Associations Between Frailty Risk and Gendered Ageism:

A Nurse Practitioner Shift Towards Health Equity for 'Old' Women

by

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We acknowledge and respect the Lək'ʷəŋən (Songhees and Xʷsepsəm/ Esquimalt) Peoples on whose territory the university stands, and the Lək'ʷəŋən and W̱ SÁNEĆ Peoples whose historical relationships with the land continue to this day.

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Abstract

This dissertation advances understandings of associations between gendered ageism and frailty risk for women to generate priority considerations for shifts in NP knowledge development and practice. Healthcare of older adults is regarded as a healthcare priority related to a rapidly growing older adult population and escalating rates of frailty, particularly amongst 'old' women. Nurse Practitioners (NP) are uniquely positioned to serve as most appropriate care providers for frailty risk and gendered ageism because of their mandate to optimize health from perspectives of holism, complexity, and associated health inequities. However, a paucity of knowledge exists to inform NP approaches to the healthcare of 'old' women in regard to frailty risk and gendered ageism, with particular gaps in understanding from intersectional, qualitative, nursing, and critical feminist angles of vision.

The overall purpose of the study was to describe and interpret associations between frailty risk and gendered ageism. Data sources included 14 published autobiographical and 12 semi-structured in-depth participant interview narratives of critical feminist 'old' women. The exploration was oriented by a critical feminist gerontology lens, qualitative study design, interpretive description (ID) methodology, and narrative thematic analysis methods. Data collection and analysis occurred concurrently with a focus on potential themes or patterns. Generated understandings of associations between gendered ageism and frailty risk are themed as: 1) shroud of conflation of 'old' and 'frail'; 2) self-inflicted typification; and 3) socially imposed typism. Extended interpretation situates priority generated understandings in existing literature. This study invites next logical steps for NP knowledge development and practice shifts to improve health and health equity for 'old' women by considering generated understandings of associations between gendered ageism and frailty risk to broaden the angle of vision from

individualistic to systemic and create safer spaces for women to claim ‘old’ and ‘frail’ free from discriminatory assumptions and responses.

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Dedication

This dissertation is dedicated to agentic ‘old’ women, frail and non-frail, who have been denied their desired healthcare support for health goals because of marginalizing assumptions which constrain their potential.

Associations Between Frailty Risk and Gendered Ageism:
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Frailty in older adults and its related healthcare implications are an increasing priority. Ageism, and particularly gendered ageism, may play an as-of-yet unexplored role in the risk of multidomain frailty, particularly for old women. Nurse Practitioner (NP) practice, with its role in the care of older adults living with complex health conditions and its social mandate to address health inequities, requires an increased understanding of this phenomenon and an informed response to improve care and health equity. This dissertation presents a research study in which I explored associations between gendered ageism and multidomain frailty risk for 'old' women.

The overall purpose of this study was to describe and interpret the phenomenon of inquiry through narratives and to inform directions for NP knowledge development and practice shifts to promote health and health equity. The particular research objectives were to: 1) examine how critical feminists with experiences of aging describe and explain their perceptions and experiences of negative gendered age stereotypes in the health domain; 2) to examine common or shared patterns and themes that might emerge in terms of how negative gendered age stereotypes may or may not be resisted or embodied; 3) examine how these processes may or may not be consequential for the development or prevention of multiple domains of frailty; 4) explore the potential salience of negative gendered age stereotypes in the health domain in terms of being a risk factor for multiple domains of frailty; 5) suggest ways for NP practice to respond in order to promote health and prevent multiple domains of frailty for individual clients receiving their healthcare; and 6) raise conscious awareness of the researcher, the study participants, and the audience of NPs in regards to any potential social injustice and health inequity that may relate to the phenomenon as a prelude to liberation or action toward change.

The particular research questions to advance this knowledge were: What perspectives and experiences are revealed in critical feminist autobiographical narratives about aging which could inform an understanding of how negative gendered age stereotypes in the health domain may play a role in the risk of multi-domain frailty? What patterns or themes may suggest commonalities or explain variances in experiences of this phenomenon? What suggestions could guide Nurse Practitioners' response to the phenomenon to promote health and health equity for older women?

To effectively answer these questions and meet these objectives, this study was underpinned by nursing ontology, epistemology and pragmatic objectives. The study design drew on a critical feminist gerontology lens, and used interpretive description methodology (Thorne, 2016) informed by narrative techniques to explore critical feminist narratives on aging from published literature and participant interviews.

Presentation of this study consists of five chapters. In Chapter One I present the literature review on the substantive area of interest which informs and justifies the need for an interpretive description study. The chapter includes a summary of literature to date; critique of this literature's epistemological and ontological underpinnings; rationale for the need for knowledge development using nursing epistemology, ontology, and pragmatic objectives; and call to action for Nurse Practitioners. In Chapter two I present critical feminist gerontology and a review of its scholarship to date as it relates to the phenomenon of interest. It concludes with a discussion of how use of this perspective for my study can contribute to knowledge development, nursing practice development, the field of critical feminist gerontology scholarship, the feminist movement, and the empowerment of 'old' women themselves. In Chapter three I explain and rationalize the proposed methodological approach of interpretive description (ID) (Thorne, 2016)

and the methods and techniques as informed by narrative thematic analysis (Riessman, 2008). This includes all aspects of the research process such as data sources, sampling, data collection, analysis, coding, interpretation, a thoughtful practitioner test, presentation of findings, knowledge translation, trustworthiness, and ethical considerations. In Chapter four I present generated understandings of associations between gendered ageism and frailty risk themed as: 1) shroud of conflation of 'old' and 'frail', 2) self-inflicted typification, and 3) socially imposed typism. And finally, in Chapter five I extend interpretations by situating priority generated understandings in existing literature. I discuss invitations to next logical steps for NP knowledge development and practice shifts to improve health and health equity for 'old' women through consideration of broadening angles of vision on associations between gendered ageism and frailty risk from individualistic to systemic, and creating safer healthcare spaces in which women may claim 'old' and 'frail' free from discriminatory assumptions and responses.

I anticipate that findings from this study will contribute to improved understandings of the phenomenon and guide a shift in Nurse Practitioner practice to support the promotion of health and prevention of risk in terms of frailty for older women individually and collectively.

Chapter One: Literature Review to Inform the Study

Background and Significance of the Phenomenon of Interest

Healthcare of older adults has been regarded as a current and future healthcare priority, globally and locally (British Columbia Ministry of Health, 2020; World Health Organization, 2014). The older adult population has been growing in Canada and is even more pronounced in British Columbia. In this province, the number of people over 65 has grown 7 times faster than all other age groups and the number of people over 85 has grown at 5 times the rate of the over-65 group (Wister et al, 2019). The aging population rates have been accompanied by escalating rates of frailty (Canadian Frailty Network [CFN], n.d. a). In British Columbia, 16% of persons aged 65-74 and 52% for those aged 85 and over have been deemed frail (British Columbia [BC] Guidelines, 2017). Women had a higher prevalence of frailty, but lower risk of frailty-related mortality, in comparison to males (Statistics Canada, 2010). According to the Canadian Frailty Network [CFN], frailty has been of concern and importance because "This growing population is both under-recognized and under-served, challenging the healthcare system to improve the quality and quantity of care delivered. Currently, we have little evidence to guide the care of older adults living with frailty" (Frailty Matters, n.d. a). They have gone on to suggest that our healthcare system is "organized to manage illness based on single body systems and diseases, not the complex multisystems of those living with frailty" (Frailty Matters).

It has been apparent that Nurse Practitioners (NP) have not been considered within that statement, as an NP practice approach to the healthcare encounter has commonly emphasized holism, complexity, and contextualization (Arslanian-Engoren et al, 2005). NPs in British Columbia, for example, have often been the most appropriate healthcare providers for complex patients (Prodan-Bhalla & Scott, 2016) and have served frail older adults in primary care and

specialty services (Sangster-Gormley & Canitz, 2015). NPs have been encouraged to follow evidence-informed best practice guidelines to prevent and minimize risks of frailty and its poor health outcomes by guiding care planning and decision-making (BC Guidelines, 2017).

However, in NP practice, a pattern has been noted in which 'old' adults with frailty may have often resisted or restricted health-promoting efforts due to what has appeared to be beliefs of their health conditions as irremediable or of their recovery as doubtful or risky related to essentialist attributions to chronological age. Thus, NP efforts to implement best practices for frailty have been stymied. This has generated questions as to what forces might underlie such beliefs, how powerful might their impact have been on the risks and outcomes of frailty, and how might frailty have been mitigated by attention and remediation of these beliefs and forces? Frailty practice guidelines generally have not provided any direction about possible systemic social factors (BC Guidelines, 2017). A review of the literature, however, has suggested an emerging body of work which has explored the influences of negative age stereotype embodiment on health decline.

Rationale for a Literature Review to Inform an Interpretive Description Study

A literature review has been deemed inherent to interpretive description (ID) research design (Thorne, 2016). It is considered a requirement for understanding the current state of knowledge about a phenomenon on the basis of available empirical evidence and to substantiate the need to proceed with an ID study (Thorne, 2016). While there was no specified approach to the literature review, Thorne has called for it to be "formal", "critical", "thoughtful", and logical in design (p. 51). These qualities have been intentionally preferred over systematic processes (Thorne, 2016). In general, Thorne has described a goal of a literature review to push scholarship "beyond that aspect to which each original investigator might have had access for the purpose of

revealing a more comprehensive and integrated understanding of that which constitutes a large theoretical whole" (p. 4) and to determine to what extent the understandings to date may have been sufficient to guide practice in the discipline of nursing (Thorne, 2016). Thus, objectives of this literature review have been to critique the existing body of knowledge from the nursing perspective to justify further research design, illuminate the possibility of patterns of experience in relation to the phenomena of interest which have been insufficiently examined to date but which may be important for NP practice, and explore and conclude whether or not a practice-based inquiry may be worth researching (Thorne, 2016). With this objective in mind, the literature review has been positioned at the outset of a study, before an investigator may even be sure whether an ID study should proceed. ID has been designed to present its literature review findings as "scaffolding" (Thorne, 2016, p. 60) for any subsequent study.

In this chapter I present the literature review which has informed a need for my ID study. Herein, I have explored and critiqued the literature addressing the role of age stereotype embodiment in the context of frailty from a nursing perspective. The chapter has been structured as per its objectives to: (1) define the concepts of age stereotype embodiment and frailty in terms of their use in my study; (2) explore the literature to date on how ageism embodiment and frailty might be associated; (3) examine and critique the underlying assumptions and objectives of the existing knowledge base; (4) explore the gaps and limitations of current knowledge to inform the need for my study; and (5) explore implications for NP knowledge and practice development. This process has informed an inquiry using nursing ontology and epistemology, with pragmatic objectives, to improve understandings and guide NP knowledge and practice.

