“I’M HELPLESS, BUT I’M NOT COMPLETELY HELPLESS”: AGENCY, IDENTITY WORK, AND RESILIENCE AMONG LOW-INCOME ELDERLY

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A Thesis

Presented to

The Faculty of the Department

of Sociology

University of Houston

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In Partial Fulfillment

Of the Requirements for the Degree of

Master of Arts

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By

Lindsay Oncken

August 2018

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ABSTRACT

In order to better serve a growing elderly population in the United States, it is important to understand the influence of resilience—or one's ability to bounce back from negative experiences—on seniors' sense of wellness. While existing research documents the importance of social interaction to seniors' resilience development, several key gaps remain: First, research on seniors does not often sample from vulnerable elderly populations, such as seniors of color and seniors living in poverty, who are arguably in the greatest need of resilience to buffer them from negative experiences. Second, there has not been much theoretical development regarding the content of social interaction most likely to facilitate resilience development among the elderly; in particular, little attention has been paid to the role of identity negotiation in seniors' resilience development.

The present research seeks to fill these gaps using in-depth, qualitative interviews with at-risk seniors enrolled in a local Meals on Wheels program. My research was guided by two key questions: (1) What are the most salient challenges seniors typically face?, and (2) In what ways does social interaction promote resilience development in the face of these challenges? I find that seniors commonly face severe limitations to their autonomy as a result of health and other age-related decline. I find that seniors cope with these challenges by engaging in forms of socially facilitated identity work that help them promote a more agentive sense of self. This sense of agency, I argue, is a key mechanism by which social interaction fosters resilience among seniors. I argue that practitioners should consider social interaction as a key site of identity work when developing programs and policies to foster senior wellness, and I encourage future researchers to further explore the relationship between identity work and resilience among seniors.

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Most of all, I want to thank the seniors who graciously offered me their stories, thoughts, and opinions. It was an honor to be invited into the homes and lives of such resilient people, and I am grateful for the opportunity to learn from them.

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The United States is facing a looming elder boom. Currently, 15 percent of our population is over the age of 65; by 2030, that number is expected to increase to one in five (Poo 2016). Further, the "oldest old" demographic—comprised of those seniors aged over 85—is expected to double in the next 20 years (Poo 2016). Advances in medical technology and chronic illness management mean our population is getting older, and this raises important questions for researchers and practitioners looking to ensure senior wellness alongside longevity. In order to craft a comprehensive, effective network of services and policies designed to best serve this growing elderly population, it is important to understand both what challenges seniors commonly face, and what factors facilitate resilience against those challenges.

Researchers focused on older adults are beginning to explore the influence of resilience on seniors' ability to age well, even in the face of hardship. Resilience, simply put, is a person's ability to weather difficult events and circumstances without experiencing a significant decline in their sense of overall wellness (Browne-Yung, Walker, and Luszcz 2017). Resilience is particularly important when looking at wellness among the elderly, because aging is naturally accompanied by such difficulties as declining health and disruptions in social support. If an aging person has a high level of resilience, they will be able to "bounce back" from hardship more easily. For this reason, a growing body of research has begun exploring the kinds of factors that impact older adults' ability to develop resilience, and thus age well even in the face of those physical and social

ailments that commonly accompany aging (see Bolton, Praedorius, and Smith-Osborne 2016).

The ability to bounce back from difficult events and circumstances is especially important for those seniors most likely to experience adversity. Based on current research, seniors who are at higher risk of experiencing hardship are those living in poverty, senior adults of color, and seniors living alone (Hummer 1996; Levine et al. 2001; Holt-Lunstad et al. 2015; Carder, Luhr, and Kohon 2016). While much research has documented the relationship between poverty, minority status, and isolation and more frequent experiences of adversity, including economic hardship and physical health outcomes (Kirk and Rittner 1992; Berkman and Kawachi 2000; Marmot 2002; Williams and Jackson 2005; Gleibs et al. 2011), little research has explored what either promotes or hinders resilience development in these specific social locations. Few studies have explored to what extent and by what means seniors living in these social locations are able to derive a sense of wellness in spite of their increased exposure to adversity. In addition, while resilient aging literature has demonstrated the importance of social interaction to resilience development among seniors, there has been little theorizing on the particular mechanisms that make social interaction important to seniors' resilience development. In other words, it is not well understood what content of social interaction is most important to seniors' ability to practice resilience.

A look at identity literature reveals social processes that may facilitate resilience development. Given that old age in the United States is a visibly stigmatized identity characterized by a lack of agency (Rapoliene 2015), it is relevant to look at the ways strategic social interactions may allow individuals to distance themselves from stigmatized

identities and promote a more positive personal identity. Specifically, Snow and Anderson's (1987) research on "identity work" among homeless adults reveals potential strategies that could be used by seniors to distance themselves from old age stigmas of helplessness and construct an agentive identity, which, in turn, has been shown to promote resilience (Bolton et al. 2016).

Using in-depth interviews, my research explores the influence of identity work on resilience development among low-income seniors enrolled in a local Meals on Wheels program located in a large metropolitan city. My findings highlight loss of agency resulting from health issues as a major challenge faced by the elderly individuals in my sample. With the understanding that old age involves taking on an undesirable social identity characterized by lack of autonomy, my findings suggest that Snow and Anderson's (1987) concept of "identity work" is an important mechanism by which seniors are able to enhance their own sense of agency through social interaction and, in turn, are able to develop resilience. Specifically, I find that seniors engage in identity talk and strategic association in order to enhance an agentive personal identity, which in turn promotes resilience development (Snow and Anderson 1987).

Ultimately, my research fills gaps in existing resilient aging literature by highlighting the interaction between identity work and resilience development. I argue that a strong sense of agency resulting from identity work likely contributes to an elderly person's overall resilience to adversity; therefore, policies and programs designed to offer seniors opportunities for identity work would likely be most effective for seniors' resilience development and overall wellness.

REVIEW OF RESILIENCE LITERATURE

Resilience Theory

Resilience can be conceptualized as "an individual's level of tolerance and ability to adapt positively to adversity and other challenging life circumstances" (Browne-Yung et al. 2017). Put more simply, resilience is one's ability to "bounce back" from difficult experiences or circumstances, without internalizing them into subjective identity, wellness, or sense of quality of life. This is important to the concept of aging, especially when guided by the understanding that aging is naturally accompanied by a higher probability of adverse experiences, ranging from disruptions in social networks to physical and cognitive ailments.

The scholarly study of resilience is generally traced back to the early work of Werner and Smith (1992), who researched the resilience of children and youth growing up in disruptive and harmful environments. In the well-known Kauai Longitudinal Study, Werner and Smith followed a cohort of 660 children born on Kauai from a prenatal period to the age of 18. They found that many children born into adverse conditions (e.g., poverty, alcoholism in the family) went on to do quite well in later life; early exposures to adversity were not necessarily associated with poor outcomes. In comparing the internal and external characteristics of resilient children, Werner and Smith (1992) highlighted such qualities as having an internal locus of control, having a strong sense of autonomy, and having a strong network of support as important predictors of resilience.

Following the Kauai Longitudinal Study, scholars and practitioners across disciplines enthusiastically embraced the concept of resilience. The medical field in particular was receptive to the concept of resilience, as it came about during the field's

shift toward more holistic considerations of patients' environmental and social contexts, in addition to their anatomy and biology, as relevant components of patient care (Bolton, Praetorius, and Smith-Osborne 2016). The end of the twentieth century saw a swell of resilience research, typically centered on resilience development in childhood and youth, but more recently expanding to incorporate adulthood and old age (Bolton et al. 2016).

Scholars have not come to a clear consensus on how exactly to theorize, conceptualize, or operationalize resilience. Depending on the discipline, resilience can be thought of as a personality trait, a tool, a process, or some combination thereof. A review of resilience literature reveals two primary schools of thought on resilience: one originates in developmental psychology, and the other is more holistic. The psychological approach to resilience tends to characterize it as an innate personality trait that provides individuals with a fixed capacity to adapt to both positive and negative experiences, foster a sense of strength and grit against potential future adversity, and, ultimately, compensate for diminished access to resources and activities in older age (Bonanno 2005; Browne-Yung et al. 2017). The important thing to understand about this perspective is that it views resilience as fairly rigid; a person who is very resilient in childhood, for example, would be expected to be very resilient in adulthood, regardless of changing life circumstances.

The holistic approach to resilience, on the other hand, takes a more inclusive look at a person's life, including such factors as "socioeconomic, family, educational, social networks, and environment/infrastructure factors" that are likely to impact one's ability to develop resilient coping strategies (Browne-Yung et al. 2017:283). Scholars across disciplines are beginning to approach resilience in this way, recognizing resilience as inherently dynamic, complex, and apt to change across both life stages and circumstances.

Importantly, scholars generally acknowledge that individuals possess and have access to varying internal and environmental protective factors that enhance their resilience, and that these protective factors are differentially available to people based on institutional structures and sociodemographic differences as well as internal disposition (Ouwehand, Ridder, and Bensing 2007; Bolton et al. 2016; Browne-Yung et al. 2017). According to the holistic view, both internal and external factors are likely to influence resilience development across the life course.

