots of money. I have to use it carefully. And the only thing I want is to save some money. For the older future, see ? I still have the habit now. I buy anything, I keep the receipt. And then I keep it, write at the book. I still have that habit. That's the habit. I feel I do it, I feel I'm happy.

In sum, of the six participants, four women originated from wealth and two women from relative poverty. Although the occurrence of divorce, widowhood, shifts in income and educational opportunity differed among the six participants, the consequence of those events in terms of socio-economic status was in the final analysis similar for most participants. That is, in spite of their more auspicious beginnings, two of the women had dropped from a high to a low, low-middle class income group by the latter years of their lives. Moreover, two women born to low income families achieved middle class status by the time they retired. Finally, women who were single parents for most of their child rearing years identified that this experience taught them how to cope with adversity.

The context of self. Emerging themes captured the participants reflections on how the naiveté of their youth had evolved into the insight and wisdom of adulthood. Youthful decisions were regretted by few. The participants' lives had been shaped by the socio-economic and political circumstances of the time. As in the participants' explorations of their cultural backgrounds, themes of sacrifice, duty and obligation to the family were frequently visited. For example, a participant recounted,

When I was 20 years old I had a lot of dreams. I had a nice bright future, I thought I would become a professional person, and I would marry a nice man and he would have me in his castle for the rest of my life and I would never have to work and I have never worked. And when I was 35, life was more secure. I not only had my husband backing me up, but my parents too. My parents provided me with all the niceties, the little extras, that I could not have had, would not have had. I had a lot of security then which I don't have today. Because in 1993, I had to go out to work

because my husband was out of work for two years. We needed to replace money we had borrowed on our RRSP's to educate our daughter.

The participant went on to describe the sacrifices she made for her parents, husband and children. She states,

You know, I said my life is 99% sacrifice. Do you know that I have never really done something I wanted to do for myself ? I always think about what the effects will be on others. My family, especially my husband , my children, my mother and father. And because of them I didn't do certain things I might have enjoyed doing. I wanted my career. I wanted to carry on with my piano had to let that go because of the children. Because when I thought I could have been practicing 8 hours a day, they have me driving them to the swimming pool, hockey games, football practices and piano lessons. So, I have to stick all these diplomas' up in the bathroom and just look at them whenever I go to the loo.

One of the women reported that she had 'no idea' about life when she was a young woman. During the war, when she was in her early twenties, the family fled Hong Kong for China. The participant stated that she didn't think much about "those things" (education or a career), she only remembered doing her housework and her lessons from school while a young teenager. She said, "I was so stupid (unworldly). Not as clever as the people like now. I never think about that." Married during the war, she offered the following insight from when she was 35 years old when she said,

I think I wasn't happy then. I have four children. I cook, I wash, I manage everything for the house. Very busy, every day to look after the young and send the eldest children to go to school and look after their homework. I say ' Do your duty. You have your lesson to do. I have my duty to look after you.' And, only one person get money. I be very careful. I watch, when I saw a kind of good things or maybe a picture ? Oh, it look lovely ! Everybody say and something like that. I say, ' How to do it ? How to write it ? ' I try to use my own way to copy, not a way to, how to, buy it. You see, its not easy to use money to buy it. So, you think you like it, you try to learn how to do it or how to make some. This is the way. If you rich, you can go out and buy this and buy that. But I say, ' No. I can't do that. '

Later in the interview, following an exchange on the consequences of war, the same participant paused as if to reflect on our words, then ventured these additional thoughts about her education. She said,

In China, mostly the land is good to grow. The country with no war, more even (stable), you see. That would be better. ...I know nothing. I have mnn, good education, but not much. I haven't go to university and I usually stay at home. Only be a housewife. I watch and I learn. Yeah. This is the only thing I can do. I usually have a lot of books to read. But really, I should go to school. Some teacher to teach me. But I have no time. I have to look after my husband.

A participant related how the circumstances of war impacted her life. She informed,

I hoped one day to finish my schooling and become independent. That was my goal. But it was never reached because of the war, because of the Japanese occupation. I was hoping to finish my schooling and then, my independence. I don't know what independence, financial as well as the other. I was thinking when I was 20, well, when I am 22 I will graduate. It was just never realized. I was in 3rd year of university. Oh, I didn't feel anything bad was coming on. We were in the middle of an exam, a history exam, when the bombs came over. We ran to China, my father and I and my sisters. And when we left for China, I did not have the right life experience. My experience up to that time was as a very good student. But, if not for the war, I would never thought of getting married. Its true...because I really wanted to be independent myself. But because of the war.... Yes. The way of thinking, at the age, the fragile age. I thought the end of the world was coming. And I really didn't care what was happening to me. And I knew that my husband wanted me. So I just obliged, obligation, you see. At age 36 I was widowed, without a husband. My elder sisters had indicated to me that there were all so many of these eligible bachelors. But I said no. I still have my duty to do, my duty towards my children.

The participant went to comment on how duty and obligation were linked to her idea of determination. She stated,

I only did what others expect me to do. Again, I was saying, it is out of obligation that I do this and do that. I think though that some good may come out of it. Because I have a very strong sense of

duty towards my family and that is how they are able to come over now. You see, through my determination. If you don't have that kind of determination, you just go on and have your own life and make your own life.

In sum, through life-review, participants identified the knowledge and skills they had learned from family members that had assisted them to adjust to the hardships of life. The participants stories reflected perseverance, determination, thrift, obedience, obligation, and sacrifice; attributes viewed as necessary if one was to cope effectively with times of adversity.

Considering the Future

Participants expressed a common concern for their ability to remain independent in the future. One of the greatest fears of the participants was becoming a burden to their children in some way in the future either in terms of requiring their adult children to be responsible for their care while at home or for organizing facility care. Facing death emerged as an additional theme.

A participant related fear of losing control of her ADL performance in the future. She said.

I don't know. I just hope that if I get old, please don't let be (sic) disabled. That's the only thing that goes through my mind. I don't want to be dependent on anybody.

Another participant stated,

I should probably just sit down and pray to God that he,...that I die before I reach what I consider to be old age. Where I lose my eyesight, or I'm on a dialysis machine, or I'm hooked up to something, or I'm in wheel chair or I have to walk with a walker. That sort of thing that would incapacitate me. I would feel a burden and I would feel sad...and those are the things that come with old age, aren't they, the price you pay for living to a ripe old age.

In discussing the inevitability of death, several of the participants revisited the deaths of family or friends. One participant talked about the importance of

saying good-bye. She remembered the circumstances of her father's death.

She recounted,

Yeah, Dad's growing old. He had a heart attack. And they took him to the emergency at the hospital, because he said he had a pain. And they said he had a heart attack. So he lived...and I wanted to go back right after work, but my sister said they were going over on the weekend and why didn't I wait. So, I waited, and we got into town late at night and I was just getting ready for bed when the phone rang. Dad had died and we didn't get a chance to go up and see him. And that's the only thing I was really sorry about. I had wanted to see him you know, one more time, you know, before he died. So, when my brother-in-law was dying I didn't wait. So, I saw him for about a week before he died and it made me feel better that I did.

Another participant described having experiences where she would actually "see" both her parents following their deaths. The experiences were positive and caused the participant to feel close to her parents in remembering what they were like in terms of their characters and in recalling special events that they had shared together. Another woman approached death in terms of her mother's longevity. She explained,

So, I have done my best. Sometimes though, I feel a little bit sad. Oh, that maybe time is coming. But I say no, no, no,. Not yet, not yet. My mother pass away at 93 years old. I say, no, not yet. I am only 76. Still a long way to go !

All of the participants accepted death as a natural part of the life. Participants likened death to the seasons of nature. One participant who was an avid gardener, used the metaphor of cut flowers. She illustrated, " Maybe like the flowers. You put to keep it and you can't put it too long. It maybe fade after the days come. So do I. I can't do anything to stop it." Another participant also used the metaphor of flowers . She described,

Like I have the camellias and rhodies eh ? And whatever I can grow I'll grow. And if it doesn't come up, well at one time I would feel so bad. Now I say its life. Its like people. If they die, they die. Its all just part of life. So you have to take it as it comes along.