Literature review process

A literature review was designed in consultation with an academic librarian to explore and

critique the existing knowledge, gaps in knowledge, and needed directions for future research. This included the need for my study, identifying surrounding associations between negative age stereotype embodiment and frailty risk factors and outcomes. Five databases (CINAHL, MedLine with full text, AgeLine, Social Science Abstracts, and PsycInfo) had been searched using the keywords (age OR aging OR ageis*) AND (stereotyp*) AND (internaliz* OR embodi*) AND (concept* OR theor*). Inclusion of the search word (frail*) had resulted in few-to-no results and so was removed. Limiters included English language and 1969-September 2024, with 1969 selected as it was the year that Butler published the seminal work on the concept of ageism. Titles and abstracts were reviewed by a single reviewer. Articles were included if they were focused on the nature, process, or extent of ageism internalization or embodiment; associations with frailty, any frailty factors, or frailty outcomes; and community setting. Literature was excluded if it focused on other types of ageism (such as stereotype threat or age discrimination), particular conditions or disease (such as cancer), acute or residential care settings, or operationalizations or interventions. The reference lists of retrieved literature were also searched for sources of relevant literature. Sixty-six results were included in the literature review. Consistent with an interpretive description (ID) approach, the review was intentionally not intended to be systematic or comprehensive.

Literature Review Findings on the Phenomenon of Interest

The literature search has revealed a growing body of knowledge exploring age stereotype embodiment and its influence on health. A summary of the review has been presented below including primary studies which researched associations of negative age stereotypes with frailty-related health risk, and explanatory propositions of included theoretical papers which largely focused on Stereotype Embodiment Theory and the extensions or debates it has provoked.

Further, a review of literature from the field of frailty study has been offered, which indirectly addressed frailty's potential association with negative age stereotypes and, more commonly, frailty's own contribution to ageism.

Primary Studies

Studies exploring the potential relationship between embodied ageism and frailty specifically have been few and inconsistent in their findings. Salguero et al. (2019) had found that neither explicit nor implicit ageist attitudes of Veterans were associated with a greater risk of frailty and Ye et al. (2020) had found that ageist stereotypes influenced frailty indirectly, mediated by attitudes towards aging. In contrast, Gale and Cooper (2018) found that persons with more negative attitudes toward aging were more likely to develop physical frailty or pre-frailty, though negative attitude was not found to be an independent contributing factor to frailty. It may be notable that the above studies had relied on attitudes toward aging generally, rather than attitudes towards one's own aging which may be relevant to individual stereotype embodiment, and on biomedical models of frailty which had constrained frailty considerations to the physical domain, rather than consideration of integral models.

The literature search revealed much more knowledge on the relationship between age stereotype embodiment and singular frailty factors, across multiple domains, and frailty-associated outcomes. These findings are summarized below.

In the physical frailty domain, negative self-perceptions of aging, were found to be associated with elevated cardiovascular stress (Levy et al., 2000b), lower levels of physical activity (Emile et al., 2014), worse experience of physical health, (Kim, 2009), beliefs of being incompetent to successfully take part in exercise and exaggerating the risk of injury and exertion related to exercise (O'Brien Cousins, 2000). Longitudinally, they had predicted a steep decline in lower

extremity performance (Sargent-Cox et al., 2012). Further, the number of health conditions, such as those appearing on a Frailty Index, attributable to ageism in the USA in a one-year period were estimated at 17.04 million (Levy et al., 2018a).

In the cognitive domain, negative self-perceptions of aging were associated with lower cognitive function and increased likelihood of having cognitive symptoms secondary to depression (Choi et al., 2019). Longitudinally, they had predicted significantly worse memory performance (Levy et al., 2011); significantly steeper emergence of the biomarkers of Alzheimer's disease (Levy et al., 2016); and, amongst those with the APOE4 gene, development of dementia (Levy et al., 2018b).

In the psychological domain, longitudinally, a negative perception of ageing was found to be a significant predictor of the onset and persistence of depression and anxiety (Freeman et al., 2016). In correlational studies, negative perceptions of aging were associated with positive screening and development of new-onset post-traumatic stress disorder, suicidal ideation, generalized anxiety disorder, major depressive disorder (Pedroso-Chaparro et al., 2023; Levy et al., 2014; Levy et al., 2019) and, more generally, psychological distress (Bergman, 2022) and the experience of worse mental health (Kim, 2009). A dose-response gradient was detected, meaning that the greater the negativity of the perceptions of aging the greater the mental health symptoms (Levy et al., 2014; Levy et al., 2019).

In the social domain, negative self-perceptions of age were correlated with increased loneliness and intra-version (Coudin & Alexopoulos, 2010). Longitudinally, they had predicted worse performance on screened hearing (Levy et al., 2006).

The outcomes of interest to frailty were also found to be impacted by age stereotype embodiment. The phenomenon was correlated with or predictive of poor self-rated health

(Coudin & Alexopoulos, 2010; Kim, 2009; Liang, 2018; Stewart et al., 2012), functional decline (Coudin & Alexopoulos, 2010; Levy et al., 2002a; Levy et al., 2012; Liang, 2018; Moser et al., 2011), morbidity (Levy et al., 2000a; Levy et al., 2009b; Levy et al., 2016; Levy et al., 2018b), mortality (Levy et al., 2000b; Levy et al., 2002b; Stewart et al., 2012); and costs to the healthcare system (Levy et al., 2018a).

Two findings had challenged the relationship between perceptions of aging and frailty. Moser et al. (2011) found that negative perceptions of aging were not predictive of falls or hospitalizations and Coudin and Alexopoulos (2010) found them to not be associated with decreased self-esteem.

Only one qualitative study was found in the literature search. Van Wijngaarden et al. (2019) had explored the meanings of metaphors about aging in older adults with a death wish to explore what might be revealed about their self-understandings and imagined futures. Ten central metaphorical concepts were reported: struggle, victimhood, void, stagnation, captivity, breakdown, redundancy, sub-humanization, burden, and childhood (van Wijngaarden et al., 2019). The investigators had discussed that "the negative metaphorical representations of old age used by the participants seem to correspond with the negative deficit-oriented societal discourse on aging AND that these shared cultural beliefs resonate in participants' self-perception, thus becoming flesh: lived and perceived as true" (van Wijngaarden et al., 2019, p. 259). The findings had indicated these effects to be profoundly alienating and potentially contributory to the participants' death ideation (van Wijngaarden et al., 2019). The study has added support, from an authentic and particular source, for the possibility that age stereotype embodiment may significantly impact multiple domains of health and frailty.

When viewed collectively, the evidence to date has provided a strong rationale for concern

about age stereotype embodiment's potential associations with various singular frailty factors. It has been viewed as justifying further inquiry into its relationship with frailty, wholly and specifically, as well as into how its influence may occur.

Theoretical Development

Researchers have explored the processes and mechanisms by which age stereotype embodiment may influence health. I have presented below a description of the predominant model discussed in the literature search, with summaries of its supporting research, followed by theoretical possibilities which may extend or challenge the model.

Levy's (2009) Stereotype Embodiment Theory (SET) has proposed a view of aging that extends to the psychosocial, in contrast to the more common exclusively biological view (Levy, 2009). It has posited that age stereotypes in the sociocultural environment may be internalized over the life course from childhood to old age, be implicit in nature, be more salient once considered self-relevant, and occur via psychological, behavioural, or physiological pathways (Levy, 2009). The propositions of this theory have been developed mainly based on the author's own research, but also have contributions and support from other scholars.

Internalization of age stereotypes beginning early in childhood has been evidenced in numerous studies, according to Bergman (2017). Levy et al. (2009b) had shown that negative age stereotypes held in early to middle adulthood impacted health in later life, specifically, increasing the likelihood of a cardiovascular event over a 38 year follow up period.

The implicit nature of the age stereotype embodiment process, in addition to the explicit, has been suggested by previous research on gender and race stereotypes which found implicit effects (Levy & Bavishi, 2018). Levy had studied the traction of such a phenomenon in the context of age stereotypes, finding that subliminal priming with negative or positive age-stereotypes had

resulted in a corresponding shift in handwriting quality, a normally subconscious task (Levy, 2000), and a corresponding shift in decision-making in terms of whether to reject or accept a hypothetical life-prolonging intervention (Levy et al., 2000a).

The SET model has proposed that self-relevancy may act as a trigger or activator of internalized age stereotypes to become embodied and, thereby, impact health. Supportive findings had found that effects of negative age stereotype priming had more prominence when the stereotypes were personally resonant (Levy, 2009), whereas, effects of priming on younger adults showed no effects, weaker effects or reverse effects (Hess, Hinson, & Statham, 2004, as cited in Levy, 2009; Levy, 1996, as cited in Levy, 2009; Levy, Ashman, & Dror, 2000, as cited in Levy, 2009). Pedroso-Chaparro et al. (2023) had found self-identification as old to be key to a positive correlation between ageism and mental health. Other authors have gone so far as to say that self-relevance may be a precondition for the stereotypes' health manifestations (Kornadt et al., 2017).

The psychological pathway referred to a process in which age stereotypes resulted in expectations which then became self-fulfilling prophecies (Levy, 2009). This effect was found to be greater when the domain of the stereotype and the outcome aligned, a phenomenon called stereotype-matching effect (Levy & Leifheit-Limson, 2009). For example, a stereotype about cognition may manifest more strongly in cognitive performance than in physical performance (Kornadt & Rothermund, 2011; Levy & Leifheit-Limson, 2009). Other research has suggested enriching the pathway with other psychological processes shown to have similar effects, including the stability of the expectation belief (Stewart et al, 2012; Pickard, 2014), attitude toward ageing (Ye et al., 2020), motivation (Choi et al., 2019), and perception of control (Sargent-Cox et al., 2012; Stewart et al., 2012). Factors such as self-esteem and body image have

been suggested as key moderators (Bergman, 2022) and loneliness as a key mediator (Pedroso-Chaparro et al., 2023). Other psychological factors, such as emotional reactions to or awareness of aging, have not been found to act as mechanisms for this pathway (Robertson et al., 2016).