Aging Well

Successful aging. Scholars have long explored what it means for a person to age well, and this research has become increasingly relevant as life expectancy increases. The concept of successful aging today is heavily influenced by the work of Rowe and Kahn (1998), who sought to counter the then-dominant medical discourse of aging as being synonymous with decline. Instead, the aim of Rowe and Kahn (1998) was to emphasize the positive aspects of aging, all with the goal of combatting what they characterized as "ageism" in the prevailing discourse (Calasanti 2016). To this end, they identified measurable benchmarks of positive aging that could be referenced by service providers and medical practitioners to help guide seniors toward more positive outcomes. By making the right lifestyle choices, the authors argue, seniors can achieve the core tenants of successful aging, namely: (1) avoiding disease or disability, (2) maintaining high levels of cognitive functioning, and (3) remaining socially active and productive (Rowe and Kahn 1998). The authors emphasize that individual choice, rather than biological imperative, is the key determinant of whether a person ages successfully; indeed, they say, "successful aging is in our own hands" (Rowe and Kahn 1998:18).

Despite some positive reception in the medical and social work community, the successful aging model has faced numerous critiques, particularly from social scientists. Chief among these critiques is that the successful aging model presents an unrealistic standard that puts too much emphasis on individual responsibility and objective measures of wellness, without accounting for complex meaning-making processes that produce subjective quality of life outcomes (Gattuso 2003; Domajnko and Pahor 2015). For instance, Gattuso (2003) notes that, given the high comorbidity rates that come with older age, Rowe and Kahn's standard of avoiding physical or cognitive impairment is unrealistic for most people, and reductionist of the aging process as a whole. In other words, measuring successful aging by quantifiable benchmarks of physical health may gloss over the potential for seniors to age happily despite objective health or social decline.

Moreover, one of the more biting critiques of the successful aging model is that it privileges an experience more reflective of economically advantaged seniors, further marginalizing already-disadvantaged groups (Whittington 2013). Given the higher prevalence of both health and social adversity among people of color and people living in poverty across the life course (House, Lepkowski, Kinney, Mero, Kessler, and Herzog 1994; Hummer 1996; Berkman and Kawachi 2000; Levine et al. 2001; Marmot 2002; Williams and Jackson 2005), the successful aging model makes it less likely for racial/ethnic minorities and seniors living in poverty to achieve "success" in aging, further denigrating already-marginalized people.

Ultimately, critics of the successful aging model argue that older adults who experience adverse health conditions cannot unilaterally be said to have "failed" at aging, and may tap into processes not touched upon by the Rowe and Kahn framework that allow

them to age well despite physical, cognitive, or social impairments. Thus, scholars have recently begun to explore what these processes may be.

Resilient aging. The concept of "resilient aging" entered the literature as a proposed replacement for the "successful aging" model. Put forth by Gattuso (2003), the resilient aging model considers "becoming old as a new way of being," which "can confer a sense of wellness growing from a kind of wisdom that prizes endurance and acceptance, rather than being founded in objective indicators of health" (p. 173). Resilience is important to the study of aging in part because of its demonstrated health impacts: While studies vary in terms of methodology and sampling, research generally demonstrates that being able to cope with adversity has a positive effect on one's health and wellness (Nygren et al. 2005; Butler and Ciarrochi 2007). This is particularly important to the aging process given the heightened probability of experiencing health and social deficiencies in later life. It is worth noting, too, that this process can work in the opposite direction, with health and wellness having the potential to impact the extent to which one is able to practice proactive coping and other resilience strategies (Ouwehand et al. 2007).

Rather than classifying normative aging events (such as illness or loss of social contacts) as signals of aging badly, the resilient aging framework embraces the idea that physical and social hardships—which are virtually unavoidable in older age—are not necessarily indicators of decline, and that wellness is the result of a more complex process of meaning-making. One can weather these problems, in other words, without aging "unsuccessfully." Further, the resilient aging model challenges earlier assumptions that resilience is a fixed personality trait, consistent across the life course. Recent research is beginning to acknowledge the dynamic nature of resilience—notably, that it is likely to

have different impacts on individuals at different life stages and across multiple domains and ecological levels (Luthar, Cicchetti, and Becker 2000; Whittington 2013).

In short, research is beginning to embrace the dynamism and importance of resilience to older adults' ability to age well, even in the face of various adversities likely to accompany aging. If health and social adversities are, as Chambers (2005) argues, part of a "normative aging process," this prompts the question: What factors support a higher level of resilience in an aging population?

Factors Impacting Resilience

To address this question, researchers have begun to examine specific protective and risk factors impacting resilience in old age. These studies are often tackled qualitatively, with much of the recent literature relying on older adults' personal narratives of resilience to assess both its impacts on wellness, and its predictors. This is consistent with the theoretical approach of resilient aging, in which person-environment interactions and social-psychological interpretations are paramount over quantifiable environmental and health determinants. The qualitative nature of these small studies means that they tend to hone in on very specific populations within the larger elderly population. For example, Browne and colleagues (2009) examined resiliency factors in Native Hawaiian elders, while Emlet and colleagues (2011) explored the same types of processes in older individuals living with HIV/AIDS.

As a beginning step to bringing these studies into conversation with one another, one meta-synthesis of such qualitative literature examined what protective factors were found across multiple aging populations and studies (Bolton, Praedorius, and Smith-Osborne 2016). Bolton and colleagues (2016) pulled out several salient thematic

determinants of resilience development, which can be divided broadly into internal and external factors. In terms of internal personality traits, respondents across studies reported such factors as having "grit," drawing on the memory of withstanding past hardships, identifying themselves as "strong," and embracing a sense of autonomy as ways older adults are able to withstand current and future difficulties (Bolton et al. 2016). In terms of external, environmental factors, the most prominent theme present in nearly all studies of resilient aging was some level of social support and community. This may include things like caring for others, having access to community resources, and overcoming loneliness (Bolton et al. 2016). This finding is supported in studies outside of the synthesis: Consistently, researchers find that emotional support, regular contacts, depth and content of relationships, and community activity are imperative to resilience development among older adults (Gattuso 2003; Whittington 2014; Holt-Lunstad, Smith, Baker, Harris, and Stephenson 2015; Browne-Yung et al. 2017). However, these studies do not go into great theoretical detail regarding the content of social interaction that is most important to resilience development—a gap that will be discussed in greater detail later in this section.

Factors Impacting Wellness

The relative youth of the resilient aging literature makes it difficult to find research accounting for specific socio-demographic factors' effects on resilience development among seniors. However, quite a bit of literature documents the relationship between seniors' demographic characteristics and wellness outcomes, broadly defined. As aforementioned, measuring quantifiable wellness outcomes is often inadequate when determining the extent to which an individual is aging "well." That said, looking at what relationships exist between socio-demographic traits and wellness outcomes does provide

some insight into what populations are most in need of resilience development, and, therefore, what demographic characteristics should be explored in future resilience studies.

Based on the current literature, adversities naturally related to aging are likely to be exacerbated for those seniors who are living in poverty, seniors of color, and seniors living alone (Hummer 1996; Levine et al. 2001; Holt-Lunstad et al. 2015; Carder, Luhr, and Kohon 2016). Existing literatures demonstrates the relationships between both economic and health outcomes and socioeconomic status, race/ethnicity, and isolation. Ultimately, the state of existing literature signals a need for resilience research to be extended to populations made especially vulnerable by their demographic traits. Studying resilience in these populations is important because their resilience development is not yet well understood, and because their heightened risk of economic and health-related adversity signals a greater need for resilience.

Socioeconomic status. The ability to practice resilience is particularly important for a growing number of seniors who experience age-related decline under the conditions of poverty. According to the United States Census Bureau, one third of elderly Americans are living below twice the federal poverty line. When using a more up-to-date, supplemental measure of poverty developed by the U.S. Census Bureau (see Cubanski, Casillas, and Damico 2015), that number jumps to 45 percent (Cubanski et al. 2015; Proctor, Semega, and Kollar 2016). Further, Census estimates indicate that the number of elderly individuals living in poverty is expected to increase by 180 percent by the year 2050 (Proctor et al. 2016). Elderly individuals living in poverty are especially vulnerable to the negative effects of high health care costs, high housing costs, and stagnated or disappearing wages (Goldberg, Lang, and Barrington 2016).

Not surprisingly, research supports the idea that poverty in old age is associated with poorer health outcomes. Consistently, research has demonstrated a link between low socioeconomic status and poor health throughout adulthood (Berkman and Kawachi 2000; Marmot 2002). Americans living in low socioeconomic conditions tend to present with illnesses at much younger ages than their higher socioeconomic status counterparts, meaning elderly adults living in poverty are more likely to be dealing with long-term health issues (House, Lepkowski, Kinney, Mero, Kessler, and Herzog 1994). Research looking specifically at an aging population finds that this association is no less true among the elderly: Seniors living in poverty are more likely to experience poor health, high use of hospitals, food insecurity, isolation, and housing instability (Kirk and Rittner 1992; Carder, Luhr, and Kohon 2016).

While aging is associated with health decline for nearly all adults, this decline is exacerbated for seniors living in poverty. However, without an understanding of how resilience is developed in these circumstances, it is impossible to say for certain to what extent adversities related to aging in poverty coalesce into the experience of poor quality of life. Understanding what factors allow low-socioeconomic status seniors to experience such adversities as poor health and food insecurity with limited impact on subjective quality of life would allow service providers to effectively and realistically address their clients' needs.

Race and ethnicity. As with socioeconomic status, there is a documented relationship between race and wellness outcomes. To begin with, studies focusing on race and economic security consistently demonstrate that adults of color are at greater risk of experiencing economic adversity, which is itself associated with worse wellness outcomes,

as outlined in the previous section (Williams and Jackson 2005). Racial disparities are no less apparent among seniors. For example, older workers of color are most at risk of unemployment, and older African American men are twice as likely to experience unemployment as older white men (Economic Security for Seniors: Fact Sheet 2016). In 2013, the poverty rate among Hispanic adults aged 65 and older was three times that of white adults aged 65 and older; meanwhile, African American seniors experienced poverty at a rate two and a half times that of whites (Cubanski, Casillas, and Damico 2015).