What can you do ? You can't just map it out and say I want it that way. There's no way.

The participants also talked about the continuity of life from one generation to the next. They felt comforted by their grandchildren which meant that a part of them would continue into the future. A participant explained,

And, like I said, I get a lot of joy from them. But to me, you see, its like they're a little bit like ...well, they're not really a spin off...but, you know, its like they're a piece of George and I.

Some participants talked about giving pieces of their china or silver to their children or grandchildren as remembrances of themselves. As one participant related, "Just so she can remember me, have something that is mine,"

In Phase Two, the consequences of relationships, cultural influences, significant life events and self perception unfolded to weave a rich tapestry of the significant chapters of their lives. A participant explained, "Oh, I think it would take some time before I can tell my whole life story. Well, I'm an old person now, so there is a long history to catch up on."

Phase Three: Optimizing Control

Phase Three identified approaches taken by the participants in balancing the changes (losses and gains) associated with the experience of aging and chronic illness. Emergent themes were living in the present and planning for the future. A participant provided this insight on aging. She related,

We Chinese say it this way. When you are old you need three things. First, that is your companion, you know, your other one, most important this one. Then its your money. You keep your money between you two. Don't give it to your children when you are living. See ? And then, the third one is your friends. You need friends. You can't live without your friends. See ? We are lucky, we have these three things.

Indeed companionship, financial security and friendships were similarly identified by the remainder of the participants as requisite needs for a satisfying "old age".

Living in the Present

Having a religious belief, enjoying the good in life and developing practical approaches to ADL difficulties were common themes reflected in the participants narratives as effective ways of coping with the changes associated with aging and chronic illness.

Having a religious belief. The majority of the participants identified themselves as Christians. However, one participant found comfort in Chinese classical literature as well. She explained that when she was young she was well tutored in the Chinese classics. The participant related,

I have quite a lot of influence from the Chinese background. My father was careful to employ a tutor. He came every day for 3 hours from 6 till 9. By the time we got back from school (English), it was 4, 5 o'clock. I remember I had to study to prepare lessons for the Chinese. We learned by rote. I would have a snack and then walk around the garden repeating what I had to recite later on when the teacher came. I learned that it is the mind that counts - not the appearance, that it is good to be unashamed of poverty, and that one learns without making noise.

The participant believed the discipline practiced in learning her lessons, as well as the strong moral character of Confucius' students that she studied, supported her in times of stress and worry. A bible study class that she had recently joined provided an additional source of strength to her as she attempted to rebuild a relationship with her adult children recently immigrated from China. A participant dealt with her marital problems through her deep religious faith. She stated, "Everyday I pray to God and thank him for my day."

The same participant also used her religious belief to counter her fear of death.

She related,

So, I don't tell anyone. Just only I feel inside. I say leave it to God. God know everything. Just trust in God. Do your best and leave everything to God. This is my way. This only thing I can do. Nobody can help me.

Enjoying the good in life. Approaching performance limitations with a sense of humor and a positive attitude toward life helped the participants to let go of standards of performance they once had of themselves. That is, accentuating what they can do, rather than what they could not promoted feelings of self-esteem. Participants shared the view that aging meant the freeing up of time and the lessening of responsibilities. A participant described,

As a matter of fact, I enjoy things now that I did not enjoy in my younger days. I have more time of leisure. I can walk, I can play games. I can do what I want ! Before that there was looking after children, looking after children and not devoting...In that respect, I feel younger in my mind that I do not have all these responsibilities.

Enjoying the good in life also addressed the participants need to contribute to the lives of others. Several participants were actively involved in volunteer work. Others were involved with helping neighbors and family members. Caring for and being part of grandchildren's lives was one of the greatest sources of pleasure for the participants. One participant stated,

Joy, that's what they bring me. The little one, he's just a year and two months. He'll come over to me and he just smiles and grabs me. That gives you a good feeling eh ? That's what I like about having grandchildren. They give you a lot of joy.

Another participant, not yet a grandmother, anticipated grandchildren in the future. She commented, " Oh, seeing grandchildren. I would love to see some grandchildren. Live near to them and to be able to play with them. That's what I

would enjoy." Another participant, divorced and living on her own stated her choice to remain a single person was a personal choice based on her genuine enjoyment of what she terms a "simple but satisfying" life.

Developing practical strategies. Strategies for coping with the hardships of aging and/or chronic illness ranged from using physical aids to reading self-help books. For example, a self-help book on assertiveness assisted a participant to manage her husband's criticism of her abilities. She related,

If he starts to criticize me and that, I just tell him, stop ! See, I'm not afraid to speak my mind now. So, now he doesn't say anything because he knows I won't put up with it anymore.. And then I said, ' Well, if you're not happy with the conditions the way they are, you can always leave.'

Taking frequent rests, learning to be content with lesser standards of performance, organizing their activities into smaller task units and learning to ask for help were strategies employed by the participants in learning to live with less control over their physical performance. As a participant related, " I have learned to do what I can and if I can't, to heck with it." Another woman, unable to tolerate walking long distances carrying heavy loads, bought herself a wheeled cart. She then organized her weekly shopping trips into loads that she could manage. She described, "See, once a month I will check on my things, like bottled things or canned things , that's when I push the cart so I don't have to carry it."

Ideas to combat forgetfulness, another common difficulty, were keeping a notepad handy to record important information, tracking appointments by writing them on a calendar with a bright colored pen and asking others to call and remind them of social or business engagements. One participant devised a mental exercise to strengthen her memory. She described,

My memory is not bad because I always try to use my memoration you see. I say this number bus go to where, and this number bus

go there. And the second thing I try to remember is the telephone number belongs to whom and this belongs to whom. Every day I just try to practice my memoration, keep my memory.

Celebrating Friendships. Finally, friendships were to be remembered and nurtured. Participants commented on the importance of establishing new friendships through support groups and volunteer agencies. New relationships were recognized for the help they offered as well as for the "good feeling" the participants gained from helping someone in return. A participant stated, "Each person that you mix with you can learn from. I think it makes a difference to how you see things." Consequently, supportive marital and family relationships as well as friendships were seen as contributing to the participants' sense of well being within the aging and chronic illness experience. A participant asserted,

And then the other things. I feel very happy. My husband and I we are very, very, happy together. You see. That's very important. And, I have lots of friends. We make lots of friends since we come to here nearly 9 years now. So we are very happy to have these friends.

Another participant emphasized the importance of establishing and maintaining friendships in her life. She said,

What happened, in getting older, I am afraid to be alone. I like someone to keep around. That why I usually try to make friends with everybody. People very friendly to me. Even they saw me far, far away, they usually call to me, "Auntie Annie, Auntie Annie." And, writing letters to the friends to keep in touch. You know at Christmas time how many cards do I write ? More than 60 ! And every card I have a note or a letter inside. That's a bonus ! And so the letters from October, I start to write. Hong Kong, Australia, and China and America, many places. This is the way I keep myself busy. I think I try to do my best.

Facing the Future

Looking after ones' health by preventing illness from occurring in the future was identified by most participants. Three themes were identified: seeking information, following the rules, and planning for the future.

Seeking information. Participants sought information from their physicians, community health units, support clinics, immigrant service agencies and from general reading they had undertaken on their own. The Canadian Diabetic Association was mentioned by five participants and a Stroke Club by the participant who had experienced a stroke. Public libraries, newspapers, magazines, radio and television were identified as additional reliable sources of information about aging and about chronic illnesses as well as venue for cultural immersion. Adjusting to a new culture did not seem to pose a problem for these women. The participants accounted for the comparatively smooth transition as a consequence of their life migration patterns, education, and social backgrounds. As noted earlier, five out of the six participants had experienced migration several times in their lives. Thus, participants recalled the difficulties they experienced in learning new dialects and customs within China following moves from Hong Kong. A participant illustrated,

And maybe I was grown up in China. Very different kind of living (than) with Cantonese. And the first time I went to school, I cry because I don't understand how to speak Shanghai dialect. And then later on I learn and learn and learn this. And then, after that I get used to it.