The behavioural pathway referred to the process by which internalized ageism impacts behaviours which, in turn, may negatively impact health. Levy (2009) had postulated two potential mechanisms: reduced self-efficacy (Levy et al., 2000b) and beliefs of the inevitability of symptoms or illness in old age (Levy & Myers, 2004; Stewart et al., 2012). These mechanisms have been supported by numerous studies in which beliefs that illness and decline in old age are inevitable and irremediable held associations with decreased engagement in self-reported health maintenance behaviors including exercise (O'Brien Cousins, 2000; Stewart et al., 2012), diet, sleep (Stewart et al., 2012), and use of healthcare services (Freeman et al., 2016; Goodwin et al., 1999; Stewart et al., 2012). Levy and Myers (2004) have found these effects to be longitudinal, with such beliefs resulting in poorer diet, less exercise, and reduced likelihood of taking medications as prescribed over a 20 year period. Compounding these concerns, older adults have been found to rate age itself as the strongest contributing factor to chronic illness, far above the contribution of unhealthy behaviours (Stewart et al., 2012). It is notable that this finding had emerged beyond the effect of health locus of control, a well-accepted predictor of health behaviour (Stewart et al., 2012). Other potential mediators have been proposed, including negative emotion (Stewart et al., 2012) and openness to experience (Emile et al., 2014). One study by Kim (2009) had found behaviour to serve as a mediator of the relationship between beliefs about aging and health, suggesting a need to maintain an openness about the potential pathways and their relationships.

Levy (2009) referred to the physiological pathway as a physiologic stress response. The

pathway had been proposed based on findings that a cardiovascular stress response in older adults escalated following subliminal priming with negative age stereotypes (Levy et al., 2000) and that cardiovascular events were more likely to occur and with poorer recovery late in life if one had held more negative age stereotypes earlier in life (Levy et al., 2009b). Subsequent studies have supported and broadened thinking on the mechanisms of this pathway. Negative age stereotype stress was also implicated in increasing cognitive impairment (Robertson et al., 2016) and psychiatric conditions (Freeman et al., 2016). The congruency of age stereotype stress with the criteria for stressors that are particularly harmful to health: negative, uncontrollable, unpredictable, and repeated over time had elevated this concern (Williams and Mohammed, 2009, as cited in Levy et al., 2016). Chronic inflammation has also been proposed as a potential mechanism in the physiological pathway as its general biomarkers have been found to partially mediate the relationship between self-perceptions of aging and survival (Levy & Bavishi, 2018).

Challenging the SET, some researchers argued that stereotype threat should be included in the stereotype embodiment process. Researchers suggested that it operates not only as a threat of confirming low expectations of others, but also of confirming self-relevancy (Fawsitt & Setti, 2017).

Furthermore, some research has suggested that the concept of internalized ageism should be reduced to more specific, distinct domains because age-identities may differ amongst these domains (Emile et al., 2014; Liang, 2018). Health-related domains; which could be further reduced to physical, cognitive, or functional domains; had been associated with exceptionally negative stereotypes (Kornadt et al., 2016) and, considering the stereotype matching effect, may be particularly detrimental. Thus, the general measures of self-perceptions of aging which had commonly been used in studies thus far may have diluted findings of health impacts, which

could have been more clearly revealed by use of health-domain specific measures.

In stark contrast to the SET model, some authors have presented the challenge that the response to negative age stereotypes may not be internalization, but rather inoculation. They had claimed that identification with negative age stereotypes may decrease over the lifespan due to malalignment with one's own personal identity (Zebrowitz, 2003) or may lead to stronger resistance (Pickard, 2014). Zebrowitz (2003) has critiqued the SET for not leaving space for the agency of older individuals to control their own response to ageism. This idea had also been supported by developmental contextualism, in which individuals are presumed to be producers of their own development (Kornadt et al., 2017). However, the associations found between self-perceptions of aging and health factors have appeared to challenge this theory.

There has also been an emerging interest in developing knowledge on the health impacts of age as it intersects with other discriminatory factors. For example, Goodwin et al. (1999) have shown a process of age and race stereotype embodiment in individuals living at these intersections.

Enrichment with Frailty Literature

To explore the phenomena of interest more fully, the qualitative *frailty* literature has been informally reviewed. No literature directly addressing ageism's influence on frailty was found, indicating a potential gap in research and understanding. However, some qualitative studies have appeared indirectly relevant because of their exploration of what older adults living with frailty identify as influences on their experiences of health. The discourse of ageism had not appeared in these findings, though this could be attributable to its taken-for-granted and implicit qualities. Nonetheless, potentially relevant congruences were found in terms of the similarity of presentations of frailty to negative age stereotypes, an experience of frailty identity crisis, and

some overlap and extension of mediating factors.

Firstly, it has been argued that the presentation of frailty may appear consistent with ageist stereotype content; thus, at risk of stereotype matching effects. Older age stereotype content has been described as predominantly negative (Hummert, 2011) and related to health concepts (Swift et al., 2017); for example, slow-thinking, incompetent, feeble, senile, depressed, lonely, hopeless, afraid, neglected, complaining, ill-tempered, demanding, and inflexible (Hummert, 2011). Consistencies between these descriptors and conceptual and operational definitions of frailty are notable. Warmoth et al. (2015) also had found older adults' views of frailty to reflect common old-age stereotypes and be negative. The possibility that an experience of frailty may increase self-relevancy of internalized negative age stereotypes, thereby increasing susceptibility to detrimental health effects, has been raised.

Secondly, older adults living with frailty have described a process or turning point of assuming a frail identity, which they held as distinct from their authentic self and found to be negative in nature (Grenier & Hanley, 2007; Warmoth et al., 2015). In some literature, this has been named a frailty identity crisis (Fillit & Butler, 2009). It has been proposed to occur when challenging transitions from independence to frailty are accompanied by a crisis of identity and a decline in psychological well-being (Fillit & Butler, 2009). Warmoth et al. (2015) explored older adults' beliefs about the progression and consequences of frailty. Identification as a frail person was described as occurring when one embodied the assumed characteristics and behaviours of the identity, such as advanced age, physical limitations, and disengagement; and willingly or resignedly accepted the label (Warmoth et al., 2105). They described how being labelled by others as 'old and frail' contributes to the development of a frailty identity by encouraging attitudinal and behavioural confirmation (Warmoth et al., 2015) and then becomes their main

identity (Grenier & Hanley, 2007). However, it was noted that labelling does not consistently correspond with its embodiment (Grenier and Hanley, 2007; Warmoth et al., 2015). These descriptions have appeared consistent with the concepts and processes of age stereotype embodiment: internalization, self-relevancy, embodiment, psychological and behavioural changes, and resistance. Indeed, the participants in Warmoth et al.'s (2015) study had voiced direct connections between ageist beliefs and frailty identity and a frailty identity with declines in health (Warmoth et al., 2015). Self-identifying as frail was perceived by participants to be strongly related to poor health and functioning, disengagement from physical and social activities, depressive thoughts, negative affect, stigmatization and discrimination (Warmoth et al., 2015). These congruencies in the discourse of age stereotype embodiment and frailty identity crisis had raised the possibility that they may be describing the same phenomena but from a different perspective.

The frailty literature had also suggested that the relationship between ageism internalization and health detriments may be bidirectional or cyclical. Older adults in Warmoth et al.'s (2015) study, had perceived that self-identifying as frail led to *and* stemmed from physical and social disengagement and decline (Warmoth et al., 2015). This finding suggested an extension of the current unidirectional model (Levy, 2009).

Finally, descriptions by older adults living with frailty had identified potentially relevant factors in the relationship between frailty identity and health detriments. A study by Ebrahimi et al. (2013) had found that feeling assured and capable, which depended on one's body and psychosocial context being predictable and within their control, were the main factors influencing older adults' experiences of health. Further, having the resources to remain in familiar surroundings, managing and controlling everyday life, and a sense of belonging and

connection to the whole were other influencing factors (Ebrahimi et al., 2013). Many of these descriptors had also appeared in the age stereotype embodiment literature and others hold potential as relevant factors yet to be examined.

A limitation to the subjective descriptions in this qualitative work was that they may only be sensitive to the *explicit* influence of the phenomenon, but not the *implicit*. Therefore, further effects may had been operating invisibly and been even greater than what could be subjectively captured. Thus, research approaches capable of capturing some criticality could have been useful in raising sensitivity to the more often implicit effects.

Review of Frailty's Contribution to Ageism

An exploration of the effects of ageism embodiment on frailty had seemed incomplete without discussion of a converse relationship; that is, the influence of frailty on ageism. Literature on this direction of the relationship has been much more common and suggestive that frailty may contribute by confirming negative age stereotypes, thus, fueling the source of the problem. More specifically, conceptions of frailty have been temporally linked to concerns about advanced age and the expense of older adults to healthcare systems.

The paralleling of frailty and 'old' age has been rooted in the social context surrounding its conception. The concept of frailty had emerged amidst, and in response to, an aging population and concerns about an associated threat to the sustainability of the healthcare system (Reed & Clarke, 1999).

Frailty models have been critiqued for their grounding on negative and stereotypical views of aging (Grenier, 2007) and contribution to stereotypes due to categorization and generalization inherent in their empirical development (Carper, 1978). Conceptualizations of frailty most commonly include chronological age as a predictor or risk factor (Tocchi, 2015), with some

conceptualizations going so far as to insist on its inclusion (Rockwood & Mitnitski, 2011). Further, it has been suggested that frailty reflects properties of aging and that its measurement could be used to assign a more accurate biological age to individuals (Mitniski et al., 2001). Such a suggestion may be of serious concern as it uses stereotypes of chronological age as a base upon which to assign an age identity and conflates the concepts of frailty and age. Other approaches have advocated for frailty screening of all persons above a pre-determined age threshold (Canadian Frailty Network, n.d.b; Santos-Eggimann & Sirven, 2016), which, again, may be concerning due to its assumption of age-related decline.

In response to these concerns, some frailty models have made efforts to distinguish the concept from age. However, these attempts have limited impact on shifting preconceptions due to frailty's symmetry with negative age stereotypes and its conception as an antonym to successful ageing (Richardson et al., 2011). As Higgs and Gilleard (2014) stated, "neither professional attempts to alter frailty nor critical deconstructions of its ontological status adequately address the symbolic network of images and narratives that constitutes the social imaginary" (p. 14).

Philosophical Underpinnings and Objectives of the Review Literature from a Nursing Perspective

The literature exploring the influence of ageism embodiment on frailty has appeared to justify concern and warrant further inquiry and intervention. To orient future knowledge development for nursing and inform the need for a proposed study, the reviewed literature must first be examined and critiqued to reveal the assumptions and objectives which guided its contribution. From there, nursing-oriented knowledge development may be envisioned to bring the scope of available knowledge into better alignment with nursing ontology and epistemology, theory, and

objectives. The exploration below focuses on the literature to date which has directly addressed the phenomenon of interest.