In addition to decreased economic security, research looking at race and health consistently finds that African Americans are at increased risk of health problems, including higher rates of infant mortality, heart disease, cancer, and mortality (Hummer 1996; Levine et al. 2001; Williams and Jackson 2005). Generally, health disparities between African Americans and whites are attributed to African Americans' exposure to residential segregation, neighborhood inequalities, poor socioeconomic circumstances and opportunities, and a scarcity of available resources (Williams and Jackson 2005). While Latinos in the United States do not experience the same level of health disadvantages as one might expect given their socioeconomic profile, they are at a higher risk of some medical conditions, such as obesity and asthma (Dubowitz, Bates, and Acevedo-Garcia 2010).

Again, a combination of heightened economic and health risks means that seniors of color are at greater risk of experiencing adversity. As with socioeconomic status, it is important to extend the resilience literature to look specifically at seniors of color in order to best address the needs of these vulnerable populations, and to understand the influence that race may have on seniors' ability to develop resilience.

Isolation. Many in the research community have expressed alarm over the increasing tendency of elderly people to live alone, especially in the United States, where more seniors live alone today than ever before (Karmarow 1995; Schnittker 2005). Declining social support in older age is generally thought to be a result of external changes accompanying aging such as retirement, the death of loved ones, and physical limitations (Schnittker 2005). Research highlights the dangers of isolation and loneliness on health outcomes: While the exact mechanism is not fully understood, isolation at any age is consistently associated with poor health and is highly correlated with disease and mortality, particularly among the elderly (Holt-Lunstad, Smith, Baker, Harris, and Stephenson 2015). Thus, the increasing trend toward seniors living alone and having diminished social contact is thought to be an alarming public health concern worth targeting in the elderly community (Holt-Lunstad et al. 2015; Gerst-Emerson and Jayawardhana 2015).

However, some scholars have questioned the way social isolation in an elderly population is measured and conceptualized (Kramarow 1995; Schnittker 2005). There is a distinction in this literature between isolation, which is a quantifiable measure of lacking social contact, and loneliness, which is the subjective feeling of being alone. Often, research emphasizing the negative impacts of isolation uses the terms isolation and loneliness interchangeably, measuring one while drawing inferences about the other. Countering the assumption that isolation necessarily leads to loneliness, some researchers argue that a lack of social contact might not necessarily equate to a lack of perceived social support, especially among older adults (Schnittker 2005). This is supported by research finding that, while seniors are much more likely to report having fewer friends and social

contacts than younger adults, they are not always correspondingly likely to report feelings of loneliness (Klinenberg 2003; Zebhauser et al. 2015). This research suggests that perhaps the process of aging renders counts of social contacts far less important than the quality or content of those interactions. In other words, while it is appropriate to measure frequency of in-person contact to evaluate isolation in young adulthood, it might be content, not quantity, of social support that matters most to seniors (Schnittker 2005).

It is likely, then, that the resilience studies mentioned earlier emphasizing the importance of social support to older adults' resilience development are not touching on the importance of quantifiable counts of socialization, such as frequency of contact with other people or number of friends. Instead, the finding that social support is important to resilience development may be touching on seniors' more subjective experiences of having gotten something beneficial from social interactions available to them. This idea has important implications for the policy recommendations that could come from research on socialization and resilience development among older adults: It is likely that ensuring seniors interact with many people is less important than ensuring that they interact in *certain* ways, with *certain* people.

Gaps in Resilience Literature

While research generally documents a relationship between specific demographic characteristics and negative wellness outcomes, this research also presents a measurement problem reminiscent of that found in Rowe and Kahn's (1998) successful aging framework. It can be argued that the relationships found between low socioeconomic status, minority status, and isolation and poor health and economic outcomes only provide a partial picture: In all likelihood, resilience protects individuals from some of the burdens

of these objective indicators of hardship. In other words, experiencing adversities related to one's socio-demographic location does not automatically doom an elderly person to poor overall quality of life. It is important, then, to understand whom resilience successfully shields, and under what circumstances.

In order to answer this question, it is crucial for researchers to include vulnerable elderly populations in explorations of resilience. To this point, few resilient aging studies have targeted senior populations most at risk; instead, many studies have sampled from such communal settings as retirement communities, nursing homes, and long-term care facilities (Bolton et al. 2016). Given that these types of settings do not typically cater to low-income, at-risk elderly folks, our understanding of resilient aging cannot be said to adequately capture the experience of less advantaged seniors. It is important for researchers to intentionally sample at-risk senior populations so that they may better understand how resilience can be developed in the face of multifaceted hardship.

In terms of theory, an important gap left by resilient aging literature involves the content of social interaction most beneficial to resilience development among the elderly. While studies have demonstrated that social interaction of various types is important to seniors' resilience development, there has not been much theorizing done on the specific mechanisms that cause social interaction to be internalized into resilience (Gattuso 2003; Whittington 2014; Holt-Lunstad, Smith, Baker, Harris, and Stephenson 2015; Browne-Yung et al. 2017). This is a key gap to fill, given the likelihood that content of socialization matters most to elderly individuals' resilience development (Schnittker 2005).

In sum, research exploring resilience development among elderly adults should focus on at-risk seniors who are not embedded in social environments, such as retirement

communities or nursing homes. In addition, conducting research on less advantaged seniors would be beneficial both because this population may be in greater need of support to develop resilience against the potential negative effects of their socio-demographic location, and because understanding resilience processes in these populations would allow for more robust theorizing on the types of social interaction that best allow for seniors' resilience development—a concept still not well understood among researchers.

REVIEW OF IDENTITY LITERATURE

One arena that has not been extensively studied in relation to resilient aging is identity. Alongside hardships related to social and physical functioning, seniors face assaults to identity as a consequence of getting older. Unlike cognitive and health decline, however, identity is malleable; Individuals are capable of engaging in behaviors that shield them from the negative consequences of a stigmatized identity (Snow and Anderson 1987). Given the salience of identity shifts in old age, identity is an important arena to look at when trying to understand how seniors develop resilience to other, more tangible hardships.

Stigma and Old Age

In order to understand the role that identity plays in seniors' resilience development, we must first situate our discussion of old age within a broader understanding of stigma and identity. According to Erving Goffman in his seminal 1963 essay, a stigma is any social or physical characteristic that diminishes an individual's identity and prevents them from conforming to public norms or ideals (Goffman 1963). Stigmatized individuals are thus unable to achieve full social acceptance, which in turn can

have significant effects on their development of a positive identity and sense of self-worth (Goffman 1963).

Old age in the United States can be recognized as a visibly stigmatizing identity (Rapoliene 2015). Though little research has acknowledged this explicitly, the social experience of old age fits Goffman's (1963) definition of stigma well: It is a visible feature that does not conform to United States ideals of youth and agency. Moreover, it is a category one enters unwillingly, and its visibility and interactions with physical and cognitive ability make it particularly difficult—if not entirely impossible—to mask.

Challenges to autonomy are consistently found to exacerbate the emotional consequences of old age stigma (Windsor, Anstey, Butterworth, Luszcz, and Andrews 2007). Pachana, Jetten, Gustafsson, and Liddle (2017), for instance, found that driving cessation in older age was related to feelings of stress over getting older, and a subjective loss of identity. In terms of driving, too, researchers have noted that losing the ability to drive causes emotional distress even when alternative modes of transportation, such as a spouse who drives, remain available (Ragland, Satariano, and MacLeod 2005; Windsor et al. 2007). In other words, emotional distress over losing abilities in old age has been shown to have less to do with the function of that ability (e.g., being able to get to the grocery store) and more to do with the subjective loss of autonomy that comes with being unable to perform that ability for oneself (e.g., being able to drive *oneself* to the grocery store).

As Goffman (1963) notes, there are several strategies one can employ to mitigate the effects of stigma, including "passing" oneself off as a member of a non-stigmatized social category. However, this strategy does not always apply; for visibly stigmatized identities whose "stigma signals" cannot be easily masked, Goffman's proposed strategies

are not sufficient to reduce the felt effects of stigma (Goffman 1963; Snow and Anderson 1987). Another potential strategy to reduce the effects of stigma is complete withdrawal from society (Goffman 1963). While many seniors do withdraw in some regard when they enter care facilities or specialized housing that caters to an elderly population, this is not sufficient to eliminate old age stigma. As Hrybyk and colleagues (2012) note, particularly in elderly settings with a mix of higher- and lower-functioning seniors, "stigmatizing behavior may be exacerbated as residents and staff monitor physical or mental declines that mark a person as 'going downhill' and may prompt a move to a higher level of care" (p. 277). Thus, as Snow and Anderson's (1987) found in the homeless population they studied, seniors are not generally offered the options of either "passing" or withdrawing from society in order to mitigate the negative consequences of old age stigma, including subjective loss of agency and status.