Further, participants who had immigrated from the British colonies of Hong Kong and Malaysia indicated that exposure to English culture had eased their adjustment. However, the most significant factor seemed to be the participants' own attitude toward adapting to a new culture which in turn seemed to arise from their social behaviors over time. That is, all of the participants had been

active in some kind of volunteer work in their former communities with three of the participants donating time to church projects. Finally, all of the three participants originating from Hong Kong were or had been involved with S.U.C.C.E.S.S., an immigrant service agency, soon after their arrival in Canada. Interestingly, all of these participants as well as the participant originating from Malaysia proposed that acculturation difficulties experienced by some immigrants of Chinese origins lay in the traditional belief that strangers are not to be trusted.

Following the rules. All of the participants talked about the importance of following the advisements of their physicians. Indeed, participants described this as "obeying" the doctor. Another participant stated she was "determined" to not ever take insulin. Activities such as walking, using an exercise bike, swimming and modified exercise groups for seniors were identified. Meditation and breathing exercises such as are taught in Tai Chi classes were used to induce relaxation. Diabetic diet regimes and diets for participants with heart disease were followed fairly conscientiously. Five of the participants admitted to occasionally cheating on their diets. However, the one woman with IDD was "religious" with her daily responsibility of measuring her blood sugar and making the necessary insulin adjustments.

Only one participant consulted a Chinese herbalist. The medications prescribed by the herbalist were for allergies and for sleeping. The participant displayed several sheaves of papers inscribed with Chinese characters indicating which prescription was for her nose or cough or for sleeping. Although different from the other participants reported health behaviors it was of interest to note the response from this participant on how she managed with her angina. A practitioner of meditation, the participant informed,

Just sit down and release. And have a good rest. I don't like to take the medication all the time. Sometimes the doctor say, if you feel not so good, just put the medication under my tongue, see ? I don't like to get it too often. Unless, I need it necessary, you see. I usually sit and look at the outside, you see. Try to release.

The participant reported it was the severity of pain that guided her decision to medicate herself. Most often the angina was relieved with rest. Further, the participant stated that, "If its keep longer(sic), not working, I go to the (heart) doctor. Very important."

Planning the future. Avoiding dependence or becoming a "burden to the family" was a major concern of the participants. This notion was reflected through phrases such as, "I wouldn't want to be dependent on my kids" and "only God knows what's going to happen" and "you can't see into the future." and "my children have their jobs to do and have their own children to raise." Participants who had the financial resources put money aside to manage their future care needs. A participant explained,

So, I've put away so much for myself in case I have to go into a care home or I need to have someone to come in and do housework for me. I don't want to be a burden to my children....
...see ?

Summary themes emergent from Phase Three revealed participant approaches to maintaining control of changes associated with aging and chronic illness. Themes of living in the present and planning for the future identified specific coping strategies.

Summary

An organizing framework, termed the Dialectic of Control, was used to report the findings of the study. Control was characterized as balancing the polarities of adversity (loss) and prosperity (gain). Adversity referred to lowered ADL and role performance accompanied by discomfort or pain. Conversely, prosperity

referred to a freeing up of responsibilities, optimizing independence in and accepting limitations of ADL and role performance, and remaining pain free.

Three phases informed the participants' understanding of their experience: Noticing the Changes, Reflecting on the Meaning and Optimizing Control. Noticing the Changes described changes in participant ADL and role performance whereas Reflecting on the Meaning explored the place of relationships, culture, significant life events and self-perception in shaping participant responses to aging and chronic illness. Optimizing Control revealed strategies for stabilizing changes associated with aging and chronic illness. Wisdom accumulated from life experience informed the participants' understanding of aging and chronic illness. In Chapter Five, I will discuss the interpretation of the findings as they relate to the literature and the organizing framework.

CHAPTER FIVE: DISCUSSION OF THE FINDINGS

I present the discussion of the findings from the Dialectic of Control in three parts. First, consideration is given to how the findings satisfy the research questions. Second, I compare the findings to the major theoretical frameworks and conceptualizations discussed in the literature. Third, the significance of the findings to feminist thought and methodology is briefly explored. A summary on the significance of the findings concludes the chapter.

The Research Questions

This study sought two understandings: the experience of aging in older, chronically ill, migrant women and, the encounter of personhood within that experience. Thus, two research questions were asked: first, what is the experience of aging and second, of personhood in older, migrant women who are chronically ill? The Dialectic of Control, the organizing framework for the exposition of these experiences, provides initial answers to the preceding questions. Each question is considered in turn.

The first question asked: what is the experience of aging in older, migrant women who are chronically ill? The Dialectic of Control determined six characteristics of the experience. Each of the five will be briefly summated. First, aging is a dynamic process of rationalization influenced by cultural, social, economic and political circumstance and contextualized by time. The Dialectic of Control, by the very nature of its title, evokes the notion of challenging self-conversation where the experience of aging is rationalized through a review of life experiences and through consideration of present and

future circumstances. The desired goal is optimizing the losses and gains associated with the experience.

Second, experiential boundaries between aging and chronic illness are often blurred. The experience of aging is closely linked to the experience of chronic illness. For example, the Dialectic of Control indicates that aging is a subtle process characterized by a gradual slowing down that is recognized by a lessening of energy: That is, there is a faster onset of and a slower recovery from fatigue. However, similar data were assigned to the experience of chronic illness. Thus, the data did not differentiate between the two experiences. This was particularly evident when the participants recounted lowered ADL and/or role performance as a consequence of fatigue. However, the more severe the limitations, the more likely it seemed the participants were able to determine a causal link to chronic illness.

Third, the most challenging aspect of aging within the chronic illness experience may be adjustment to lowered ADL and role performance. Adjustment to lowered standards of effectiveness and efficiency in performance of ADL and relationship roles presented some of the most evocative findings in the study. The notion of continuing to be useful seems closely aligned with this part of the experience. Usefulness refers to the capacity to contribute to the lives of family, friends and to society at large. In terms of the latter, distress is expressed regarding the perception that society characterizes aging as becoming "less of a person". Finally, aging within the experience of chronic illness elicits present and future fears regarding the likelihood of progressive

debility, dependence, pain and death. Gains identified in this regard are the absence of pain and/or severe disability as well as continued independence.

Fourth, aging within the experience of chronic illness is less significant when the sum of life experience is considered. The data state that aging and chronic illness form “only a part” of life. This may suggest that the experience of aging when one is chronically ill occupies a lesser part of day-to-day life. That is, the data show that aging within the experience of chronic illness introduces losses related to lowered ADL and role performance. However, the inference is that the greater portion of life is content with family activities, friendships, hobbies and interests. The difficulty of the researcher in differentiating aging from chronic illness in the data precludes further consideration of perceived differences between the two experiences.

Fifth, wisdom is the broker in optimizing the losses and gains associated with aging when one is chronically ill. The Dialectic of Control shows the experience of aging in older, chronically ill, migrant women is optimized through the voice of wisdom. Gathered from a wide variety of life experiences, wisdom provides the knowledge, insight and attributes necessary for adjustment to the experience of aging. That is, for the chronically ill, it is wisdom that interprets the significance of and optimizes response to the losses and gains associated with aging. For example, in Optimizing Control, the final phase of the Dialectic of Control, adjustment strategies are drawn from mentors (family, friends, teachers), life experience (war, migration, political

oppression), culture (beliefs and values) and social circumstance (marriage, divorce, single parenthood, widowhood, poverty).