Grounding and Objectives of the Review Literature

Studies I identified, through the literature search, with a single exception, were quantitative in approach, negative in their views of aging, and individualistically-oriented.

Quantitative research has been an approach common in the discipline of psychology, which has dominated the literature on the topic. The approach has generally aimed to show correlation, causation, and mediators or moderators of relationships between variables with objectives of advancing theory. However, its over-riding goal in terms of the phenomenon under study has been to contribute to the amelioration of the potentially harmful health effects of negative ageist self-stereotypes (Levy, 2003).

The angle of perspective represented by quantitative research approaches was guided by postpositivist leanings. Researcher objectivity was assumed and taken for granted, without discussion of their location or influence on the formation of the research question or selection of variables. The phenomenon of interest was reduced to distinct variables and made measurable. The selection of the variables was often guided by previous work which, though not reviewed in detail, appeared to have been based on a similar paradigm. Findings have intended to reveal parts of a static reality which, it assumed, could potentially be exposed in its entirety (Risjord, 2010). Understandings were developed in a hypothetico-deductive manner in which researchers hypothesized based on previous research or theory, tested for adequate occurrences of a hypothesized relationship to generalize (Dahnke & Dreher, 2016), and proposed modifications or clarifications to pre-existing knowledge (Rodgers, 2005). The intention has often been to predict, control or manage the phenomenon through an understanding of the variable relationships

(Risjord, 2010). It has resulted in a linear, empirical construction of knowledge about the phenomenon (Dahnke & Dreher, 2016). Many of the quantitative investigators have, in presentation of findings, acknowledged a need for qualitative understandings, for example, Meisner and Levy (2016).

Beyond the research approach, the body of work so far has assumed that changes in health and function with age were unquestionably negative and problematic, consistent with the stereotypical view. However, there have been suggestions in the literature that this view may not consistently resonate with older adults (Grenier & Hanley, 2007). For example, help-seeking and dependency have also been viewed as highly adaptive strategies which improve the experience of aging (Baltes & Baltes, 1990). There had been a void in research that approached the phenomenon from this angle.

The knowledge developed so far has also held an individualistic stance. Despite acknowledging sociocultural influences, the issue of ageism embodiment has been positioned as a problem of and for the affected individual or on services to manage them. The associated health detriments have been framed as being the result of how an individual feels, thinks, behaves, and physically responds based on their own self-perceptions. This framing has resulted in placing the work and burden of resisting or remedying the situation, likewise, on the individual (Ebrahimi et al., 2013) and de-emphasized the cooperative and communal responsibility for social change that may be required to target the source of the health issue.

The individualistic positioning of research so far has also risked de-emphasizing the impacts of the phenomenon on the socio-political power of older adults, which may affect health from a broader perspective. For example, some research had found that older adults have been more likely to oppose federal programs aimed at benefiting them than younger adults (Pickard, 2014).

Based on this, it was postulated that ingroup preference may not apply to older age and, thus, older adults may continue to hold a preference for the younger group and believe that federal funding would be better spent on them (Pickard 2014). It has seemed possible that older adults, having internalized ageist stereotypes, implicitly act socially and vote politically in ways that may support their own subjugation. This has served to politically stymy a group who, otherwise, could hold significant political power in terms of numbers (Gilleard & Higgs, 2011). Of course, those currently in positions of power, largely younger, have had their own interest in allowing this to continue unnoticed. The indirect sociopolitical effects on health due to ageism internalization warrant further study.

The examination of the reviewed literature on the phenomena has revealed predominant philosophical assumptions of postpositivism, negativity of the aging process, and individualism. Its direct objective has been to advance theory, though its ultimate, as of yet nebulous, purpose has been to improve the health of older adults. A critique of the research design elements of these studies, such as the predominance of secondary data analysis, also has value in identifying suggestions for future research.

Nursing Philosophy, Theory and Objectives to Orient Knowledge Development

The nursing discipline has distinct ways of seeing and knowing required to inform practice. My study is grounded in nurse scholarship which has described these as a plurality of approaches; authentic sources; holism, complexity, and contextualism (Munhall, 1998); particularization and generalization (Thorne & Sawatzky, 2014); and nursing theory and praxis (Thorne, 2016).

Nursing has been underpinned by assumptions that knowledge development may never be complete and that there may be no one truth to be found (Thorne, 2016). Instead, nurse scholars

have appreciated and required a plurality of ways of seeing and knowing, each of which can offer partial knowledge (Thorne, 2016). Thus, nursing as a discipline has valued contributions from postpositivist paradigms, such as quantitative research; however, it has also required knowledge from interpretive and critical paradigms, such as qualitative research (Polit & Beck, 2017). Beyond empirical approaches, nursing has sought inquiries that take advantage of aesthetic or intuitive knowing for aspects of phenomena for which there may be no language (Porter, 2010) and the use of philosophy to evaluate all knowledge (McIntyre & McDonald, 2013). Further, nursing has demanded a dimension of openness to allow space for what is unknown (Munhall, 2012). From this view, it becomes obvious that, in terms of the research to date on the effects of ageism embodiment on frailty, there has been a lack of multiple knowledge dimensions.

The authentic source has referred to the subjective voice or lived experience. The research to date on ageism embodiment and its health impacts, dominated by quantitative approaches, the voice of older adults has only been heard through self-ratings of health measures and discussed as limitations to the accuracy of the data. Further, older adults living with frailty, or other significant health issues, have largely been excluded from the samples of studies so far, with few exceptions. Munhall (2012) has alerted us to the limitations of this approach, in describing that "too often we conduct quantitative studies based on our own knowledge of the world and not the knowledge of 'experiencers' of phenomena" (p. 70) and that "for any research enterprise to be authentic, we must begin with qualitative inquiry as a foundation from which we can identify variables, understand the context of experiences, and develop instrumentation" (p. 70). The voice of subjectivity and lived experience has needed primary emphasis in development of knowledge about phenomena for nursing. This exclusion must be critically reflected upon to expose any

underlying ageist assumptions, such as older adults' lack of agency or inability to contribute in a substantial way (Higgs & Gilleard, 2014; Hummert, 2011). The inclusion of older adults with frailty, for whom age stereotype internalizations may be the most self-relevant and most likely to inflict health detriments, seems most urgent and yet, so far, unexamined.

Understandings of phenomena as complex wholes in context has also been required for nursing. Research to date on the phenomenon of interest, inherent to its quantitative approach, had developed understandings based on reductionism and determinism, extending complexity only to the level of a series of relationships or pathways amongst multiple variables. Nursing has demanded an understanding of the phenomenon as it is lived, in its wholeness, and with temporal and contextual nuances, because that would be what would be experienced in the care encounter with a particular individual (Thorne, 2016).

Nursing has been described as grounded in a dialectic between knowledge of generalizations and nuanced individual particulars (Thorne & Sawatzky, 2014). Nursing has used the generalizations found in practice guidelines, quantitative research, or common patterns and themes to inform the care of distinct individuals (Risjord, 2010); while at the same time, it has recognized that the generalizations must not be taken for granted or assumed to be useful for any particular individual. In other words, recognizing that a pathway or association exists, has shed little light on how it may be experienced by a particular person, influenced by particular factors, or affected by particular contexts. For example, nursing has recognized that those in the margins or socially located with intersecting discriminations, including older adults living with frailty, have often been excluded by generalizations (Thorne, 2016). Thus, nursing epistemological orientation has required a seeking of individual nuances and variations on the generalized themes and a practice responsive to these (Thorne, 2016).

Nursing theory has also been explored for its potential to offer direction for knowledge development on the phenomenon of interest. Core concepts of person, health, environment, and nursing have been posited for the discipline (Fawcett, 1984, as cited in Risjord, 2010) and have offered some orientations for the direction of study. For example, in terms of developing knowledge on ageism embodiment and frailty, nurses may have orientations toward personhood, the health-specific domain of age stereotypes, or interdependence and cooperation rather than individualism. Looking to nursing theory for guidance on a disciplinary approach specific to aging have offered little direction. Wadensten and Carlsson (2003) had reviewed 17 nursing theories to explore their views on aging and found that most of the theories adopted a developmental perspective, but specified little in terms of what that meant for older adults or for a nursing approach. A developmental approach had posited that, as a function of individual experience, people develop and change during the life course, emphasizing individual responsibility and opportunities for growth (Wadensten & Carllson, 2003). It had posited that to understand a person's aging, it must be known how that person developed over time and what factors were influential under what circumstances (Kornadt et al., 2017). This approach had offered some direction for developing nursing knowledge on the phenomenon of interest, but had also raised concerns that neither its meaningfulness nor impacts on health outcomes and care needs for older adults had been made clear (Wadensten & Carlsson, 2003), it had appeared to equate aging with inevitable decline, and its individualistic emphases had limited nursing's vision for public health and social justice perspectives.

Further, lack of attention to theories of aging from a nursing perspective may have left the discipline long leaning into those of other disciplines and steering or restricting nursing knowledge and practice in ways misaligned with nursing intentions. Munhall (2012) had advised

caution in using theoretical frameworks from other disciplines due to a risk that the underlying logic and assumptions be inconsistent with nursing knowledge or applicable to nursing practice. In terms of ageism embodiment and frailty, there had been little contribution from the nursing discipline. Of the literature reviewed, only one quantitative primary study had been generated by nursing. The majority of the literature had been generated by psychology and medicine. SET, for example, had been based on a narrow epistemological perspective and intended for application to theory development rather than practice. However, nursing's pluralistic epistemology has embraced the sharing of knowledge from other disciplines, while recognizing that their work may serve different mandates (Thorne, 2016). Nevertheless, there has been space for nursing-oriented theory development for aging generally to frame a disciplinary response to the phenomena.

Nursing has offered an ontological and epistemological orientation to direct inquiry and knowledge development on the phenomenon of interest in ways that remain unexplored to date and that are needed for practice. This nursing inquiry has asked of the phenomenon of interest: what is the practice relevant knowledge gap? How may we advance knowledge and develop theory to facilitate improved practice (Thorne, 2016)? What knowledge may be gained from practice to advance knowledge and theory (Dahnke & Dreher, 2016)? An objective of relevance to practice has been key to the development of knowledge via this study (Thorne, 2016).