The question, then, is how seniors construct and maintain a positive identity, even in the face of a stigmatized social role. Some research has explored the ways that seniors negotiate their stigmatized identities, particularly in relation to conceptions and labels of "frailty." For instance, Grenier (2006) found that older adults distinguish between "being frail" and "feeling frail": The former is acknowledgement of an imposed medical classification, while the latter indicates an emotional or otherwise internalized state. Similarly, Puts and colleagues (2009) found that seniors did not always identify as "frail," even when they were formally classified as such. Warmoth and colleagues (2016) found that seniors did not necessarily regard frailty as an inevitability of aging, and further, most resisted being classified as frail by engaging in particular resistance strategies, such as

staying physically active. Thus, research suggests that seniors engage in negotiations of identity that allow them to reject stigmatizing labels imposed on them by others.

However, the particular strategies seniors engage in to maintain a positive self-concept are still not well understood. Therefore, we turn to identity work as a lens through which to understand how seniors may foster a sense of agency and self-worth, despite belonging to a visible, immutable social category not highly valued in broader society.

Identity Work

In their seminal research on the identity negotiation of homeless adults, Snow and Anderson (1987) explore the strategies individuals use to reduce the distance felt between internal identities and stigmatized social identities imbued on them by others. They introduce "identity work" as a class of strategies allowing individuals to confront "the problem of constructing personal identities that are not a mere reflection of the stereotypical and stigmatized manner in which they are regarded as a social category" (Snow and Anderson 1987:1340). The concept of identity work can be used to understand how individuals occupying stigmatized identities—including that of old age—may behave in order to offset the effect of those identities.

Drawing from the work of Snow and Anderson (1987), this paper distinguishes between social identities, personal identities, and self-concept. Social identities are those imputed by others in order to make sense of a person as a social object; thus, social identities are not self-ascribed, but instead are ascribed by others based on observed behavior, appearance, and roles (Turner 1978; Snow and Anderson 1987). Personal identities, on the other hand, are systems of meaning ascribed to the self. Personal identities can draw from biographical and demographic attributes, but are distinct in that

they can differ from social identities ascribed by others based on those attributes (Snow and Anderson 1987). Finally, self-concept can be thought of as a "working compromise between idealized images and imputed social identities" (Snow and Anderson 1987, p. 1348). In other words, one's self-concept is an overarching view of the self, encompassing both experienced and idealized social and personal identities accrued over a lifetime.

When there is a discrepancy between one's self-concept and social identity, individuals can engage in identity work, defined as "the range of activities individuals engage in to create, present, and sustain personal identities that are congruent with and supportive of the self-concept" (Snow and Anderson 1987:1348). Snow and Anderson (1987) found that identity work encompasses a diverse mix of activities, including identity talk and selective association.

Identity talk. Identity talk, defined as the "verbal construction and assertion of personal identities," involves using talk itself as a tool to distance oneself from an undesirable social identity (Snow and Anderson 1987, p. 1348). Within this concept, Snow and Anderson (1987) introduce "role distancing" and "associational distancing" as two effective forms of identity talk that allow stigmatized individuals to distance themselves from harmful social identities.

Role distancing involves verbally asserting oneself as distinct from the social role one occupies and "[fostering] the impression of a lack of commitment or attachment to a particular role in order to deny the virtual self implied" (Snow and Anderson 1987:1350). This form of expressed distancing can take various forms, including expressed difference from "typical" members of a role (e.g., asserting oneself as different from a "typical street person") and detachment from specific kinds of activities associated with members of a

social category. For example, in their work with homeless adults, Snow and Anderson (1987) found that role distancing manifested frequently in expressed disdain for the degrading, poorly paid work available to street people: Telling stories in which individuals refused to perform demeaning work by walking out on a job, Snow and Anderson (1987) argue, "may function as a means of social identity disavowal, on the one hand, and personal identity assertion, on the other" (p. 1351). Thus, by expressing themselves as detached either from the "typical" member of a social group or specific activities associated with that group, individuals can verbally construct an identity that is distinct from the stigmatized social identity they are trying to avoid.

Similar to role distancing, associational distancing is a form of identity talk in which individuals verbally assert themselves as different from other members of a negatively-valued social group to which they belong. Being able to claim an identity, according to this perspective, depends in part "on one's ability to manage his image by drawing distinctions between himself and others he does not want to be associated with" (Anderson 1976:214). Snow and Anderson (1987) found that homeless individuals would verbally distinguish themselves from other "street people," as in the following quote: "They have gotten used to living in the streets and are satisfied with it. But not me! Next to my salvation, getting off the street is the most important thing in my life" (p. 1349). Thus, associational distancing allowed stigmatized individuals to promote positive identities defined, at least in part, by the positive attributes that make them distinct from other members of their stigmatized group.

Selective association. A second form of identity work, selective association involves strategically engaging in social interactions with particular kinds of people in

order to promote a more positive self-concept. While Snow and Anderson (1987) did not concentrate on this particular type of identity work in their study on homeless people, they did introduce it as a form of identity work likely to be used by members of stigmatized groups to promote positive self-concepts. In their work with North African immigrant women living in France, for instance, Killian and Johnson (2006) found that selectively engaging with highly educated, worldly people allowed immigrant women to reduce the stigma they felt as immigrants. This particular form of identity work has not been widely studied, and deserves further investigation.

Gaps in Old Age and Identity Literature

While some research has indicated that seniors engage in identity negotiation to reject stigmatizing labels such as "frailty," little research has looked at this identity negotiation process through the lens of identity work. In addition, the dearth of research on selective association as an identity work tool in elderly populations is a gap worth filling: Given the demonstrated importance of social interaction to elderly resilience development, it is important to better understand in what ways identity work may be facilitated by social interaction.

METHODS

The present research seeks to fill gaps in both resilient aging and identity research by intentionally sampling at-risk seniors, as well as developing theoretical insights gleaned from in-depth, qualitative interviews to explore how identity work may factor into the kinds of social interaction that best promote resilience. This research was guided by two key questions: (1) What are the most salient challenges that seniors typically face?, and (2)

In what ways do various forms of social interaction promote resilience development in the face of these challenges?

Sampling

I recruited from a local YWCA Meals on Wheels program, which is designed to serve low-income, food-insecure elderly living in a large, metropolitan area. The Meals on Wheels program houses two smaller programs: Congregate Meals and Home Delivered Meals (HDM). The Congregate Meals program provides meals to participating seniors at several public sites in the metropolitan area, while the HDM program is in charge of delivering hot meals every weekday to seniors aged over 60 with a documented physical ailment that prevents them from attending Congregate Meals. My study population consists of seniors enrolled in both programs.

The demographic breakdown of the seniors served by the YWCA reflects a less advantaged senior population than do the populations of many other resilient aging studies. The YWCA Meals on Wheels program serves well over 800 seniors in a given day, spread across 17 zip codes in the Houston area. Approximately 65 percent of the population is female, and 35 percent is male. The racial-ethnic breakdown of Meals on Wheels recipients is as follows: 53 percent African American, 20 percent Hispanic, 19 percent White, and 8 percent Asian American. While the YWCA does not ask their clients to disclose their veteran status officially, staff members have communicated to me that a high number of the seniors they serve are veterans. Perhaps most importantly, all seniors participating in the Meals on Wheels program are, by nature of their participation in the program, both disproportionately likely to be experiencing health issues and socioeconomically disadvantaged.

In addition to providing nutritional meals, the YWCA Meals on Wheels program prides itself on providing social contact and general care to the seniors it serves. While the Meals on Wheels program ostensibly is centered on nutritional service, it serves an important social function in the elderly community as well. YWCA staff members have expressed concern to me about the isolation their seniors face—particularly those seniors who are homebound, or relegated to their homes due to physical ailment. The organization is motivated to learn more about needs their seniors have so that they may develop programs for those with diminished autonomy and without extensive social or financial safety nets.

For this study, I employed two recruitment strategies designed to target each of the Meals on Wheels programs. First, to recruit homebound seniors receiving Home Delivered Meals, the YWCA staff and volunteers created a list of seniors who are generally understood to be socially willing, mentally competent, proficient in English, and located in a safe environment. Once the list was finalized, I created flyers advertising my study to be passed out by volunteer drivers. Seniors who were interested in being interviewed were invited to call me, and we arranged interviews to be held in their homes. This method of recruitment proved to be quite slow and difficult, for reasons I will explore further in the discussion section of this paper. For this reason, in total, I recruited only three seniors who were homebound.

While I acknowledge that using staff members as a gatekeeper to participating seniors likely created a sampling bias that brought more social, functioning seniors into my sample, I used this recruitment method in order to reduce potential harm to myself, ensure there would be no linguistic barriers to open conversation, and ensure a safe and

comfortable interview experience for both parties. In addition, allowing organization staff and volunteers to create the initial participant pool served as a kind of vetting process to make sure I did not include subjects who were mentally compromised to the point that they would not be able to provide informed consent.

Second, to recruit seniors receiving Congregate Meals services, I visited three participating senior centers around the time that lunch was served. One is a community center that seniors visit for lunch and other communal activities, and the other two are activities centers located within low-income housing facilities catering to elderly tenants. (For a more detailed description of each senior center, see Appendix B.) Upon arriving at each center, I verbally explained my study to the seniors gathered in the communal space and invited anyone interested in being interviewed to come speak with me. Staff members also helped me by informing seniors who came in later of my study, and pointing them in my direction. To avoid any ethical issues involving coercion in this vulnerable population, I did not offer incentives to seniors for their participation. I recruited eleven seniors from two different senior centers.

In total, I interviewed 14 seniors whose ages range from 61 to 85, with an average age of 73. Of the 14 seniors in my sample, three are homebound, while the remaining eleven live in housing catering to the elderly; three are men, and eleven are women; eight are Black, two are Hispanic, and four are White; and all but two live alone. (For a more detailed look at the demographics of my sample, including assigned pseudonyms, see Appendix A.)