Of these, culture stands out as a major influence and accordingly is identified as the sixth characteristic. For example, data arising from the findings indicate that duty, determination, perseverance, thrift, sacrifice and obligation are "named" requisite attributes in adjustment to aging within the chronic illness experience for the Chinese migrant women.

The second question asked: what is the experience of personhood in older, migrant women who are chronically ill? The Dialectic of Control does not explicitly answer this question. That is, the term "personhood" is not named in the data. I suggest the following reason for this finding: the term was not used in the interview process as the concept does not hold meaning to most Asian populations. Instead, arising from the orienting definition of personhood, notions such as self-awareness, self-esteem and life review were used to explore the experience of personhood. As will be noted further in this chapter, conceptual themes and processes in the data relate significantly to both the orienting definition of personhood and to other literature concerned with the concept. Thus, the experience of personhood in older, migrant women who are chronically ill is illuminated by the findings in the following manner.

The findings suggest two characterizations of personhood: first, a naming of what is meaningful in life and second, wisdom as the emergent manifestation of personhood. Each will be reviewed.

First, the experience of personhood in this study is revealed as the individual exploration of and search for personal meaning in life. This characterization is recognized in the voices that particularize the journeys represented in the elemental themes and phases of the Dialectic of Control. Cultural, political, economic and social circumstance as well as time past, present and future are the informants of personal meaning. The findings show a strong cultural influence. Thus, the experience of personhood in this study is understood in terms of Chinese culture, values and belief systems that are primarily reflected in the attributes identified as duty, determination, perseverance, thrift, sacrifice and obligation. However, this strong cultural viewpoint and multiple migration experiences of the participants forecast the eventual collision with Western culture as differing values and belief systems of the two worlds, indeed of personhood, conflict.

Second, I propose that the experience of personhood is manifest in the findings through the conceptual window of wisdom. Wisdom is the emergent voice of personhood. The wisdom of old age arises out of the naiveté of youth. Though life review, sources of wisdom are revisited, remembered and drawn upon for direction and support. Exploration of self comparing the hopes and dreams of youth to those middle age and older age provides validation of knowledge and attributes gained across diverse life experiences of adversity and prosperity. Finally, as found with the experience of aging, the Dialectic of Control reveals that personhood reaches beyond the chronic illness experience. That is, although personhood is influenced by the experience

chronic illness, the significance of chronic illness represents "only a part" of personhood. Thus, as life was to aging, personhood, is greater than chronic illness because it is the summation of life experience.

The Dialectic of Control

In the second part of chapter five, I discuss the findings from the perspective of the Dialectic of Control, the organizing framework. The name of the framework arose from my interpretation of the participants' description of an inner "dialogue" that took place within; discussions that sorted through life experiences, conversations that weighed times of adversity and prosperity, a "dialectic" directed towards an understanding of their current encounter with aging and chronic illness. Data elicited from the Dialectic of Control reflect the dynamic nature of the narrative form in articulating how personal meaning is constructed from life stories. Luborsky (1993) in study of 16 randomly selected depressed and non-depressed elderly persons cautions against the "idealization" of life story narratives both as a source of research data (and as a means of promoting well-being) in the absence of critically examining the ways in the "knowledge of a group or culture" is informed by mind set, social influences and health-related ways of relating meaning (p. 451). Still, the emergent nature represented in the construction of personal meaning may be congruent with the Dialectic of Control. The author states,

The meaning in life stories may be those that are still being made, are yet unresolved, or were the resolutions to prior meaning dilemmas of the individual and now are an important frame for the self.

Several notions in the findings modeled fundamental frameworks and conceptualizations in the literature. However, as the literature did not explain the Dialectic of Control, each of the three phases is considered.

As noted above in Figure 1 (page 67) , the Dialectic of Control, comprises five constructs and three phases. Aging, chronic illness, wisdom, adversity and prosperity form the group of constructs with the latter two respectively representing the loss and gain associated with aging and chronic illness. The three phases of the Dialectic of Control are Noticing the Changes, Reflecting on the Meaning and Optimizing Control. It is interesting to note that the number and kinds of chronic illness reflected in the study mirrors the literature on the occurrence of multiple chronic illnesses in the elderly (Chenitz, Stone, Salisbury, 1991; Murray & Zentner, 1985).

Phase One: Noticing the Changes

Noticing the Changes identifies the losses and gains related to aging and chronic illness. Losses include an increased onset of and slower recovery time from fatigue resulting in less effective and efficient ADL and role performance. This was particularly noticeable when compared to youth or prior to the onset of chronic illness. Fatigue is a commonly experienced symptom of aging (McConnell, 1994). Moreover, several of the participants were on medication regimes for treatment of various cardio-vascular illnesses. Many of the medications used in treatment of cardiac problems and/or hypertension are anti-cholinergic. Fatigue is common side effect of anti-cholinergic medications (McConnell , 1994). Fatigue may also indicate depression (McConnell, 1994).

Salisbury (1991) warns that depression and chronic illness may confound one another in terms of symptom overlap: for example, fatigue, low concentration and insomnia. As I did not conduct a formal medication review or assess the participants using a conventional geriatric depression rating scale, I am unable to rule out the existence of this diagnosis within the participants. Thus, the preceding points are raised for reference only. However, I did not hear in the participants' stories, nor did I observe, any overt signs of depression or of anti-cholinergic side effects during the interviews.

The data reveal that feelings of sadness, frustration and guilt accompany the participants' loss of lowered ADL and role performance. Corbin and Strauss (1987) describe "a failed body"; the structural self has been fundamentally broken or altered in some way and consequently, past, present and future notions of self are profoundly shaken. Lambert (1987) describes the profound loss of self arising from changes or losses in past roles and fear of being a burden in the future. The impact of loss reported in the data is seemingly governed by the notion of feeling "useful". That is, as long as one maintains the capacity to contribute to family and friends lives as well as to society then the impact of loss seemed less severe. This may reflect the observation that the experience of chronic illness increases the dependency on others for validation of the self (Charmaz, 1983).

Cultural influence in terms of belief systems is noted in the overwhelming guilt articulated by a participant who was unable to accompany her husband on a walk because of fatigue. Here, the woman believes that she has failed as

wife in her "duty" to make her husband happy. Chang (1981) proposes that a traditional Asian woman would feel shame and be self-blaming if her husband was unhappy. This underscores the caution offered by Gelfand and Baressi (1987) that equal recognition must be given to the positive and potential negative effects of ethnicity on the older person (emphasis added). That is, consideration must be given to the impact of cultural belief systems that have the potential to place "blame" on a person already struggling with health related losses; in this case, the loss of lowered ADL and role performance associated with the experience of aging and chronic illness.

Phase Two: Reflecting on the Meaning

Reflecting on the Meaning, the second phase of the Dialectic of Control reflects on the cultural, socioeconomic and political past and explores the future as a way of creating meaning from the experience of aging and chronic illness. Hochschild (cited in Burbank, 1986) stresses the importance of seeking what personal meaning the experience of aging holds. Given the paucity of studies on aging women notwithstanding that of older, migrant women, this phenomenological, feminist study offers a beginning understanding of what "personal" meaning the experience of aging in chronically ill, older migrant women holds. Smith (1990) encourages researchers to consider the significance of seeking women's perspective,

...the worlds opened up by speaking from the standpoint of women have not been and are not on a basis of equality with the objectified bodies of knowledge that have constituted and expressed the standpoints of men (p.13).

Smith advocates that in the absence of women's perspective the opportunity to effect change within social and health care practice is limited.

Adversity (war, poverty, migration, single parenthood) is a common theme in the findings. Ujimoto (1987) proposes that adversity is wide-spread among older migrant people and that it is often heightened by the lack of access to services and resources (e.g. health , education, social, and economic) enjoyed by dominant White society (Gelfand & Barresi, 1987).

Significantly, passages of Phase Two, Remembering the Past, reflect the notions of Kleinman, Eisenberg and Good (1978) whose work continues to shed light on the impact of culture on the illness experience. The authors instruct,

Illness is culturally shaped in the sense that how we perceive, experience, and cope with disease is based on our explanations of sickness, explanations specific to the social positions we occupy and systems of meaning we employ (p.252).