Implications for Nurse Practitioner Practice

NPs have recognized the need to mitigate vulnerabilities and prevent risks in order to promote health and improve outcomes for all individuals in their care. However, with emerging understanding of the interconnectedness of frailty and ageism, nurse practitioners may need to

re-consider how to engage with the concept of frailty, to sustain the benefits that its use may offer while concurrently avoiding harms related to ageism.

The evidence to date has been sufficient to call nurse practitioners to action and many authors have proposed suggestions for practitioners to improve the health of older adults in the context of the phenomenon of interest. Nurse Practitioners may embrace the opportunities inherent in this shared knowledge, while remaining mindful and critical to avoid the pitfalls of borrowed knowledge and sparse evidence of effectiveness. Future exploration of intervention research related to the phenomenon is warranted to justify and support practice change. Until such a review is made available, Nurse Practitioners must act to mitigate potential risks for older adults receiving their care by critically reflecting on their own assumptions, shifting approaches in care encounters, and disrupting social systems.

Action for Nurse Practitioners

Nurse practitioners have been encouraged to critically reflect on their own age assumptions. There has been great likelihood that those raised within North American culture, in particular, may have internalized ageist stereotypes over their lifespan (Ayalon & Tesch-Romer, 2017) and brought them implicitly into practice. This has been shown to manifest as misattribution of health problems to age (Levy, 2009) or paternalistic approaches to care provision, thereby perpetuating social harms. Studies have found ageism to be prevalent and unintentional amongst healthcare professionals (Robb et al., 2002, as cited in Stewart et al., 2013; Ben-Harush et al., 2017). Higgs & Gilleard (2014) have pointed out that “It is through our [well-meaning] professional actions that society is enabled to imagine…those we deem frail” (p. 16).

Nurse practitioners have also been encouraged to critique their knowledge of biological changes as associated with advanced chronological age. Firstly, NPs have needed to be aware

that much variability in objective and subjective perceptions of older adults' age and health exists (Levy, 2009; Warmoth et al., 2015). Secondly, NPs have been encouraged to query whether evidence of age-related changes has captured authentically biological processes or unintentionally measured other unacknowledged influences, such as stereotype embodiment. For example, how much of slowed memory retrieval with age might be due to biological deterioration of the brain and how much might be the result of reduced use or stimulation of the brain that accompanies forced retirement with expectations of engagement in leisure pursuits, institutions of education organized for the young, and beliefs that "you can't teach an old dog new tricks?" As another example, how much of kyphosis might be age-related biological deterioration and how much might be due to beliefs that exercise is too risky (O'Brien Cousins, 2000), embodied social inferiority, or efforts to appear enfeebled enough to receive required services (Pickard, 2014). Nurse practitioners have been encouraged to recognize that the attribution of age-related changes to inevitable biological decline, which has remained predominant in our education and interprofessional practice environments, may have been over-emphasized and served to reinforce the misinformed construct of the age stereotype (Pickard, 2014; Stewart et al., 2012).

Action for Clients

Themes have emerged from the literature review which offer a number of innovative approaches for nurse practitioners to consider in care encounters with individuals. These have included assessing for self-identified age and health, intervening in ageist expectations and stereotypes, optimizing client control, and reconsidering the usefulness of 'frailty' in practice.

Firstly, NPs have been encouraged to include individuals' self-identification of age and health status in assessments, just as we might for gender or ethnicity. This would respect the variability

of these perceptions and experiences amongst individuals (Levy et al., 2006), avoid assumptions of a frail identity (Grenier & Hanley, 2007; Warmoth et al., 2015), and avoid labels of frailty which risk activating an identity shift which could exacerbate health detriments (Levy, 2009). Further, NPs have been encouraged to recognize individuals' self-identification with negative age stereotypes as reversible risk factors for frailty across domains of health (Choi et al., 2019; Levy & Myers, 2004; Levy et al., 2014; Ye et al., 2020).

NPs have been encouraged to actively promote positive outlooks on aging (Kim, 2009; Levy 2009; Levy & Leifheit-Limson, 2009; Levy & Myers, 2004; Sargent-Cox et al., 2012) and sensitively disrupt negative expectations of aging (Goodwin et al., 1999; Levy et al., 2002a; Stewart et al., 2012) for individuals. Studies had shown that self-perceptions of aging may be made significantly more positive with intervention and that even small increments of change in these perceptions may create a significant health impact (Levy et al., 2018b). For example, attribution of signs and symptoms to a particular cause or part of the body (Warmoth et al., 2015) rather than attribution to old age (Stewart et al,, 2012). Age-associated changes may be acknowledged, but with an emphasis that age may not necessarily be a barrier to treatment or recovery (Freeman et al., 2016; Stewart et al., 2012). There has been a call to inform older adults, their families, and caregivers about ageism and its implicit nature in order to expose and disempower its impacts (Coudin & Alexopoulos, 2010) and emphasize active coping skills (Levy et al., 2019), health promotion activities and chronic disease self-management (O'Brien Cousins, 2000; Kim, 2009; Warmoth et al., 2015) regardless of individuals' age or frailty. NPs have been encouraged to optimize individuals' control over health and healthcare decisions (Freeman et al., 2016) to support agency and diversity as well as prevent a need for individuals to assume a frail identity in order to beckon attention and services to meet their needs (Grenier & Hanley, 2007).

Lastly, NPs have been called to reconsider the usefulness and harms of frailty conceptualizations and operationalizations in practice. It is worth questioning why and to what benefit have frailty labels and tools been employed largely for older adults if holistic, complex, contextual, client-centered assessments and care planning to prevent decline and promote health have been inherent to NP practice in general. This question has seemed particularly important in light of literature highlighting that suggestions that frailty may potentially cause harm by triggering self-relevancy, embodiment, and related health risks. Thus, with little usefulness in distinguishing a practice approach, its harms have certainly appeared to outweigh its benefits.

Actions for Social Justice and Health Equity

The focus on the care of *individual* older adults in NP practice has been essential, but should not have been without concurrent social action to relieve the source of the issue: societal ageism (Levy et al., 2018b). Grounded in a social justice mandate, NPs may recognize the phenomenon of interest as a threat to health equity for older adults which requires their action. The International Council of Nurses' position statement on nursing and human rights had delineated nursing's responsibility to act on threats to human rights in health care, mentioning the 'elderly' specifically (International Council of Nurses, 2011) and "A Nursing Manifesto" has promoted the goal of emancipatory research and practice (Cowling et al., 2000). Systemic ageism and its perpetuation of age stereotypes and health inequities of older adults has persisted largely unchallenged (Levy, 2009). Exceptionally notable had been that age has not yet been explicitly included in the United Nations Declaration of Human Rights (United Nations, n.d.). Suggestions for NP actions have included large-scale campaigns by our local, provincial, and national associations; NP representation in political realms to disrupt the common denigration of older adults (Levy et al., 2018b; Levy et al., 2002; Ye et al., 2020); leadership of a shift in values

toward cooperation and interdependence in healthcare; and allyship with older adults for structural and policy changes that outlaw age discrimination and facilitate engagement of older adults in society and politics (Freeman et al., 2016).

Conclusion

NPs provide healthcare for a large number of older adults, including those experiencing frailty, and these numbers are expected to increase over coming years. Frailty prevalence is significantly higher for women (9%) compared to men (5%) (Pitter et al., 2024; Statistics Canada, 2010; Zhang et al, 2018). Practice experience has generated concern about potential relationships between frailty and ageism, as supported by a review of the literature which had indicated a negative age stereotype embodiment process. The existing literature had appeared largely unexplored in terms of frailty specifically, leaving an intriguing space for investigation. Understandings generated from current knowledge had been useful for nursing, but narrow in perspective. To contribute to filling this gap, further inquiry informed by nursing ontology and epistemology and with pragmatic objectives, has been needed for expansion of understandings and guidance for NP practice. To develop knowledge in this direction there is a requirement for interpretive, critical, and experiential perspectives; holistic, complex, and contextual understandings; recognition of patterns or themes; appreciation for appropriate clinical and emancipatory responses; and openness to all that remains unknown, some of which may emerge from practice (Thorne, 2016). Thus, my study aims to inform understandings of the role of age stereotypes in the health domain and their risk to multidomain frailty through inquiry into the perspectives and experiences of older adults. In the meantime, NPs have been called to action based on an emerging awareness of the phenomenon's potential for harm and health inequity for older adults. NPs may take action through personal and professional critical reflection, a shift in

their approach toward age and frailty in practice with older individuals, and disruption of social complacency on the issue of ageism.

CHAPTER TWO: Critical Feminist Gerontology

Critical feminist gerontology has offered a useful lens to extend and focus understandings of associations between age stereotypes and frailty in new directions and orient knowledge development commensurable with nursing action. The perspective has highlighted intersection of gender with old age and supported an orientation towards scholarship which seeks different, varied, and pluralistic understandings, beyond traditional approaches. This chapter discusses critical feminist gerontology's work in the area of interest to date, perspectival orientation, objectives, methodological implications, limitations and gaps in the field of scholarship. It explores needed directions for future work and potential contributions to this scholarly approach.

Literature Review Process

To explore existing literature on associations between age stereotypes and frailty from a critical feminist gerontology perspective, literature searches were designed in consultation with an academic librarian. Five databases (CINAHL, MedLine with full text, AgeLine, Social Science Abstracts, and PsycInfo) were searched using the keywords (feminism OR "feminist critique") AND (frail*) OR (ageis*). Limiters included English language, age group 65years and over, and publication date of 1969-present, with 1969 selected as it was the year that Butler published the seminal work on the concept of ageism. Titles and abstracts were reviewed by a single reviewer. Literature was included if it included a feminist approach to ageism and/or frailty factors. Literature was excluded if the approach was not identified as feminist, or if the focus was on particular sub-groups of older women (such as those experiencing abuse or terminal illness), specific conditions unrelated to frailty (such as intellectual disability or cosmetic surgery), or fictional literature. The reference lists of included literature were also searched. The review was not intended to be systematic or comprehensive, but rather to provide

a thoughtful and reasoned understanding of what this field of scholarship has offered to date on the phenomenon of interest.

Summary of literature

The search results included three results related to frailty and thirty-seven results related to ageism, after removal of duplicates. The included literature dated back only so far as 1995, and twenty-two of which were written in the past 15 years, since 2006. The included literature was predominantly generated from the social sciences and, less so, from psychology, geography, English literature, and education. In terms of healthcare disciplines, only counseling made one contribution. I found no literature from the nursing discipline. The literature review found the study of the phenomenon of interest from a critical feminist gerontology perspective to focus on social, political, demographic, and economic aspects. No literature was found with a focus on health or frailty. The works were largely theoretical arguments or personal essays and narratives. Four results were empirical studies. These results are a testament to the paucity of work that has addressed the phenomenon of interest from this perspective. Nonetheless, the literature is useful for its insights into the field of critical feminist gerontology, its perspectival orientation, methodological implications, and objectives.