It is worth noting, as I mentioned, that the seniors I sampled are likely those who can be thought to be more resilient than their peers receiving assistance from the YWCA.

Of course, this is not something I can say with absolute certainty, but the purely voluntary nature of seniors' participation would suggest that those I interviewed were those with more energy, more agency, and more willingness to engage in social interaction—all traits broadly associated with a higher level of resilience. Thus, the findings of my study likely point to instances and strategies that foster resilience, rather than pointing to pervasive problems in this senior community. I would not, for instance, be able to speak to the pervasiveness of loneliness or isolation through my data.

Interviews

I began the interview process by reading participants a consent form, which they signed to indicate their consent to being interviewed and having our conversation audio recorded. Due to space restrictions, conversations in senior centers were only minimally private; generally, I conducted interviews within the same space where other seniors were gathered, but we would sit at our own table, in our own corner of the room, or in a nearby common area. Interviews with Home Delivered Meals clients took place in seniors' homes, sometimes with family members either walking through or in adjacent rooms.

During interviews, I took notes in addition to audio recording our conversation in order to guide my thoughts and remind me to come back to certain points. After each interview, I jotted down field notes about details surrounding the interview, including the conversations that occurred but were not recorded, the setting we were in, any unplanned interactions with other people that occurred during the interview, and my overall takeaways from the conversation. In senior centers, each interview ended with a brief conversation with the facility's coordinator, during which I gathered a better sense of how the different senior centers operated.

I organized my interview guide thematically, with prompts for topics and suggested probes. However, I allowed seniors to guide the conversation as much as possible. Because I allowed each participant to guide our conversation, each interview had a slightly different emphasis, and each was informed by data gathered prior. Broadly, the topics covered in each of my interviews included: common challenges faced by seniors, how seniors coped with these challenges, seniors' social lives, seniors' interactions with organizations and care providers, and seniors' plans for the future.

Analysis

Borrowing from Glaser and Strauss's (1967) grounded theory, I allowed themes to emerge organically from interviews and adapted subsequent interview guides accordingly. Guided by the data, I engaged in theoretical analysis during the interview process. While my project began with a focus on resilience, themes of identity and identity work emerged organically from the data and informed the interviews collected later on.

I obtained transcriptions of each interview using a secure third-party transcription service.[1] I then went through each interview and compared the transcription to the audio recording to correct wording, fill in missed audio, and otherwise ensure that nothing was missed in the transcription process. Once I cleaned up my interview transcripts, I coded each one using Atlas.ti. Guided by grounded theory, I continually analyzed my data while still in the process of interviewing (Glaser and Strauss 1967). Thus, my coding schemes changed throughout the process of interviewing. I first began with a broad range of

[1] Funding for this project was generously provided by Dr. Michael Cottingham and the University of Houston Department of Sociology and went entirely to the cost of transcription.

detailed codes, which were later re-coded to reflect the theoretical model proposed in this paper.

While I did employ techniques associated with Glaser and Strauss's (1967) grounded theory, I did not ultimately create an entirely new theory from my data. Instead, I used my data to support proposed adjustments to existing social psychology theoretical models, and introduce a potential interaction between two disparate social psychological concepts. Namely, my data suggests a potential interaction between identity work and resilience theory that, I argue, should be investigated further in future identity research on the elderly.

FINDINGS

Challenges to Autonomy

The most prevalent challenge discussed in my interviews was that of autonomy being threatened both by aging and, more specifically, by particular effects of age-related health problems. The health issues experienced by seniors in my sample were varied, but nearly all of my participants reported experiencing a significant decline in autonomy as a result.

Typically, a loss of autonomy was closely related to a loss of mobility resulting from health problems. Seniors whose health problems prevented them from driving, walking, or otherwise moving around freely seemed to experience the most loss of autonomy as a result. For example, Dave[2], a housebound man who was temporarily living in a hotel when I interviewed him, describes the limitations he must deal with as a result of having broken his neck several years prior:

[2] All names contained in this article are pseudonyms.

> It's nerve damage. Death nerves, I think, in my hands and feet. It makes things difficult. I can't hold things in my hand. My writing is horrible because of that. And my feet, it makes it so that I can walk from here to the… I can get to Walmart [across the street]. That's about it. And the pain is just… Every step I take is walking on cactus needles. And at night, it's like somebody's got a hot poker and is just ramming it through my feet. (Dave, 61, White, Homebound)

Throughout our conversation, the limitations Dave must deal with as a result of his physical ailments came up consistently, ranging from his need for a live-in caregiver to his inability to drive to social gatherings with his friends. While the need to rely on others does not mean that Dave is unable to do what he wants, it does reduce his sense of being able to do things for himself.

This loss of absolute autonomy was frequently discussed by seniors in my sample, particularly in the context of driving. "I can't drive anymore because I have seizures. I am a survivor of brain surgery, cancer, and two other major surgeries I've had. The brain surgery caused me to have seizures" (Theresa, 62, Black, Center A). Of the fourteen seniors I spoke with, nine reported being unable to drive themselves. Though social contacts and formal services (including Meals on Wheels) allowed some seniors to achieve the functional goals of driving (such as getting groceries and going to doctors' appointments), seniors still expressed frustration with not being able to do these activities on their own. Having to rely on others was frustrating for many seniors I spoke with.

The results of losing agency seeped into many areas of life. Lack of mobility was often framed as a reason that seniors were unable to get out and see other people. Particularly for those seniors whose social groups were not in the same location as they were, being unable to travel to them was difficult. Even when seniors were close to potential social contacts—such as those living in communal housing—significant health issues could keep seniors in isolation. Brian, for instance, lived a few floors above the

senior center where I interviewed him, but he described the ways his physical limitations sometimes kept him from interacting with other people:

> Right now, I'm kind of really handicapped. I need a hip replacement… I've had surgery on my back, called a laminectomy. It didn't work. I got a three-inch incision, where they went into my back and did some stuff. It worked for a little while, but now it's back to where it was. Pain. Lots of pain. I'm very limited in what I can do. I can't walk too far. I stay in my apartment a lot. Sometimes I have to walk around in my apartment with my walker or cane, it would be hurting so bad. (Brian, 67, Black, Center A[3])

Brian experiences a form of isolation when he has to stay inside of his apartment due to pain. Even though potential social interactions are only a few flights of stairs away, he is often secluded within his apartment due to extreme pain. Given the documented prevalence of isolation among elderly individuals, it is important to keep in mind the ways that mobility might contribute to isolation, even for those who are ostensibly located in communal environments (Holt-Lunstad et al. 2015; Gerst-Emerson and Jayawardhana 2015). And for seniors like Brian, it is important to explore potential ways that these mobility limitations can be overcome.

The consequences of physical limitations extend beyond mobility. As a result of health-related physical limitations, seniors were often forced to rely on others. Due to exacerbated health problems, seniors frequently reported being unable to perform day-to-day tasks without the help of someone else. Mildred, a housebound woman with severe spinal issues, articulated her frustration with being unable to do things herself—a sentiment commonly expressed by seniors in my sample:

> I have spinal stenosis that's where my spine is all compressed. All the nerves were compressed and it affected my walking, and my mobility of my legs… Without the walker, I don't have the strength to stand on my own… so that's frustrating. I want

[3] For a description of the three senior centers from which I recruited, see Appendix B.

> to be able to go out and do things, do my own shopping and stuff so I don't have to depend on nobody. Right now it's a struggle. (Mildred, 67, Black, Homebound)

An active church-goer who prides herself on caring for her two adult sons, Mildred struggles with the fact that she is unable to perform her household tasks on her own. She doesn't want to have to depend on others, but she is forced to because of her poor state of health.

The stress of a loss of autonomy was particularly felt when framed in relation to the work seniors used to be able to do. Seniors' lack of autonomous work was felt as a lack of usefulness, and often framed as a loss of great personal magnitude. Dave was perhaps the most extreme example of this internal strife. A career Navy man with a background in weapons design, Dave struggled with being unable to work with his hands as a result of nerve damage:

> I would go back and work for them tomorrow if I could, but unfortunately I can't. There's not a doctor in the world who's gonna sign off on me going back to work… I just kinda sit around the house and read. I try to take a little, small walk every day, but it's just too painful… I guess you'd say [my biggest challenge is] boredom. Yeah. Like I said, I'm very highly educated. I've got two college degrees. And I only watch TV that's interesting, like History channels, and stuff like that, the programs. I don't wanna watch Judge Judy and turn to mush. (Dave, 61, White, Homebound)

Though he does what he can to stay reasonably active and keep his mind busy, Dave is acutely aware of his physical limitations and worries about letting his mind deteriorate. For him, a loss in autonomy translates to a loss of identity; he is no longer in a position where he can be the worker who must think his way through complex problems (though, as he notes, he would be happy to reclaim that identity if he could), but instead is forced to try and maximize his mental stimulation from television and books.

Despite pervasive challenges to physical autonomy, the social identity seniors in my sample had to contend with—one lacking in agency and containing low social value—was neither static nor prescriptive. In the next section, I will explore identity work as a way that seniors are able to reclaim their sense of agency, even when they must grapple with significant health-related challenges to their sense of autonomy.