Consequently, the cultural context of Phase Two may enrich our understanding of the impact of Chinese culture within the aging and chronic illness experience.

Here the notions of duty, honor, respect, obedience, sacrifice, thrift and obligation illuminated in the data are represented in the literature by Chang (1982), Hsu (1985), King and Bond (1985), Lai and Yue (1990), Louie (1980), Wu and Tseng (1985). Arising from past mentors deeply emersed in Chinese culture , Phase Two voices powerful instructions with the capacity to both

enhance and as noted above, constrain (Gelfand & Baressi, 1987) the interpretation of, and response to, loss in general and to loss associated with the experience of aging and chronic illness in particular. Weihzen (1985) identifies Confucian thought as a significant source of these traits, a factor alluded to by several participants in this phase. The notion of obligation, clearly articulated in the data, is a clear reflection of family kinship ties that seemingly provided the impetus for many of the participants to rise above times of adversity.

Chow (1983) and Holroyd and MacKenzie (1995) discuss the significance of the erosion of these traits for the elderly in Hong Kong. For example, "filial piety" (the responsibility to care for and respect one's elders), steeped in the tradition of moral obligation, is slowly being effaced by an increasing fascination with Western values introduced through the rapid adoption of Western technology. This shift in values signals a softening of family moral obligations, creating ambivalence and thus, the potential for family conflict as to how family caring behaviors are to be understood. Conflict in intergenerational values significantly represented in Phase Two, underscores the need to research the dynamic nature of culture, to reveal an "emergent" ethnicity" (Gelfand & Baressi, 1987) that in turn re-informs the values and belief systems shaping family kinship ties and caring behaviors (Holroyd & MacKenzie, 1995). Finally, Louie (1980) also acknowledges that the contemporary life styles and social behaviors of adult children are common sources of conflict for traditionally inclined - in this case - aging parents. Importantly, the stories of adversity and

prosperity told by a group of older, Chinese Canadian women echo many of the themes and concepts that illuminate the concerns of the study participants (Sugiman, 1992).

Phase Three: Optimizing Control

Optimizing Control identified strategies to optimize the notion of control in balancing the losses and gains of aging and chronic illness. Again, the data from this phase reflect Gelfand and Baressi's (1987) argument for an "emergent" view of ethnicity that, in this instance, facilitates recognition of the adaptive process that occurs over an individual's and ethnic group's natural life. That is, strategies articulated in Phase Three arose from the "work" of Phase Two where past problem solving approaches, learned or imagined from mentors long since gone and informed by the context of politico- cultural and socio-economic circumstances provided the supportive framework for direction in Phase Three.

Curtin and Lubkin (1986) advise that effective adaptation to chronic illness requires the individual to perceive that the effort given to the rehabilitation process is worth the outcome, an improved quality of life. Anderson (1991) notes that although the notion of restructuring of self within the experience of chronic illness is recognized by all cultures, the significance of the notion lies in understanding the processes from where the experience is situated, the economic, socio-political and ethno-cultural context of the person's life. Evidence of these notions in Phase Three data is found in the themes of adherence to doctors "rules", using self -help programs, practicing meditation,

exercising and devising practical solutions to ADL and role performance concerns. Although, the primary purpose of these behaviors was to maintain control over their chronic illness, the findings show the behaviors were also employed to slow the aging process and thus, ultimately, prolong life.

Crissman (1977) underlines the idea of the cultural molding of health behaviors. When health behaviors are situated within the context of culture, understanding of the lay health systems as well as the larger medical system is facilitated. Health behaviors included: shifts in role behaviors, lay consultation and referral, treatment actions and adherence. Each of these behaviors was characterized in Phase Two and Three. Significantly, the participant who consulted a Chinese herbalist draws particular attention to the notion of lay health systems, raising questions about the relationship of the data finding "obeying the doctors rules" to the concept of adherence (for a fuller discussion of the rationale for the use of adherence in place of compliance, see p. 27).

For example, Thorne (cited in Wuest, 1993) offers that non-compliance may be seen as positive approach to health management, preserving "a valued quality of life" and "protect(ing) themselves from what they viewed as inappropriate clinical decisions." Wuest (1993) proposes that use of reflexivity found within a feminist framework advances understanding the nature non-compliance.

The cultivation and maintenance of friendships is a major source of support in adjusting to aging within the chronic illness experience. Building a strong

network of friends is congruent with the Confucist notion espousing construction of a social network (King & Bond, 1985).

Personhood

The notion of personhood is revisited to explore how the articulation of personhood in the study compares to what is known in the literature. I begin with a brief review of how personhood was revealed in the findings. I follow with a summary of the fundamental constructs of personhood as they are presented in the literature. I conclude this discussion by providing the orienting definition of personhood employed in the study.

As noted above, two assertions are made. First, that the experience of personhood in this study is characterized by the individual exploration of and search for meaning. Second, that the characterization is manifest in wisdom, the personal voice that particularizes the journeys represented in the elemental themes and phases of the Dialectic of Control. Cultural, political, economic and social circumstance as well as time past, present and future were seen as informants of personhood. The findings reveal the experience of personhood as a dynamic entity, representing the totality of life experience and, in this study, strongly reflective of cultural, political, economic and social change.

The following indicates a summary of how personhood is represented in the literature. Cassell's (1983) descriptors of personhood are the emotional, social, physical, familial, private and spiritual aspects of the individual. Leonard (1989) advances the Heideggerian perspective of the person; a gradual weaving over time of meaning, language, culture and family tradition into the

fabric of each individual life that creates the person. Personhood is seen as agency by Taylor (1985). Agency is the vehicle for making evaluations that form the self or self-identity. A person is known through the capacity to interpret life and life cannot exist without interpretation. Finally, Corbin and Strauss (1987) offer this understanding of personhood within the experience of chronic illness. The authors propose,

...when chronic illness comes crashing into someone's life, it cannot help but *separate* the person of the *present* from the person of the *past*, and affect and shatter any *images of self* held for the *future*....the who I was in the past and the who I hoped to be in the future, in whole or in part, are rendered discontinuous with me in the present. *New conceptions* of who and what I am, past, present and future must *arise out* of what remains.(p.249, emphasis added)

The orienting definition of personhood for this study defines personhood as the human capacity for an awareness of self; the realization of a personal past, present and future, a system of personal beliefs reflecting values and choices. It is the capacity to be a self-interpreting human being within the context of the personal, familial, social, cultural and spiritual traditions and the concomitant capacity to act with agency, to articulate these aspects of self through language and action. Accordingly, I propose that the Dialectic of Control reveals the experience of personhood as it is presented in the orienting definition for this study.

Nexus: Dialectic of Control, Feminism and Nursing

The impetus for this study arose from my experience of being called a “foreigner” while working with a group of older women of Chinese ethnicity. The experience caused me to reflect upon the power of cultural, socio-economic

and political bias. Although the extensive literature review for the study both broadened and deepened my knowledge of feminist theory generally and of black feminism particularly; the experience of listening to and reflecting upon the narratives of the study participants firmly rooted my awareness of and appreciation for the authoritative voices of cultural, social, economic and political circumstance as well as time past, present and future.

Moreover, data arising from the Dialectic of Control emphasises the importance of considering the “wholeness” of older women’s life experiences when perceptions of health and illness are explored. This caution may be discovered in the narratives of older, migrant women who describe themselves and their lives as “more than” aging or chronically illness. Here, the fullness of life experience from childhood to older age awaits detection; revealing insights, skills and resources that acknowledge a cumulative wisdom born of and shaped by the contexts of social, economic, cultural and political circumstance.

Analysis of the transcripts and conceptualization of the organizing framework brought an applied understanding of the fundamental tenets of feminist thought and methodology. The concept of naming and notion of “the personal is the political” held particular significance.