Perspectival Orientation

Critical feminist gerontology is generally a feminist lens added to a critical gerontology approach. Its perspective can be understood through discussion of critical gerontology, feminism, and the resulting critical feminist gerontology.

Critical Gerontology

Critical gerontology has approached the study of aging using a social constructionist view to examine the extent to which aging experience is shaped by the interaction of cultural (Carney,

2018), social, political, and economic factors (Freixas et al., 2012). The field of study has sought to recognize and expose hegemonic ideologies about aging created by dominant voices and systems (Estes, 2008). Three hegemonic perspectives have been commonly referred to in the critical gerontological literature: medicine, youth, and individualism. Medicine has shifted old age from being an accepted phase of life to being a set of health conditions to be managed (Cole, 1992). Underpinned by disease theory, medicine has aligned the progression of age with pathology which, in turn, required and justified the invention of medically-oriented knowledge to explain the aging experience in these terms (Vertinsky, 2000). The youth perspective has framed oldness as subjugate or disruptive to youthfulness, which has been held as the dominant and preferred frame of reference (Twigg, 2004). The negative meanings which have become attached to old age have come to be interpreted as the source of the problems of old age (Twigg, 2004). In response, and similarly to medicine, the young have created gerontology to examine and correct these problems, blind to their own contribution to the problematization of old age. The individualist ideology has extended and validated the positioning of responsibility for these problems on the affected aged individuals (Estes, 2008).

Critical gerontology has taken the perspective that due to the hegemony of these three privileged ideological positions, the knowledge they have generated has become essentially all that is known (Estes, 2008) and come to be taken-for-granted as ‘truth’. Interest or advancement of understandings of broader or different constructions of old age have consequently been constrained and subjugated (Estes, 2008; Twigg 2004), and less visible. As a result, homogenous expectations and experiences of aging and old age have emerged as stereotypes. Critical gerontology has not attempted to counter these ageist stereotypes by denying possible experiences of decline or loss as some individuals age, but rather has rejected the *assumption* that

this will be the case and has held space for diversity and that which cannot be presumed (Cole, 1992; Gullette, 2008). The approach, thus, has not denied aging per se but resisted its devaluation.

Further to this, critical gerontology has examined the consequences of these assumptions on individual experiences of aging. In terms of individuals, it has recognized that the weight of centuries of senescent assumptions and essentialist reasoning may implicitly and acquiescently, without explicit coercion or repression, have imposed discrimination and harmful material consequences on aging individuals (Carney, 2018; Estes, 2008). Hegemonies have taught and encouraged people to read signs of old age as a failure, shame (Twigg, 2004), and devaluation of status (Carney, 2018). As Gullette (2008) highlighted, people have been aged by their culture not just their bodies. She has described that the common explanation of decline in aging

> "depended on an ideology that sank its nails deep in ordinary people. Fiercely supported by institutions and dollar signs, it affected unconscious habits, every sub-identity, ways of seeing bodies, explanations of history. It distorted visual culture. If you fought it alone, that fight warped your eyesight and sapped your energy." (p. 191)

These ideas have been so internalized and manifested in their expected ways, that they have validated and perpetuated the privileged positions of hegemonic constructions, thus, further undermined opportunities to shift these perspectives.

Feminism

Feminism moves to shift one's perspective of the world (Crotty, 1998). Crotty has discussed feminist epistemologies as pluralistic but sharing some common ground. Feminists "express concerns, raise issues, and gain insights that are not generally expressed, raised, or gained by male epistemologies. Few would want to quarrel about that." (Crotty, 1998, p. 174). It is

discussed as often viewing categorizations or dichotomies, such as man-woman or young-old and their inherent characteristics, as masculine ways of understanding the world; in contrast to feminist understandings which shift concern to such groups' experience of different social pressures, encouragement to do different kinds of work and behaviours, and, most importantly, development of different characteristics as a result. Such discrimination has severely limited human possibilities for all groups (Crotty, 1998). To overcome this and advance egalitarianism, feminism has recognized that it requires more than the willpower of the subjugated group alone, but rather demands significant systemic reorganization of power and privilege and changes in the consciousness of all (Crotty, 1998).

Critical Feminist Gerontology

Feminists within critical gerontology have argued for explorations and understandings of gendered intersections and distinctiveness in the experiences of aging (Carney, 2018; Ray & Fine, 1999) and that these should be central in the analysis of aging (Twigg, 2004). Critical feminist gerontology has emerged as a result, extending critical gerontology to include common principles of feminist epistemology (Freixas et al., 2012) including emphases on power relations and inequity, social and cultural construction of the body, diversity, impact of individuals, and shifting of responsibility for the discrimination and inequities onto social systems and institutions.

Firstly, the perspective has recognized that men and women and/or old and young gain identities and power in relation to one another which become dynamic structural forces with important consequences for individuals (Calasanti, 2004). In recognizing both age and gender as aspects of identity that matter in terms of how one lives in the world (Holstein, 2018). Scholars in critical feminist gerontology suggest that the intersectional synergy of age and gender

escalates the impacts of either identity on its own (McFarland & Taylor, 2021). Individuals living at these intersections have been challenged individually and collectively in their attempts to age with dignity and diversity due to discrimination (Carney, 2018). The problems of population aging have readily become constructed as the problem of old women, both because old age has been feminized and stereotypes of aging have been harshest for women (Carney, 2018). Freixas et al. (2012) had stated that "the most important deprivations suffered by women as they age originate in the age-related social stereotypes" (p. 48). For example, the term 'old woman' has been so contaminated with negativity that it is avoided in conversation (Freixas et al., 2012) and 'little old lady' has been understood in the social imagination to be an oppressive signifier (Grenier & Hanley, 2007). Concurrently, social invisibility has existed, and old women have found no reflection of their own situations in the cultural imagery that surrounds them (Twigg, 2004). Such ageist and sexist discrimination has been, however, often ignored, diminished, or denied because of the relative powerlessness of old women's social, economic, and political positions (Carney & Gray 2015).

Secondly, the approach has generally perceived of the body, particularly the woman's body, as socially and culturally constituted (Twigg 2004) and resisted or rejected the idea that there is a 'natural' body or 'natural' way to age. Though the limits of social constructionism in relation to the body and the nature of resistance have been topics of debate within feminism (Twigg, 2004), there has been general agreement within critical feminist gerontology that the gendered ageist stereotyped constructions of old women have been predominantly negative on themes of body and health (Twigg 2004). Women's bodies have been rendered both invisible, no longer seen and no longer a source of power and hypervisible, all that is seen (Twigg, 2004). The narrative of feminine aging has been overpowered with abject decline; whereas, in contrast,

masculinity has been represented with improvements, such as being associated with vintage items, such as fine wine and cheese (Pickard, 2019). Women have also been more prominent in categories of frailty, conceptions of which have been associated with the negative feminized characteristics of weakness, passivity, dependence, (Grenier, 2007; Kaufman, 1994) to the exclusion of positive or flourishing possibilities (Pickard, 2019).

Thirdly, critical feminist gerontology has recognized that hegemonic constructions of old women in Western societies have been created by paternalism and medicalization whose perspectives reduce their experiences to biologic essentialism (Pickard, 2014). Historically, understandings of the woman's body have been constrained by a reduction to their reproductive biological organs and social role (Vertinsky, 2000). For the past couple of centuries, medical and scientific sexism have constructed women's bodies and femininity as weak, passive, dependent, and/or vulnerable (McFarland & Taylor, 2021). An aging woman's body has been conceived of as worn out from decades of menstruation and childbearing leaving it low in energy and vitality, degenerated, and less socially functional (Vertinsky, 2000). Menopause, as constructed by medicine's disease theory, has come to be viewed as a pathological condition which burdens women with earlier, more robust, and biologically determined bodily deterioration. Such a perspective has rendered old women "eternally wounded" (Vertinsky, 1995, p. 230, in Vertinsky, 2000) in their efforts to pursue life goals into advanced age. Further, this construction has served to create barriers in economic, political and social domains (Carney & Gray 2015). In terms of health, little research has been done on old women's health concerns (Carney, 2018). Again, this has been due to hegemonic use of men as the norm and lack of interest in, or rendering as inevitably unhealthy, woman past menopause (Vertinsky, 2000).

Fourthly, scholars in critical feminist gerontology have recognized that diverse or complex understandings of old women have been excluded as a result. This has done a disservice to individuals facing various realities of old women, even amongst those experiencing some decline (Holstein, 2018) or frailty. Knowledge development has been constrained by the taken-for-granted explanations and expectations. One example of the ignorance of diversity, as highlighted by McFarland and Taylor (2021), had considered the intersection of race, which has been historically neglected from hegemonic constructs of womanhood and femininity. They had explored the work of critical race scholars who revealed how, in the Western social imaginary, femininity and frailty discourse have been constructed to align with whiteness (McFarland & Taylor, 2021). Critical feminist gerontology has brought an openness and thirst for exposing and exploring more diverse and plural experiences and models for any woman (Freixas et al., 2012).

Critical feminist gerontologists have recognized the imposition, instruction, and entrenchment of these restricted constructions on individual old women (Vertinsky, 2000) causing demoralization of their behaviour and potential (Freixas et al., 2012) and invisibility or erasure of their own distinct subjective perspective (Cole, 1995). Instead of recognizing and resisting, aging women may internalize and manifest the negative constructions in multiple life domains, including health and frailty (McFarland & Taylor, 2021). Examples of such manifestations in the literature are few.

Carney (2018) raised the example of gender-based differences in dementia rates, that are generally higher in women. She had debated the sources of discrepancy, including a hegemonic medical attribution of the difference to women's longevity versus the potential contribution of public health campaigns which historically targeted men. A specific example was a smoking cessation campaign targeted at men and effective in reducing cardiovascular disease in this group

(Carney, 2018). She had questioned the cumulative implicit disadvantage to women who were commonly ignored in such health promotion efforts (Carney, 2018).