Identity Work

Recalling the work of Snow and Anderson (1987), "identity work" refers to the actions individuals take in order to close the distance between their personal identities and the stigmatized, disparaged social identities imbued on them by others. The conversations I had with seniors about their daily struggles and coping mechanisms directly confronted perceptions of them as helpless and not valuable due to their physical limitations. Specifically, seniors engaged in identity talk and selective association to construct identities that are, in fact, rich in independence and autonomy. Engaging in these forms of identity work, I argue, allows seniors to enhance their own sense of agency, thereby enriching their resilience against hardship.

Identity talk. As discussed previously, identity talk is one form that identity work can take. Identity talk involves the use of talk itself as a form of identity work: Through identity talk, individuals are able to control the narratives of their lives, and therefore are able to construct a self through the simple act of talking. Given the narrative nature of my research, identity talk was particularly relevant. In my research, identity talk takes two related forms: Role distancing, in which individuals verbally distance themselves from an undesired role, and associational distancing, in which individuals verbally distance themselves from others who occupy the same undesired role that they do.

In my sample, role distancing occurred frequently. Like the homeless people in Snow and Anderson's (1987) study, seniors tended to distance themselves from the old age role by distancing themselves from stereotypical characteristics of that role. In this case, they distanced themselves from assumptions of helplessness and fragility, instead asserting themselves as independent, stubborn, and capable. Given the understood stigma of old age as a time of feebleness, seniors' verbal assertions of independence were direct contradictions to the "old age" role they occupied. In this way, seniors used the act of narrating to distance themselves from a role characterized by lack of autonomy. They frequently narrated their own independence to me, and described the ways that they actively resisted any implication that they were anything less than self-sufficient.

Theresa, who was unable to drive due to her history of seizures, described herself to me this way:

> I'm real independent. And I'm really very stubborn. So it's like, okay, well if I can't get someplace right then [without asking someone], 'I need you to do this for me, I need you to take me,' I would put it off and say, well, I'll do it another day. Unless it's something that has to be done that particular day. (Theresa, 62, Black, Center B)

Here, Theresa expresses the idea that she is unwilling to ask others for help unless it is absolutely necessary. Whether or not this is consistently true in her day-to-day life, her narrative assertion of it allows her to construct a self that is entirely autonomous, and altogether different from the helpless old person she does not want to others to think of her as.

Similarly, Rose, who typically relies on what she characterized as an unreliable metro system to get her from place to place, nonetheless described to me her reluctance to accept favors from others:

> In fact, if I get ready to go to church, well, I go out across the street and catch a shuttle and go on my way… There used to be a lady that was coming out that way, but I wasn't really relying on her, she had just asked me [if I needed a ride] and I would just accept. But I gave her some gas money to do what she did. I didn't just get in there for nothing. (Rose, 77, Black, Center B)

Rose gets ahead of the idea that she might have been practicing old-age helplessness by asserting, rather insistently, that even when she accepted help from somebody else in the form of a ride to church, she "didn't just get in there for nothing." Instead, she says, she paid the woman for her time. Like Theresa, Rose uses the act of talking to construct an image of a self who doesn't accept help without giving something in return; she rejects the notion that she is in need of any kind of charity. Whether or not this is consistently true, she is able to use her narrative of the situation to construct a sense of self that does not embody the helplessness of a stigmatized old age identity.

Several seniors expressed to me their frustration with encounters in which others treated them as though they occupied a helpless role. Typically, these encounters were with care providers, who by their very nature reinforce a level of helplessness in seniors that, often, did not sit well with them. In order to combat this feeling, seniors used verbal expression to adjust what they perceived as a misconception: In their retelling of these situations, seniors were able to express to me, if to no one else, that the person telling them they lacked autonomy was wrong.

Hector, for instance, took issue with the behavior of different staff members at the apartment complex where he lived. He perceived them as being too bossy; they treated the seniors like children, in his view:

> You know, when you're older and then you have a young woman telling you what to do and where to sit down, that you couldn't sit in the front, that you couldn't sit outside… I got up in the meeting and told them, 'Look, when you go to your house,

> and you want to sit on the porch, does anybody tell you no? This is my house. I pay rent here.' (Hector, 67, Latino, Center A)

Whether or not Hector actually expressed this to the staff members with whom he took issue, his retelling of the story to me allows him to engage in identity talk. Through his telling of the story, he is able to create an image of himself that is far from the helpless old man he knows others see him as. In his narrative, he is outspoken, collected, and rational, and he refuses to be mistreated. By forcefully asserting himself as such in narrative form, he is able to promote an identity that is more in line with his positive self-concept.

Similarly, Julie, a 70-year-old woman living in the same senior apartment complex, expressed to me several times that she resents being treated as though she is less than capable. As a former care worker herself, she is familiar with the many needs of the elderly, and reluctant to be on the asking side of things. She told me that she does not like when people offer to help her without her having asked for help first; an offer to help, to her, means the other person is assuming a level of helplessness in her that she does not want to validate by accepting. Her retelling of her time living with her daughter illustrates her attitude on independence well:

> I wanted my independence from [my children]. I stay with my daughter two years. Soon as [this] apartment came available, I moved. I didn't plan on staying anyway. I don't want to be treated like a child. 'Momma, did you do this? Momma, you didn't have to do that.' I don't wanna do that. I want to be as independent as long as I can. (Julie, 70, Black, Center A)

Not only does accepting help bring Julie uncomfortably close to a child-like role with which she does not identify, it also gives her the feeling of deterioration: In her view, declining independence may be inevitable, but by hanging onto her autonomy as long as she can, she may be able to put off the old age identity. Importantly, whether or not Julie is able to carry out autonomous acts on a regular basis, her ability to emphasize this

viewpoint in her discussion with me constitutes role distancing. She is able to verbally assert herself as an independent person, regardless of the expectations others hold for her.

"I want to be as independent as long as I can" was a sentiment felt by many of the seniors I spoke with. While they accepted—to varying degrees—that they needed help in some arenas, there was often resistance to the idea of accepting any help that was not absolutely necessary. For people who work with seniors, this can be frustrating: Why won't the elderly person you love allow you to do things for them, when you can do it more quickly and with less effort? Identity talk provides one framework through which to understand the stubbornness often expressed by elderly individuals. Being able to narrate oneself as hanging onto independence, even if it is through small acts, allows seniors to maintain a sense of self that is not entirely characterized by helplessness. As one senior put it: "I'm helpless, but I'm not completely helpless" (Grace, 75, White, Center C).

Like role distancing, associational distancing occurred frequently in my research. The crucial difference between role and associational distancing is that, when associational distancing, seniors further stigmatize specific members of their elderly group in order to elevate their own sense of self within that stigmatized group. Often, seniors would assert themselves as "independent" and "in good health" *relative* to other elderly people they interacted with; this occurred in spite of earlier assertions that they may have needed help coping with day-to-day activities. In this way, seniors were able to verbally distance themselves from their stigmatized social group by distancing themselves from people who also occupied it. They might be old or unhealthy, for instance, but they are not *as* old or unhealthy as *other* people.

Brian, who had earlier detailed his own need for a walker due to hip and spinal pain, demonstrated associational distancing when speaking about the elderly people he lived with:

> Sometimes it just seems so depressing. I wish I could have been in a regular apartment complex, with some kids and families and stuff like that. But here with older people, I just see older people. I'm older, but I see these old people getting around, on their walkers and walking sticks… It kind of depresses me, to see these people. (Brian, 67, Black, Center A)

A recent addition to the senior apartment complex where he lives, Brian is young relative to his neighbors. He is also new to the social role of an unemployed elderly person; he worked as a security guard until the pain from his physical condition caused him to be laid off just months prior to our interview. Brian expressed difficulty with the transition to a new, undesirable social identity: "It's not that I dislike it here, but I'm old and I'm trying to get a hold on aging. Sometimes I still think I'm 25." Brian indirectly enhanced his own sense of self by characterizing the other people in the elderly home as "depressing." The implication is that Brian does not see himself as one of them, despite the fact that he deals with similar physical limitations and occupies both a similar age group and physical space.

Like Brian, Dave was relatively young within my sample. His physical limitations, in addition, were the result of injury rather than deterioration in old age; thus, he seemed to struggle more than others with being cast into an "elderly" identity. In order to cope with this, he engaged in associational distancing throughout our conversation. When discussing time he had spent previously in a nursing home, he said of his roommate there:

> And the guy they had me in [the nursing home] with was 80-some years old. Didn't know who he was half the time and every time he'd go to the restroom, I'd walk in and there would be feces smeared all over the walls, on the toilet seat… Most nursing homes to me are just, they're God's waiting room. (Dave, 61, White, Homebound)

Like Brian, Dave casts himself as different from his roommate in terms of ability—in this case, mental ability. Though the assertion is indirect, the implication of his statement is that truly old people—the kind who ought to occupy "God's waiting room"—are the ones who are completely mentally incompetent. As Dave would demonstrate by discussing his education and utility as a worker, he did not feel he occupied the same category.

As a strategy of distancing the self from other members of an undesirable social group, associational distancing seemed to help individuals maintain a sense of agentive, useful personhood in spite of the health conditions that limited their mobility.

Selective association. Closely related to associational distancing, I found, was selectively engaging in types of work that elevated seniors' sense of self relative to other members of their social group. According to Snow and Anderson (1987), selective association involves strategically associating with specific people or groups of people in order to elevate one's personal identity and distance oneself from an undesirable social identity. However, their research did not elaborate on what, exactly, this might look like. During the course of my interviews, I built on Snow and Anderson's (1987) definition by conceptualizing selective association as selectively engaging in particular *types* of social interactions with particular people. Specifically, I found that engaging in different forms of work—particularly work that benefitted other members of a stigmatized social group—increased distance between seniors and their stigmas, and resulted in a greater sense of agency. Thus, I expand Snow and Anderson's (1987) definition of selective association to include strategically engaging in particular types of interactions as a form of identity work.