The significance of the findings in naming the cultural, socio-economic and political shaping of life experience recalled the words of two feminist theorists. First DuBois (1983) states that naming is fundamental to feminist research because naming confers power as it denotes value and quality to that which is named. The theorist advises:

That which has no name, that for which we have no words or concepts, is rendered mute invisible: powerless to inform or transform our consciousness of our experience, our understanding, our vision; powerless to claim its own existence. (p.108)

Second, Smith (1990) proposes that when women's experience separates from the notions (male dominated) of ruling in modern society, a critical standpoint arises where new insights are realized and new knowledge is created. Smith explains,

The only way of knowing a socially constructed world is knowing it from within. We can never stand outside it.
...Even to be a stranger is to enter a world constituted within as strange. The strangeness itself is the mode in which it is experienced. (p.92).

Given my white, middle class background, my experience in listening to the naming of war, involuntary migration, political and cultural oppression is one of "stranger". That is, I have no capacity to know in a "lived" sense, the terms and conditions of the participants' experience for they are "worlds" that I was not exposed to. Yet, the participants and I seemingly co-created a kind of understanding through the following process. As I listened, the participants' words created new images and texts. My "old" knowledge formulated from print, film and video accounts of war and oppression in general and of Chinese culture in particular, were seemingly suspended within the participants' stories. There, in the context of the participants' stories, my words and images of these phenomena were reworked, shaping "new" images and texts of understanding. Thus, my reference points on war, oppression and cultural meaning are restructured into a more profound perspective. Here, I suggest,

Chin's (1985) proposal of the feminist slogan "the personal is the political" as a conceptual imperative for nursing was validated in this study. For it is the personal voices of the participants that name the source(s) of their cultural, socio-economic and political oppression. Sigworth (1995) states that attempts to relieve women's oppression is an overt characteristic of feminist research.

However, hooks' (1984) caution is worthy of consideration here. The Black feminist scholar notes that the most vocal of social feminists are white women who advance the argument of class struggle yet have failed to establish class as a fundamental component of the feminist movement. The author explains,

Despite their support of socialism, their values, behaviors and lifestyles continue to be shaped by privilege. They have not developed strategies to convince bourgeois women who have no radical political perspective that eliminating class oppression is crucial to efforts to end sexist oppression (p.61).

Emphasizing class struggle, often attributed solely to social feminists, should be the concern of all persons committed to the feminist movement. Moreover, gender bias, racism and classism separate women from one another. hooks expands her argument by saying,

Every woman can stand in political opposition to sexist, racist, heterosexist and classist oppression. While she may choose to focus her work on a given political issue or a particular cause, if she is firmly opposed to all forms of group oppression, this broad perspective will be manifest in all her work irrespective of its particularity (p.61-62).

Thus, hooks' caution sheds new light upon the interpretation of the personal is the political. It illuminates the significance of the social, economic, cultural and racial shaping of women's lives and further, the profound yet subtle workings of

these contexts upon the political and social consciousness found within and outside of feminist work.

Morse (1995) advocates that a feminist paradigm provides a new awareness of women, one that values women's stories and perspectives, one that indeed challenges conventional patriarchal praxis but , perhaps most significantly for this study at least, one that names the socioeconomic, racial, ethnic and political contexts of women's health. Kavanagh and Kennedy (1992) reinforce the preceeding perspective with the following advisement regarding the advancement of cultural diversity in health care. They state,

Social stratification and inequity are touchy topics for many members of a society that idealizes equality but prioritizes personal freedom and is, in reality, highly stratified....Affirmation of diversity involves recognition of the effects of differences, similarities and social processes on lives...In the real world they must be acknowledged as long as they have an impact on the life experience of individuals. (p.26-27).

Mulholland (1995) also warns against transcultural nursing models that fail to adequately address the theoretical foundations of power, its relationship to knowledge and consequent impact for nursing; the ways in which faculty, student and client relationships of understanding are then shaped.

Tripp-Reimer and Fox (1990) suggest a transcendent approach to the recognition of cultural diversity proposing that all persons face the "same human dilemmas". And, although these dilemmas obviously differ in form and kind, ultimately, it is the "unconditional concern for and affirmation of that which is universally human" that informs our ways of

recognizing and knowing the common bond of human experience that exists within life stories. I suggest that this notion of transcending the recognition of difference is applicable to the data from the Dialectic of Control. That is, the efforts of myself and those of the participants reach beyond my personal "knowing" of war, political oppression, forced migration and poverty to create new knowledge, albeit imagined, shaping a different understanding, arising from the participants' stories of human experience.

Finally, hooks' (1984) pronouncement that feminism must continue to shed light on the diversity among women's social and political worlds, particularly those women "whose social conditions have been least written about, studied or changed by political movements." p.25). may be recognized in the data of the Dialectic of Control

Summary

In sum then, The Dialectic of Control supports and, in some instances, may expand upon what is reflected in the literature regarding what is known and is yet to be known about the experience of aging and of personhood in older, migrant women of Chinese ethnicity who are chronically ill. In the next chapter, I discuss what meaning the findings hold in terms of nursing research, education and practice.

CHAPTER SIX

SUMMARY, CONCLUSIONS AND IMPLICATIONS FOR NURSING

In this final chapter, I provide a summary of the study including the background, purpose, literature review, research methodology and findings. Conclusions from the study are drawn and the implications for nursing research, education and practice are identified.

This study examines the experience of aging and personhood in older, migrant women of Chinese ethnicity who are chronically ill. Impetus for the study arose from my experience of being viewed as a cultural “foreigner” within a group of senior women of Chinese ethnicity living in the Lower Mainland of British Columbia. The impact of the experience directed me to explore nursing’s understanding of ethnicity and culture in caring for chronically ill older migrant women.

By the year 2021, Canada’s senior population will more than double. Moreover, within the past two decades alone, Canada has witnessed a rapid rise in the numbers of seniors from ethnic minorities; approximately six thousand seniors of differing minorities immigrate to Canada each year.

Advanced technology in the Western world has extended the natural life span of its members. Consequently, as life expectancy has risen, the prevalence of chronic illness in the elderly has risen. Chronic illness, common in the elderly, can be an especially difficult adjustment for the older person placing the ill elderly at higher physiological and psycho-social risk.

Little is known about women and aging and still less is known of the differences in class and ethnicity in aging women many of whom experience socio-economic and cultural marginalisation. Twice as many women as men confront language barriers among the 24 % of seniors who do not speak either English or French. Because of their gender, advancing age and cultural placement within white patriarchal society, older, ethnic minority women's ability to voice their sense of culture and well being is diminished.

The voices of senior, migrant women speak from and to the personal forming ethno-cultural rich histories of personhood. Knowledge and understanding are found within the language of narration, of personal meaning. The experience of aging and chronic illness and an understanding of personhood in older, migrant women are poorly understood phenomena within nursing. It seems imperative then, that nursing empowers the voices of older, migrant women by seeking their stories of health and illness experiences.

The literature presents the concepts of personhood, aging, chronic illness and ethnicity within socio-economic and politico-cultural contexts. Accordingly, phenomenological and feminist theory were selected as methodologies for the study. A qualitative paradigm is applicable when the researcher is seeking emergent knowledge from the subjective perspective of human experience. Phenomenology seeks the subjective interpretation of a given lived experience and the effect that perspective has on the experience. A feminist perspective was selected to gain a deeper understanding of socio-economic, politico-cultural contexts of older, ethnic minority women's lives.

Participants were selected from a group of women who participated in a study by Anderson (1991). Additional participants were selected through a Chinese social services agency. Of the six women who participated, four were married, one was divorced and the other was widowed. The ages of the participants ranged from 60 to 78 years. All of the women had children and most women described their relationship with their adult children as fulfilling.