Vertinsky (2000) had offered a detailed exploration of women's involvement in sport and the consequent detriment to women's strength and fitness, thus physical frailty risk. She had described how the hegemonic medical explanations about women's health served to inform societal views and policies which limited women's opportunities to participate in and reap the benefits of sport. Some physicians argued that "too-active women would squander the birthright of future generations" and that "nature groaned for the muscle-energy wasted by excessive sport" of women (Vertinsky, 1994b, p. 76, in Vertinsky, 2000, p. 397). Instead, paternalist physical educators had recommended 'play days' of modified sports emphasizing health for women (Kuscsik, 1977). In terms of running, women were thought too frail to compete in runs lasting longer than a few minutes or 800m in length. Women completing marathons were portrayed in the media as collapsing or staggering over the finish line, while men were portrayed as strong, despite both women and men all finishing in an equivocal range of states (Vertinsky, 2000). Such constructions and presentations had resulted in a ban on distance running for women which lasted for decades, lifting for the marathon only 50 years ago in 1984. One competitive woman runner had described that as a young girl, 'marathon' was not even in her vocabulary, let alone framed as something she might aspire to (Vertinsky 2000). Since being allowed to compete, women have displayed a more hardy, practiced, successful capacity for running, with records already being within close proximity to those of men (Vertinsky 2000). As Guttman (1991) had described,

> clearly, the narrowing of the difference is explicable, not by evolutionary changes in the male and female of the species, but by social and cultural factors. More women are

> involved in sports; they train longer and harder than they did; they are less inhibited than they were by fears of masculinization, by the stigma of aggressiveness (p. 252).

Critical feminist scholars in gerontology have recognized that older women have been even more constrained from physically strenuous activity by medical discourse aligning women's aging with loss, failure, and decrepitude (Vertinsky, 2000). For women in the age range of 70+ today, these ideologies and realities had existed throughout their formative years, increasing their risk of internalization. They have lived this historical conceptualization of vigorously active old women as an oxymoron (Vertinsky, 2000). This has begged the question of how these intersecting social constructions of 'old' and 'woman' may have limited potential for fitness and health and increased risk of frailty for today's old women. It is worth noting that there has been evidence of resistance, specifically increasing numbers of older women participating in or holding positive outlooks toward vigorous sport and exercise (Vertinsky, 2000).

However, the exposure of such societal limitations has not directly translated into it becoming personally optional. As Twigg (2004) had described,

> "We live our lives in a particular historical period and culture. We are part of that, and there are limits to our capacity for cultural resistance, and thus of our capacity for age resistance. Aging ultimately is not optional, however much we may want to resist its more malign cultural meanings" (p. 63).

Moi (1994) had named this a woman's "situation" (p. 66), and emphasized that it is:

> not an external structure that imposes itself on the individual subject but rather an irreducible amalgam of the freedom (projects) of that subject and the conditions in which that freedom finds itself. The body as situation is the concrete body experienced as meaningful, and socially and historically situated (p. 72).

Thus, a critical feminist gerontological view has been in part an effort to shift the blame for the lower status of older women from the individual onto the institutional and social norms which systemically disadvantage them in the distribution of social, economic, and political power and resources (Carney & Gray, 2015) and reconceptualize the ruling class to include the existence of age hegemony, in addition to sex hegemony (Pickard, 2014). Thus, the personal has been political for old women because cumulative effects of ageism and sexism have inhibited freedom and potential (Pickard, 2014).

Objectives

Feminist epistemologies and approaches have oriented and extended critical gerontology aims toward revealing, analyzing, and taking action on socially constructed meanings and values that derive from gender and age differences, constraints on women's free existence in old age, and consequences for the lives of old women individually and collectively (Freixas et al., 2012).

The most important and urgent task for feminist researchers to accomplish for older women has been to provoke a deep curiosity about, if not disrupt, resist and reject, the essentialist view that there exists an ahistorical, pre-discursive, inevitable, immutable, natural biologic determinism that justifies the social devaluation imposed on them (Gullette, 2008; Twigg, 2004; Vertinsky, 2000). This began with the objective of questioning "what exactly has age [or gender] got to do with it?" (Gullette, 2008, p. 194). Such questions have considered possibilities that age and gender may be red herrings, scapegoats, or proxies for other crucial factors (Gullette, 2008). This line of inquiry has aimed to challenge and unpack current constructions.

The approach has also aimed to hold space for unexamined, unheard, diverse or alternate constructions of gendered aging from different ideological and contextual perspectives. These

include examples such as social justice and equity, community, interdependence, and intersectionality (Freixas et al., 2012).

Further, feminist approaches have demanded that critical gerontology extend beyond its focus on developing knowledge and theory to taking action (Carney & Gray 2015). Critical feminist gerontology has committed to scholarship that makes sense and serves to enlighten culture and manifest change (Ray, 2004; Ray & Fine, 1999). For individuals, it has aimed to employ emancipatory strategies, such as development of a realization that they may potentially be aged by culture through experiencing "the embodied psyche, in culture, over time" (Gullette, 2008, p, 191). This step has challenged participants in research, researchers, and readers to critically and consciously recognize, deconstruct, and unlearn the cultural and institutionalized ageism in which they are embedded and which they have internalized (Ditzion et al., 2018; Ray, 2004), reconceptualize what it means to be an old woman (Calasanti, 2004), and emancipate one's position in terms of their own power and ability to change or resist hegemenous ideology and structures (Ray & Fine, 1999). Put another way, the objective has been to offer a social map and historical context to re-design an identity and a potential, distinct from how one has been socialized (Ray & Fine, 1999). As Freixas et al. (2012) have stated, it is "Only through individual revision of ageist stereotypes [that it] will it be possible to carry out high-quality research that empowers" (p. 46) and transforms (Ray, 2004). As such, alternative discourse, reflexive thinking, emancipatory knowledges, and re-framings may be considered actions as they are exercises in agency and creators of change (Estes, 2008). Thus, an objective of critical feminist scholarship has been to ground activism in personal passions and political struggles (Ray & Fine, 1999).

For the broader social context, the objective of critical feminist gerontology has been to improve the location of old women as a social group through disrupting stigma, preventing harm from inequities, and reclaiming experience and language to serve old women. Further, it has aimed to position freedom of choice, rather than identity, difference, or equality, as the main project of research (Moi, 1994). As Holstein (2018) had highlighted, progress toward achieving critical feminist objectives may be shown once society demonstrates "as much respect to the 80-year-old [woman] bent over her walker as to the 83-year-old who discovered hurdle-jumping at age 70" (p. 149) or, further, to a 45-year-old athletic male physician.

For the feminist movement itself, critical feminist gerontology has been called upon to push the movement forward through amplification of the voices of old women. Their voices have been more absent and less effective than the voices of old men, as demonstrated by recent tumultuous political events in the Western world (Carney, 2018).

Methodological Implications

Critical feminist gerontologists have proposed that a feminist approach to the study of sexism could also offer a way to approach the study of ageism (Carney & Gray, 2015). They have challenged the view that feminist scholarship can only apply to the study of gender, reorienting the emphasis toward power relations and the situatedness of all groups in relation to each other (Calasanti, 2004), including age-related groups. As an approach to research, a critical feminist gerontology perspective has required rejection of a fixed reality, space for alternate and complex understandings, methodological diversity, subjectivity, and researcher reflexivity.

Feminist approaches have generally held an approach to research which rejects the notion that there is a fixed reality to be discovered (Ray 2004). Rather, knowledge development has been perceived of as a journey of discovery which is ever evolving and never complete (Estes,

2008), and all scholarship as produced within a context that is in a perpetual state of becoming (Ray, 2004). As such, the approach has embraced a willingness to err or admit the unknown, in stark contrast with traditional white, masculine models of science (p.3). However, with a demand to take productive action, many feminist approaches have held that there can be some grounding universals or shared themes and patterns (Thorne, 2016). For example, an approach to feminism such as Estes' (2008) had described human needs that are both universal and transcultural and that social circumstances can cause serious harm and suffering.

Critical gerontology has offered a way to loosen the research focus on dominant channels of knowing to other possibilities that recognize diversity and complexity, adaptability and strength (Holstein, 2018). For example, Carney and Gray (2015) had presented a political economy and demography model for research on ageing which challenges the dominant biomedical and cost-oriented approaches and is instead based on capacity, embedded in culture, and focused on untapped potential. de Beauvoir (1972) had proposed a conceptual framework focused on embodied subjectivity, in contrast to the decline narrative, which offered opportunities to acknowledge paradoxes in the lives of ageing women such as the accumulation of disadvantage and suffering of inequalities while simultaneously experiencing opportunities for social and personal power and liberation from constraining modes and roles of youthful femininity (in Carney, 2018).

Thus, methodological approaches in critical feminist gerontology have been diverse (Calasanti, 2004). Interpretive methodologies and strategies have been sought to critically extend thinking about the way knowledge has been made and disseminated (Ray & Fine, 1999). For instance, it has sought understandings of the whole and the complex, as can be accomplished with traditional qualitative methodologies, though critical feminist gerontology pushes these

further to include context and self-awareness, using and valuing strategies such as contemplation, reflection, insight, and intuition (Ray, 2004). The use of such strategies has been effective in overcoming the implicit nature of some of ageism's effects. They have embraced tensions such as experiences of resisting ageist stereotypes while living the challenges of aging decline (Twigg 2004). The most important and urgent call for feminist gerontological researchers has been to be even more critical and self-reflective in their approaches by integrating cognitive, emotional, ethical, and spiritual ways of knowing; self-consciousness of their own age identities and the images of aging embedded in their own work (Ray, 2004); and resistance to cultural narratives of decline (Freixas et al, 2012).

Research approaches informed by critical feminist gerontology methodology have emphasized, and held as trustworthy, old women's definitions, expressions, and decisions about their own identities and experiences (Holstein, 2018), or "the way she lives her embodied situation in the world...the way she makes something of what the world makes of her" (Moi, 1994, p. 72). This situated knowledge of personal experiences of older feminists experiencing the marginalization oppression or liberation (Twigg, 2004) has been deemed especially useful for the grounding and development of epistemologies which aim to challenge dominant perceptions and stereotypical narratives (Carney, 2018; Twigg, 2004). Such approaches have encouraged aging women to press memoir hard for potential social critiques and insights (Ray & Fine, 1999) which might enable new and different interpretations and representations of female aging (Freixas et al., 2012).

Feminist narrative writing has offered one of the most significant achievements of the feminist movement in which women's individual experiences have been validated, politicized and used collectively to challenge the status quo (Ray & Fine, 1999). Aging feminists have taken

up the same approach with great effect, expressing personal experiences of aging and ageism in feminist terms (Carney, 2018). Gullette (2008) had referred to this as "age autobiography":

> the mental place where a self confronts huge social forces--the dark closet under the front-hall stairs where learning, internalization, and resistance occur—[at] an exciting, scary intersection…We cannot get far if we don't plumb the full range of our age-related assumptions. Over, time, my increasing sense of the powers at work on us helped me de-internalize more of my age-related biases. (p. 192).