In my sample, seniors often engaged in selective association that was closely related to associational distancing. Specifically, seniors frequently spoke about the benefits

of engaging in volunteer work that heightened their sense of fortune relative to others within their own stigmatized social group; thus, selective association by assisting "worse-off" individuals within a stigmatized group was strategically used as a more active and agentive form of associational distancing. It was not uncommon for seniors to describe helping other members of their social group, while simultaneously casting the people they helped as less fortunate than they were.

Hector, for example, is a highly educated man who considers himself a "Hispanic activist" within the elderly apartment complex where he lives. He describes how he helps his fellow residents:

> I try to help. There's a lot of illiteracy here that they don't know how to read and write and they don't know about their benefits. I try to help them… I'll fix their chairs or whatever they need. If they don't have groceries or something, we try and get people together and we pitch in... Right now I'm healthy. I'm not really healthy but I can take care of my own right now, but I'm going to get old and like I help these people and watch over them, that's what I want people to do when I get older. (Hector, 67, Hispanic, Center A)

Despite his own status as a physically limited, older man who has to receive care services in order to manage his day-to-day life, Hector nonetheless sees himself as a relatively fortunate case. Further, he takes it upon himself to assist those members of his social group that he views as less fortunate. This is an important point: Despite objective indicators of limitation and dependence, Hector engages in work that heightens his subjective sense of agency, usefulness to others, and relative fortune in life. In line with resilient aging literature, this demonstrates the importance of taking subjective assessments of wellbeing into account when evaluating the experiences of elderly people.

Eva, a 70-year-old Hispanic woman living in the same apartment complex as Hector, engages in volunteer work to heighten her own sense of fortune and agency. When

asked about how the apartment complex had fared during Hurricane Harvey, Eva told me about how she was able to help other people in the complex during their two-week period without electricity:

> In this building, we didn't have light for two weeks. And all the people, they has problems… For three days, I help the people here. The other places came and brought things to eat, and the people that can't walk, or, you know, have disabilities? I help the other people and bring them plates and things. (Eva, 70, Hispanic, Center A)

Eva had a strong sense of responsibility to help others, and further, was eager to tell me about her usefulness in a dire situation. In this way, like Hector, she used a combination of associational distancing and selective association to elevate her own position in relation to other, less fortunate members of a low-mobility senior population.

Engaging in work allowed seniors to elevate their sense of fortune relative to members of other stigmatized social groups, too. Dave, as discussed earlier, struggled with a lack of autonomy due to extensive nerve damage sustained during an injury. However, later in our conversation, he spoke about the volunteer work he does with other disabled veterans:

> I do a lot of volunteer work for the Paralyzed Veterans of America… And we take guys out to the woods [to shoot] who are a lot worse off than I am. And they're quadriplegics in wheelchairs and stuff like that. And I made with my two little hands, these gun mounts. They're battery pack operated, and the guys in the chair can operate them by blowing in or out, sucking or blowing through a straw basically… And I spot for them. (Dave, 61, White, Homebound)

Engaging in this kind of volunteer work not only allowed Dave to perform a form of work that was highly valuable to him—designing and building weapons with his "two little hands"— it also allowed him to enhance his own sense of fortune relative to other people who share with him a stigmatized social identity—in this case, that of a disabled veteran.

Selective association by strategically engaging in volunteer work was beneficial to individuals' sense of agency, even when it was not characterized by associational distancing. Seniors spoke frequently about engaging in helping behaviors that connected them with their broader communities. Church, in particular, was a powerful site for seniors to engage in helping behaviors that allowed them to feel useful within a broader community. Helen, for instance, spoke extensively about her church and the group of volunteers she had joined there, emphasizing how important they are to the functioning of church events: "We make sure that if we're having a function or something at the church, we make sure all the food and everything is taken care of. And we do the tables and all that" (Helen, 77, Black). Similarly, Theresa described her unique role within her church:

> I have several people that are in the church that are trying to get back into the church and that have been out in the street life, all wild, and they're trying to get back, but they find that it's kind of hard with some of the older parishioners in the church. So they talk to me, because I'm talking to them openly, frankly, you know. I don't judge. I don't judge them because we've all been there. (Theresa, 62, Black, Center B)

Volunteer work, in these cases, is a form of selective association that allows seniors to connect with their community in ways that enhance their sense of agency, highlight their unique skills, and allow them to be useful to others in their communities.

Engaging in types of work that held great significance in seniors' life histories allowed them to gain a heightened sense of having particular skills and unique utility. For instance, Grace, a lifelong Jehovah's Witness, expressed the ways she continues to connect with her religion and carry out what she feels to be an important duty in her life:

> Well I used to go to homes and study with people, and walk those long streets. Like we have pioneers, Jehovah's witnesses that go out every day and go house to house to see if somebody's interested in learning more about the Bible and what God expects of us … [Now,] when people come in [to the apartment complex], I explain about our religion and tell them that we have home Bible studies if people are

> interested in learning more. Like I said, I used to go door-to-door more in my younger days. But now, it's harder to walk and get around. So mainly, it's talking to people at the bus stop or if they come and wait on me. Providers and stuff like that. (Grace, 75, White, Center C)

Within her religion, missionary work is central. Though her health ailments prevent her from engaging in missionary work to the extent that she used to, she still carries out this work to the extent that she can. By operating within her limitations, she is able to hang onto a sense of self characterized by the religious work that has dominated her life.

Other seniors expressed the ways they continued to connect to their previously held roles, both paid and unpaid. As discussed previously, Dave felt most useful when he was able to build weapons to be used by disabled veterans; because he was a trained weapons designer for most of his career, this type of volunteer work allowed him to engage in work that contained a lot of personal value, in addition to helping less fortunate members of his social group. Similarly, Theresa, a former grade school teacher of thirty-plus years, still offers paid private tutoring and volunteers as a story time reader for preschoolers. Susan, who was trained as a caretaker, said of some of her fellow residents: "They like just having somebody to wait on them. And that's what I went to school for. To help people" (Susan, 85, Black, Center A). Performing work that was a significant part of their past and for which they were uniquely trained allowed seniors to assert their utility and resist being lumped into a social identity that did not adequately encompass their self-concept.

Overall, social interactions that allowed seniors to create associational distance between themselves and other members of a stigmatized social group, engage with their community, and perform work with which they had a lifelong connection, were all opportunities for seniors to enhance their own sense of agency and assert autonomous identities. In turn, they were able to distance themselves from stigmas of helplessness and

uselessness associated with old age. Given the importance of agency to the development of resilience, I propose that these defiant performances of identity work are important indicators of how social interaction may provide opportunities for resilience development among at-risk, largely immobile seniors.

DISCUSSION

Theoretical Development

This paper helps to fill theoretical gaps in our understanding of resilience development in older adults. While prior research highlighted the significance of socialization to seniors' resilience development, it did not offer much theoretical insight into the relevant content or mechanisms of social interactions that best enhance resilience. This gap in knowledge is particularly important given that prior research on the disconnect between objective counts of isolation and subjective experiences of loneliness among older individuals highlights the distinct possibility that it is content, not count, of socialization that is important for seniors' resilience development (Schnittker 2005). To this end, I have used in-depth, qualitative interviews to explore the question of what types of social interaction might be most important to at-risk seniors' resilience development, and thus offer a potential theoretical explanation to guide future research and program development.

My research brings together theories of identity work and resilience. Specifically, I introduce identity work as an important component of resilience development in elderly individuals. I propose that social interaction designed to give seniors the opportunity to enhance personal identities will result in a higher sense of agency, which, in turn, has been shown to be imperative to resilience: Individuals who have a higher sense of control over

their lives tend to be more resilient, across the life course (Bolton et al. 2016). In my sample, identity work took two distinct forms: identity talk and selective association.

First, my research suggests that opportunities to engage in identity talk—one form of identity work—are important to resilience development. This idea offers a different lens through which to interpret prior research on resilient aging. Prior studies have shown that seniors' sense of having grit and internal strength are important to their ability to practice resilience (Bolton et al. 2016). Through the lens of identity work, however, I propose that it is not only having these qualities, but having the opportunity to *assert oneself* as having these qualities, that best allows seniors to develop resilience. While a person cannot change their ability status, they can construct narratives of self that enhance their sense of autonomy. Identity talk, then, allows seniors to verbally distance themselves both from the stigmatized social roles that they occupy, and from other, less agentive individuals who occupy those social roles. For elderly individuals, whose social stigmas tend to carry with them expectations of helplessness and uselessness, identity talk provides an opportunity to take control of how they are perceived. This strategy may be particularly important for seniors in poverty and seniors of color, both of whom occupy other stigmatized social roles characterized by a lack of agency.

Second, this paper highlights selective association, or engaging in particular kinds of social interaction such as work, as an important way for seniors to enhance their sense of agency. Further, I offer a definition of selective association that expands on that of Snow and Anderson (1987): I argue that the *type* of social interaction, as well as the person or people interacted with, can be strategically chosen to promote a positive personal identity. Prior research has highlighted the fact that seniors who may be objectively

isolated do not necessarily feel correspondingly lonely, and, conversely, that seniors may feel lonely despite being embedded in communal settings (Schnittker 2005). Through this revised lens of selective association, it is likely that both the types of people and types of social interaction may have a bearing on how seniors internalize social interactions. Engaging in agentive forms of social interaction, I propose, may allow even objectively isolated seniors to develop a sense of agency, which, in turn, heightens their ability to practice resilience. My research highlights volunteer work both in and outside of the elderly community, as well as work that connects to seniors' earlier lives (e.g., work they were trained for as younger adults), as types of selective association seniors may engage in to enhance their resilience. Like identity talk, selective association allows seniors with limited means to promote a more positive, agentive sense of self.