The average educational background was first year college. All of the women were of Chinese ethnicity, although one woman was 2nd generation Canadian born. Of the five women migrants, three had immigrated from Hong Kong, one from Malaysia and another from England. All of the women had diabetes: five had IDD and one woman had NIDD and all had had contact with the Canadian Diabetic Association. All of the women had one chronic illness in addition to diabetes, four women had two. Heart disease and hypertension were the most commonly occurring chronic illnesses.

Interviews, which were audio-taped and subsequently transcribed, as well as the researcher's field notes provided the data for the study. Four participants were interviewed twice and two participants were interviewed three times. A participant was interviewed only once as she was unable to participate in a second interview.

Giorgi 's (1975,1985) method was used as a guide in analyzing the data. Feeling or thought units identified within the participants' narratives were subsequently grouped together to form sub-concepts. These sub-concepts were then formed into larger concepts and themes which, when validated by

the participants, were used to conceptualize an organizing framework called the Dialectic of Control. The framework was used for interpretation and presentation of the findings. Sandelowski's (1986) adoption of tests of rigor (credibility, fittingness, auditability and confirmability) adapted by Guba and Lincoln (1985) were also employed in this study.

The Dialectic of Control has three phases: Noticing the Changes, Reflecting on the Meaning and Optimizing Control. Phase one, Noticing the Changes identified alterations or changes (loss and gain) in ADL and role performance as a consequence of aging and chronic illness. Here, adjustment to lowered effectiveness and efficiency in ADL and role performance was the most difficult aspect, whereas, feeling useful, maintaining independence, being free from pain and/or more severe forms of disability were the most gratifying aspects of the two experiences.

Phase Two, Reflecting on the Meaning described the search for understanding on the significance of the change. This phase encompassed a life review of significant persons and events as well as an exploration of the future. The influence and relevancy of cultural, socio-economic and political contexts in forming life perspective was revealed.

Phase Three, Optimizing Control, focused on strategies constructed to balance the changes associated with aging and chronic illness to regain a sense of control. Emergent sub-themes were living in the present (having a religious belief, enjoying what was good in life, celebrating friendships, and developing practical approaches to lowered ADL and role performance) and

facing the future (seeking information, following the rules, and planning for the future) Ultimately, it is wisdom arising from life experience that informs an understanding of aging and chronic illness. Wisdom forms the conceptual window into an understanding of personhood as the wisdom of old age emerges from the naiveté of youth. Cultural, political, economic, and social circumstance as well as time past, present and future are the informants of personal meaning and thus, of personhood.

Conclusions

In sum, I drew the following conclusions about the experience of aging and chronic illness and of personhood from the study data:

1. Aging is a dynamic process of sorting out life experiences shaped by cultural, economic and political circumstance and contextualized by time.
2. Experiential boundaries between aging and chronic illness are often blurred.
3. The most challenging aspect of aging within the chronic illness experience may be the adjustment to lowered standards of effectiveness and efficiency in the performance of ADL and relationship roles.
4. The notion of maintaining a sense of usefulness or of being useful is a highly desired attribute.
5. The most gratifying aspects of aging within the chronic illness experience are the avoidance of pain and/or more severe forms of disability and maintaining a sense of usefulness (capacity to contribute to the lives of family and friends).

6. The experience of aging and personhood when one is chronically ill is less significant than the sum of life experience.
7. Wisdom is the voice of personhood that optimizes the losses and gains associated with aging and chronic illness.
8. Naming, the individual exploration of and search for personal meaning in life is a characteristic of personhood.
9. Personhood is manifest through the conceptual window of wisdom.
10. Health behaviors of older, migrant women are influenced by personality traits and by culture (country of origin as well as dominant culture e.g. English colonies).
11. A feminist perspective of the social, cultural and political context of older migrant women's lives is imperative in the delivery of nursing care.
12. Class or income level influences the experience of aging and personhood in older, women who are chronically ill.

Implications for Nursing Practice

The nursing process benefits from integration of the study's findings. This study underscores for the nurse the importance of reflecting upon the complex barriers to effective nursing practice. Specifically raised in this study are the contexts of cultural, socio-economic, and political bias and further, the ways in which these biases inform the nurse's approaches to and implementation of the nursing process. Self-awareness of the nurse's ethnic, cultural, socio-economic, and political background allows exploration of personal belief and value systems and the ways in which these may influence the nurse's steps

through each phase of the nursing process. Finally, and perhaps most importantly, consideration of the feminist paradigm, in particular of Black feminism where the nurse takes into consideration, the profound yet subtle workings of these contexts upon the political and social consciousness found within and outside of feminist work. In other words, the nurse considers her/his feminist stance and how this is "lived" or "played out" in both practice and her/his personal life; a practice and indeed, a life situated in a world that overtly continues to support classist, sexist and racist oppression.

Assessment Phase

In the assessment phase, the nurse, gathers data based on the three phases of Dialectic of Control to identify: perceived changes (loss and/or gain) in ADL and role performance; the cultural, social, and economic interpretation of the impact of change; the role of wisdom (accumulated knowledge, skills and attributes) in past, present and future adjustments to change; migration history (cultural influence past and present). For example, data from this study suggests that when an older woman of Chinese ethnicity expresses guilt regarding lowered levels of ADL and role performance, the nurse considers the potential link between this data and culture regarding a woman's "duty" in marital relationships to ensure her husband's happiness. Examples of questions to be considered by the nurse in preparing for and implementing this phase of the nursing process may among others include: What are my assumptions about my culture in relation to cultures different than mine ? What is known about the culture of this client in terms of the ways in which the

experience of illness is related and/or disclosed ? How is it that I “hear” and interpret data of a client from a socio-economic, cultural and political background different from my own: in particular of health practices in relation to the notion of compliance or adherence ?

Planning Phase

The nurse incorporates these data in the planning phase of the nursing process. That is, when working with the client , the nurse plans interventions to optimise control (reduce or eliminate the impact of loss and/or sustain or increase gain). The nurse takes care to relate the plan to the cultural words and images the client has revealed to facilitate personal meaning and relevancy for the client. For example, data from this study suggest that when the nurse is working with an older woman of Chinese ethnicity, the notion of duty is explored within and beyond the boundaries of the marital relationship for evidence of gain and loss. The nurse may assist the client to recognise aspects of older age wisdom (knowledge, skills and attributes) as strategies for optimising control. In addition, awareness of the client's health behaviours related to personality, migration patterns and cultural exposure provides direction to the nurse in assisting the client with the selection of culturally relevant social service and health care agencies to solicit needed support. Here, as evidenced from this study, the nurse may consider the influence of the country of origin upon the health practices and beliefs of the client. That is, although five of the six participants in this study immigrated from Asia, all had experienced a degree of acculturation due to English colonisation of their countries of origin.

Finally, the Dialectic of Control and the study's orienting definition of personhood guide the nurse in assisting the client to set achievable and measurable strategy outcomes in optimising control.

Evaluation Phase

In the evaluation phase of the nursing process, the nurse employs the Dialectic of Control to determine the effectiveness of the strategies utilised to optimise control. Where the strategies have not achieved the expected outcomes, the nurse may review the phases of Dialectic of Control with the client to explore a cause(s) for this occurrence. Further, searching for clarification within the Dialectic of Control may reveal misinterpreted data that directly or indirectly (potentially) confound the construction and implementation of effective strategies. For example, dialogue with a client who consults lay health advisement while adhering to conventional Western medicine and health practices may reveal aspects of each that are conflictual in terms of application and/or outcome. Or the nurse following a review of the data, may determine that cultural barriers have blocked effective communication between the client and the nurse. Here, the nurse may determine that a cultural "broker" is needed to explore and negotiate alternative approaches and interventions with the client (AAN, 1992; De Santis, 1994; Culley, 1996).

In sum, this study shows that nursing care of older, migrant women requires a feminist awareness of the socio-economic and politico-cultural contexts of the slogan "the personal is the political". That is, the voices of older, migrant women must be sought, encouraged to tell their stories and

perhaps more importantly, heard in an environment free from social, cultural and political bias. Nurses then, must seek evidence of these potential blocks to effective caring of older migrant women not only within themselves but within the institutionalised setting of health care practice.