In sum, I propose that social interaction that gives seniors the opportunity to engage in identity work is imperative to seniors' ability to develop resilience. This strategy is especially important for at-risk seniors who occupy other stigmatized roles and who are at a higher risk of experiencing adversity, such as seniors of color and seniors living in poverty. My research fills theoretical gaps left by prior resilient aging literature and provides guidance for policy and program development, as well as future resilient aging research.

Program and Policy Recommendations

Following from this understanding of identity work as a component of resilience development, I propose two major recommendations for service providers catering to vulnerable elderly populations: First, I recommend the development of programs that allow

seniors to engage in agentive identity work. Second, I recommend continuing to target mobility issues in the elderly community.

Given the demonstrated utility of engaging in both volunteer and paid work, I would recommend that service providers targeting at-risk elderly populations focus their efforts on giving seniors as many opportunities as possible to engage in this type of work. Some examples of activities that might provide seniors with agentive roles include: teaching their fellow seniors basic skills, such as reading, or unique skills, such as crafts; participating in and possibly leading special interest groups within a senior community, such as a book club or political group; hosting something like a talent show to give seniors the opportunity to share their unique skills; creating volunteer groups designed to help less fortunate seniors, perhaps by making grocery store runs (for those who can drive); and engaging with their community through small acts of volunteer work, such as reading stories to children or caroling in the holiday months. These are simply suggestions, however, and those who are in charge of program development within a particular organization will have a better sense of what is realistic given both pragmatic restraints and the population. The larger point is that it would be beneficial for programs, resources permitting, to provide as many opportunities as possible for seniors to enhance their sense of autonomy.

On a more concrete level, I would recommend that service providers continue to funnel resources into services that provide seniors with opportunities for travel. While some seniors I spoke with were frustrated by the limitations of the transportation services available to them (such as Metro ride services with inconsistent schedules), they did express appreciation for their existence. Continuing to improve mobility services for

seniors who are unable to drive would go a long way toward giving them more opportunities to engage in meaningful social interactions.

Limitations and Future Research

My study was not without limitations. Importantly, both the mobility restrictions of my sample and the space restrictions within senior centers meant that most interviews took place in only semi-private locations. While I did not feel that this tempered seniors' willingness to talk to me, it did seem to restrict their answers when it came to more personal topics. For instance, my conversation with Brian was interrupted by a friend of his walking by and teasing him for talking too much; unfortunately, this occurred right when we had begun to dig into Brian's difficulties with coming to terms with aging, and the interruption caused him to reset the conversation. Similarly, during my conversation with Mildred in her home, I noticed that she was not willing to discuss her relationship with her ex-husband or children in much detail, likely because both her ex-husband and her son were intermittently walking in and out of the kitchen where our interview was taking place. Where possible, future research should ensure completely private interview conditions to ensure that participants are comfortable with a full range of topics.

Recruitment of elderly homebound populations also proved difficult. Throughout the recruitment process, I encountered significant issues getting in touch with seniors by phone: Often, phone numbers would be disconnected, or seniors simply would not answer. It was not uncommon for seniors who had received my recruitment flyer to call me with complaints about their Meals on Wheels service, apparently with the understanding that I was a representative of the organization. Some seniors misunderstood the flyer to be an indication that they were in trouble. While such confusion was expected and is likely a

byproduct of working with an elderly population, future research should create a line of communication that is as direct as possible to reduce these misunderstandings.

A significant difficulty when recruiting homebound seniors involves their sense of safety. Seniors are vulnerable to scams, many of which occur when seemingly-well-meaning representatives of a familiar organization show up for ostensibly innocuous reasons. Several times, I encountered frustrated family members after seniors had reached out to me to be interviewed. The family members—often children of the seniors who were interested in being interviewed—acted as gatekeepers to their elderly relatives and would contact me with suspicions about my intentions. Given the prevalence of senior-focused scams, it is completely understandable that both seniors and their family members would be wary of a researcher looking to enter seniors' homes and ask them personal questions.

While I entered this project with the misplaced expectation that this population would not be overly wary of my intentions, future researchers should be mindful of the safety concerns of an elderly population, and be more proactive about assuring potential participants of their legitimacy. For instance, I was asked several times if it would be possible for me to conduct the survey via phone. While I declined for the purposes of this particular study, in part due to concerns about the richness of phone interview data, phone interviews would be a much less invasive tactic and could be a method to consider for future research.

I should also note that my positionality may have limited this research somewhat. It is entirely possible that my status as a white, young, able-bodied woman created a barrier between my study participants and me. For instance, seniors frequently used veiled language when alluding to current romantic and sexual partners, and generally declined to

elaborate when pressed. Theresa, for instance, indicated that she has "a friend [she] spend[s] time with," but she did not elaborate further when I asked for specifics of their relationship (Theresa, 62, Black, Center B). Similarly, Rose mentioned that she "prefer[s] the company of men," but declined to offer details when I asked what she meant by that (Rose, 77, Black, Center B). To the extent that I was able, I worked hard to foster rapport with the individuals I interviewed, but it is likely that there was data I could not access because of the perceived distance between my participants and myself.

As with all qualitative research, my findings are limited in scope. Given that I did not systematically recruit my sample, it is entirely possible that the individuals I interviewed are not representative of the broader population, and that my findings would not hold in a representative sample of low-income elderly. In addition, it is possible that the salience of identity work was closely related to the fact that my sample was comprised entirely of seniors occupying multiple stigmatized identities, including racial/ethnic minorities and seniors living in poverty. It is possible that identity work would be a less salient predictor of resilience in more privileged elderly communities.

In addition, the connection I have identified between identity work and resilience development is not directly measured in this research. While I was able to directly access examples of identity work in my sample, I did not measure resilience directly. This was in large part because resilience is methodologically difficult to access; individuals tend to assess their own resilience positively, so tapping into accurate measures would be difficult. Still, it is important to keep in mind that the relationships identified in this paper are theoretical in nature and should be studied more directly in future studies. Quantitative scales of resilience might be a useful tool for future research.

Despite these limitations, this research is an important step toward understanding the mechanisms of social interaction that best enhance resilience in an at-risk, largely homebound aging population. My findings contribute important theoretical insights that may be used to guide future research. In particular, this study brings together previously disparate social psychological concepts of identity work and resilience, and introduces a potential pathway between the two—namely, that identity work promoting agentive identities is likely to enhance seniors' resilience in the face of hardship. I also expand on the concept of selective association to include type of interaction, something that could be studied further in future identity work research. Future research should use creative methodological strategies to further explore the connection between identity work and resilience in order to better understand the unique needs of a growing at-risk elderly population.

APPENDIX A: SAMPLE DEMOGRAPHICS

Pseudo-nym	**Age**	**Sex**	**Living Status**	**Race**	**# of people in home**	**Marital Status***	**Veteran Status****	**Drive**
Dave	61	M	Homebound	White	2	D	V	No
Mildred	67	F	Homebound	Black	2	W	N	No
Helen	77	F	Homebound	Black	1	W	N	Yes
Eva	70	F	Center A	Hispanic	1	W	N	No
Susan	85	F	Center A	Black	1	S	N	No
Theresa	62	F	Center B	Black	1	W	N	No
Rose	77	F	Center B	Black	1	W	N	No
Brian	67	M	Center A	Black	1	D	N	Yes
Hector	67	M	Center A	Hispanic	1	D	V	Yes
Candace	82	F	Center A	Black	1	W	N	No
Julie	70	F	Center A	Black	1	D	N	Yes
Margaret	83	F	Center C	White	1	D	N	No
Alma	78	F	Center C	White	1	D	N	Yes
Grace	75	F	Center C	White	1	D	N	No

* M=Male; F=Female
** D=Divorced; S=Separated; W=Widowed
*** V=Veteran; N=Non-Veteran

APPENDIX B: DESCRIPTION OF SENIOR CENTERS

Center A

This senior center is located within a federally funded public housing apartment complex that caters to elderly residents. The apartment complex has 200 units and is located in a low-income, suburban neighborhood. Residents are required to pay subsidized rent monthly. Within the complex is a community center filled with cafeteria-style tables and plastic chairs. Here, residents may watch television, play games, and participate in scheduled community events. There is some outdoor space containing a few grassy areas, benches, and an outdoor grill. Participants recruited in Center A were all residents of this apartment complex, where Meals on Wheels delivers lunch five days a week.

Center B

This senior center is located within a local YWCA office. All seniors who attend this center must travel to it. Inside the office, a large community room contains tables and televisions where seniors frequently play games, chat, and watch TV. Seniors at this center frequently go on field trips and are visited by guest speakers and teachers.

Center C

Similar to Center A, this center is located within a senior apartment complex. This complex is not federally funded, but nonetheless offers affordable housing for elderly and disabled residents. As with Center A, Meals on Wheels brings lunch to this center five days a week. The grounds of this center are rather expansive, with several walking paths, gazebos, and a lakefront view. The community room is located downstairs and has large, wooden tables and chairs. Upstairs, there is a small library with tables, chairs, and several bookshelves. Most Center C interviews took place in the library.

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