Implications for Nursing Education

Nursing education is informed by the Dialectic of Control in the following manner. The Dialectic of Control identifies the need to create a deeper awareness of and appreciation for first, a feminist perspective and second, a cross-cultural approach in understanding the perspectives of older, migrant women with chronic illness. Current knowledge of the complex issues related to these phenomena is lacking. As a result, service delivery to this population group is vulnerable to failed health outcomes because of poorly understood and/or misinterpreted data.

Initially, general consideration may be given to identifying what cultural, socio-economic and politico-cultural biases and prejudices are brought to the experience of nursing education by students and faculty alike and by extension, the institution itself. Acknowledgement of the existence of these biases is not to lay blame but rather to increase awareness of how assumptions of understanding are socially constructed belief systems shaped by cultural, economic and political circumstance; hence my experience of "nurse as foreigner". Additionally, discussions with nursing students on what personal understanding they have of feminist theory in general and of Black feminism in

particular and the relationship of each paradigm to the presentation of ethnicity, ageing and chronic illness in health and illness may facilitate the student's interpretation of women's experience of these phenomena. In the same vein, faculty and students may wish to discuss the implications for women's health in a science informed by a feminist perspective that is anti-racist, anti-sexist and anti-classist. For example, using feminist theory, students and faculty alike may wish to consider how the marginalisation of women in general and of older, migrant women in particular is reflected within practice. Finally, involving older, migrant women as informants and thus, "teachers" of the socio-economic and ethno-cultural realities of ageing and chronic illness experience will not only enhance nursing education but will also exemplify a fundamental tenet of feminism, social emancipation. Support for these strategies is found in the literature addressing current nursing education issues (Culley, 1996; De Santis, 1994; Gioiella, 1994; American Academy of Nursing, 1992).

Implications for Nursing Research

This study is an exploratory examination of the experience of ageing and chronic illness and of the experience of personhood in older, migrant women. Several questions arising from the study findings invite further investigation. For example, differentiating the relationship between ageing and chronic illness may facilitate a greater understanding of the impact of each. Further, the Dialectic of Control data indicate a need to explore what similarities and differences may exist in the experiences of ageing, chronic illness and personhood between older, migrant women from countries of origin dominated

by Western culture and from countries of origin where the indigenous culture is intact. As well, in view of the nascent shift in traditional Chinese family values, questions articulating the implications for health care delivery to aging Chinese seniors and their families may inform service planners and providers.

Moreover, given that the majority of study participants averaged middle class standing, further exploration of the impact of socio-economic status on older, migrant women's interpretation of and adjustment to the experience of aging and chronic illness is required. The study of the influence of feminist thought in conceptualisations of ethnicity, aging, chronic illness and personhood may provide a means of clarifying definitions and articulating research methodologies within a feminist paradigm. Indeed, the need for clarification of the various ways in which ethnicity, cultural diversity, trans-cultural nursing and culturally competent care are defined and understood is well documented in the literature (AAN, 1992; De Santis, 1994; Habayeb, 1995; Mullholland, 1995; Tripp-Reimer, 1990; Wuest, 1993). Finally, investigation into the impact of socio-economic and politico-cultural bias in nursing practice, education and research heightens awareness of obstacles blocking cultural competency in the delivery of health care services. The recent increase in the number of immigrant workers representing a wide variety of ethnicities and cultures entering the health care system demands close attention. Research into the ways in which nurses and indeed all health care workers from differing cultures experience one another in terms of social behaviours, communication styles, health belief practices and values is needed. Such research would shed light

upon ways to increase understanding and avoid misinterpretation of the words and actions of "others", that is, persons seen and/or heard as "different" from self. hooks (1984) states,

One factor that makes interaction between multi-ethnic groups of women difficult and sometimes impossible is our failure to recognise that a behaviour pattern in one culture may be unacceptable in another, that it may have a different significance cross-culturally (p.56).

The profession must explore means of evaluating current approaches to nursing education, practice and research to determine evidence of bias and to identify effective strategies for creating an environment that promotes rigorous and respectful analysis of such bias. Nursing research must provide direction to nursing education and practice in this regard. These tasks are requisite if as a profession we mean to practice as we profess we wish to - without prejudice and without bias.

Summary

I have provided a summary of the study including conclusions drawn from the study findings. The implications for nursing research, education and practice arising from the study findings have been identified.

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APPENDICES

APPENDIX A

Letter of Information (On School of Nursing Letterhead)

Dear Potential Participant,

My name is Carol Anthony. I am a graduate student in the School of Nursing at the University of British Columbia. I am currently working towards obtaining a Master of Science in Nursing with a clinical specialization in geriatrics. My nursing background is in the community and because of my recent experience working with Chinese and Indo-Canadian seniors, I am particularly interested in older women from different ethno-cultural backgrounds.

For my Master's thesis, I have chosen to study the experiences of aging and chronic illness in older, Chinese women. I believe it is important that nurses understand what it is like for an older woman to try to adjust to a chronic illness in a culture that is different from her own. Nursing, as well as other health care disciplines, recognizes that there is much to be learned about how to better provide services to people from different ethno-cultural backgrounds. As many of our new immigrants to Canada are seniors, there is an urgent need to develop knowledge of how we may more effectively plan services for seniors from different ethnic communities. Your perspectives of your experiences with aging and chronic illness would help nursing to better understand how to improve nursing care services to senior women like yourselves. Other health care professionals may learn from this study as well.

The study will involve 2-3 interviews of approximately one to one and half hours in length. The purpose of the interviews is to explore with you what kinds of experiences you have had with aging and chronic illness. The interviews will be conducted in the privacy and comfort of your own home or in an alternative comfortable setting of your choosing. The interviews will be audio tape recorded so that I may pay close attention to what you are saying about your experiences without the distraction of trying to take extensive notes. No names or other identification will be recorded on the tape. The tape will be erased and

above, and the typist transcribing the tape will have access to the audio tape of my interview with Carol Anthony.

I UNDERSTAND THAT I AM UNDER NO OBLIGATION TO PARTICIPATE IN THE STUDY. SHOULD I DECIDE TO PARTICIPATE IN THE STUDY, I UNDERSTAND THAT I HAVE THE RIGHT TO DECLINE TO ANSWER QUESTIONS, TERMINATE THE INTERVIEW OR REQUEST ERASURE OF THE TAPES AT ANY TIME. I ALSO UNDERSTAND THAT SHOULD I DECLINE TO PARTICIPATE IN OR WITHDRAW FROM THE STUDY AT A FUTURE DATE, MY MEDICAL OR NURSING CARE WILL NOT BE AFFECTED.

I understand that I am free to ask questions at any time. Should I require additional information or interventions beyond what Carol Anthony is able to provide at the time, such assistance will be gained through referral to other services at my request.

I understand that the knowledge gained from this study may be used to inform other nurses, health care professionals and or other women like myself and that the results of this study may be published or presented at conferences or meetings for this purpose.

I acknowledge that this study has been adequately explained to me and I give my consent to participate in the study. I acknowledge receipt of a copy of the information letter and consent form.

Signature: _____

Witness: _____

Date: _____

APPENDIX C

SAMPLETRIGGERQUESTIONS

1) What is it like for you to experience yourself growing older ?

What do notice most about the experience ?

What do you enjoy least about the experience of aging ?

What do you enjoy most about the experience of aging ?

2) How do you experience aging in relation to your chronic illness ?

3) What do you notice most about the experience of chronic illness ?

4) Are you different than when you were say 50, 35, or 20 years old ?

What is different ?

5) How did you imagine yourself as an older woman when you were younger:
say when you were 50 years old, 35 years old, 20 years old ?

Is this different than the way you see yourself today ?

6) What has this been like for you to talk about aging and your experience of
illness ?

7) Do you have any questions for me ?