Narrative evidence has had the power to question the presumptions about normal ageing (Carney & Gray, 2015), bring more attention to positive and empowered narratives of age and ageing (Gullette, 2008), offer unique understandings of gendered ageisms' explicit or implicit oppression, and serve as a basis for social action (Ditzion et al., 2018).

The study of authentic narrative of aging or old women has revealed understandings of the experience which starkly contrast with those of hegemonic stereotypes. For example, narrative from older persons has suggested that they may be more satisfied with their bodies than when they were younger and experience their bodies as healthy despite impairment or disease (Pickard, 2014). Narrative from old women has suggested that they feel more positive and comfortable in their bodies and experience greater freedom and fulfilment (Pickard, 2019). These examples have highlighted possible malalignment of societal age norms with personal experience which Carney (2018) has acknowledged may result in old persons not finding a meaningful identity within the strictures of the institutional envisioning of old age as it currently stands and old women either denying or distancing from their chronological age (Carney, 2018). However, in denying one's aging, one denies old age as a political status and, thereby, relinquishes power to the hegemonies which misconceive of them (Carney, 2018).

Critical feminist gerontologist researchers have been urged to turn this same critical gaze upon themselves and their interpretative work (Ray & Fine 1999). Such work has demanded a deliberate conscious effort by the researcher to intervene critically in their own life, in addition to the lives of others (Ray & Fine, 1999). The researcher has used this as a standpoint from which to ground analysis, generate theory, and orient action in order to produce scholarship which is progressive, critical, resistant, interventionist, and enabling (Ray & Fine 1999). One such methodological approach used in critical feminist gerontology has involved methods of personal criticism in the context of explicit autobiographical performance (Ray & Fine, 1999) or integration with research (Freixas et al., 2012) and academic theorizing (Twigg, 2004). Such work has involved researchers weaving critical self-narration into their research accounts to frame an essay, punctuate an argument, offer support to a claim, or infuse text with personal values and political beliefs in order to contest and reconfigure relationships between personal experience, the positional stance assumed in research and writing, and the political effects of the scholarship (Twigg, 2004).

Critical feminist gerontology has been pluralistic in its methodological approach to scholarship (Crotty, 1998). Generally, it has responded to calls for qualitative, holistic, complex, contextualized understandings of phenomena as lived and expressed by the authentic voice for a practical purpose and emancipatory action, consistent with nursing scholarship.

Gaps and Limitations

Gerontology itself has not held as much prominence as other social sciences (Calasanti, 2004) and key areas of study have been neglected (Carney, 2018). Scholars have explored barriers which may have constrained gerontological work including the field's youthfulness and grounding in helping professions; difficulty asserting social explanations of aging; discomfort

engaging with the old woman's body; penalization of feminist approaches; neglect of age within feminism itself; and granting of predominance to binaried conceptual framings of an ageless third age or an unwanted, dependent fourth age (Higgs & Gilleard, 2021).

Western gerontologists have predominantly been young in age themselves, with few having adequate years lived to claim experiential knowledge of old age (Carney & Gray, 2015) or personal ownership of a third or fourth age (Twigg, 2004). This has made it difficult or inauthentic for them to critique their own aging experience or internalized stereotypes. For example, there have been numerous studies on aging using participants with a chronological age range between age 50-70, arguably more mid-life, and a persistent exclusion of those who are in advanced years (Twigg 2004). This has raised concern that relatively young researchers may blindly hold assumptions that those living in advanced years may have little meaningful to contribute.

In addition, many have come to the field of gerontology from medical or legal professional backgrounds in which their exposure to older adults has been limited to those in need of help (Twigg, 2004). Both of these factors have likely influenced the nature of research questions and designs that have been constructed within the field.

Gerontology has primarily viewed aging through the theoretical lens of a third and fourth age (Pickard, 2019). This has left little conceptual room for possibilities of a co-existence of good and bad or gain and loss, let alone space for considering growth or potential (Carney & Gray 2015). This position has been seen in gerontological research on frailty, which has been (1) focused on how so-called age-related diseases impact life expectancy (Carney, 2018), and (2) presented with distant, objective discourse about 'them', a wholly separate and different category of being (Twigg, 2004). Carney and Gray (2015) have provided a reminder that:

> Expert knowledge around ageing both reflects and creates wider social practices, institutional structures, and narratives. This raises the concern that, in effect, gerontological experts were unconsciously contributing to the construction of an 'elderly mystique'. (p. 125)

That is, they have been constrained by stereotypes, contributed to their validation and perpetuation (Carney & Gray, 2015; Freixas et al., 2012), and uncompelled to interrogate or counter these stereotypes or explore a potentiating reality (Freixas et al., 2012). The result has been that the diversity of the older population has been inadequately addressed (Carney, 2018).

Critical feminist gerontology has emerged in recognition that gender and age have often been taken for granted as important parts of research, though their study has lacked a critical or feminist view (Calasanti, 2004). Very few studies have considered the significance and consequences of differences in socialization, life options, and experiences between old women and men (Freixas, 1977, in Freixas et al., 2012). Those that do, have struggled to assert their explanations of a social, rather than a physiological, basis for understanding old age within a culture which grants privilege and dominance to the biomedical position (Twigg, 2004).

Concurrently and paradoxically, there has been a discomfort in gerontology with engaging with the body due to concerns that such an emphasis may be perceived as demeaning to older people. In particular, a focus on the body of old women has been seen as doubly deplorable, in recognition of the long history of misogyny by which women have been denigrated by reduction of their person to bodily characteristics (Twigg, 2004). This concern has extended to *feminist* reluctance to engage with the ageing body. However, the resulting silence on bodily issues of aging, has no doubt contributed to the allowance, strengthening, and dependence on hegemonic biomedical bodily explanations. Perhaps this discomfort with

addressing the body in critical gerontology and critical feminist gerontology has contributed to the lack of focus on health issues in this approach.

Conclusion

In summary, no works had been found in the literature review which directly focused on systemic social influences on health or frailty risk. This has indicated that feminist scholarship on detrimental health effects of ageism on old women remains lacking. Such understandings would enrich the critical feminist gerontology field by illuminating key contributors to women's health inequity and new opportunities for collaborative actions (Holstein, 2018). A critical feminist gerontology approach brought to my study the ability to expand and deepen knowledge of the phenomenon of interest in as-of-yet unexplored ways, orient gerontological nursing in new directions, and contribute to development of critical feminist gerontology in ways that narrow gaps in the field.

Chapter Three: Methodology, Methods, and Techniques

Gaps in research inquiries and epistemological approaches to examining potential associations between gendered ageism and frailty risk have limited existing understandings and usefulness for the nursing discipline, NP practice and, most importantly, 'old' women's healthcare. An expansion of knowledge about this phenomenon has been needed to support nursing's mandate to optimize health from a holistic perspective and address related health inequities. Such gaps have served to justify a need for my study which has aimed to describe and interpret relevant themes and patterns, subjective or experiential elements, links between elements and a broader context, and meaning and implications for NP practice (Thorne, 2016). In this Chapter, I define my study's foundational constructs and review my theoretical lens of critical feminist gerontology. An appropriate methodological approach to such a research effort has been Thorne's (2016) interpretive description (ID). In the sections below, I have described definitions, assumptions, and objectives of ID and the narrative-informed methods and techniques as used in my study. These include sampling, data collection, analysis, coding, interpretation, consultation with a referent group, presentation of results, trustworthiness, and ethical considerations.

Foundational Constructs

'Old' Women

In my study, I have used the term 'old' women to describe women with experience of living into later life and the population of interest. The term 'old' woman, as commonly understood, has signified oppression (Grenier & Hanley, 2007), contamination with negativity, avoidance in conversation (Freixas et al., 2012), and representation of a social imaginary in which women of advanced age likely find no reflection of themselves (Twigg, 2004).

Nonetheless, this term has intentionally been selected for use in my study this in an effort to reclaim and reframe these words as potentially representative of the experiential diversity of aging women. Study participants were asked in their interviews what language they preferred to represent their demographic, and they generally preferred this language.

Frailty

For my study, frailty has been conceived of as "a dynamic state affecting an individual who experiences losses in one or more domains of human functioning" (Gobbens et al., 2010b, p. 342) including physical, psychological, social (Gobbens et al., 2010b; 2010c), cognitive, (DeRoeck et al., 2018), and/or environmental (DeWitte et al., 2013a; De Witte et al., 2013b) "caused by the influence of a range of variables and which increases the risk of adverse outcomes" (Gobbens et al., 2010b, p. 342).

Gendered Ageism

Gendered ageism has been understood as a double jeopardy in the social context of patriarchal norms and preoccupation with youth (Barrett & Naiman-Sessions, 2016, in Krekula et al., 2018) which produces ideologies and systems of disadvantage for 'old' women (McMullin & Berger, 2006). Understandings of associations of gendered ageist disadvantage and health have been sparsely explored to date.

Theoretical Lens: Critical feminist gerontology

As introduced in Chapter 2, critical feminist gerontology has been used as the theoretical lens. Its perspective has extended critical gerontology to include common principles of feminist epistemology (Freixas et al., 2012). Critical gerontology has been conceived of as a social constructionist view of the study of aging which a) examines the extent to which aging experience is shaped by the interaction of cultural (Carney, 2018), social, political, and economic

factors (Freixas et al., 2012); b) seeks to recognize and expose hegemonic ideologies about aging (Estes, 2008); and c) examines the consequences of these assumptions on individual experiences of aging (Carney, 2018; Estes, 2008; Twigg, 2004). Principles of feminist epistemology have extended the study of aging in ways which a) "express concerns, raise issues, and gain insights that are not generally expressed, raised, or gained by male [or youth-inspired] epistemologies" (Crotty, 1998, p. 174); b) overcome and advance egalitarianism through systemic reorganization of privilege, reconceptualization of the ruling class to include the existence of gender and age hegemony (Pickard, 2014), and stimulation of profound changes in consciousness (Tong, 1995, in Crotty, 1998); c) recognize that because ageism and sexism have cumulative effects which inhibit freedom and potential of old women, the personal is political (Pickard, 2014) and shift the blame for the lower status of 'old' women from the individual onto the institutional and social norms which systemically disadvantage them (Carney & Gray, 2015); and d) take action on socially constructed meanings and values that derive from gender and age differences, constraints on women's free existence in old age, and consequences for the lives of old women individually and collectively (Freixas et al., 2012).

Methodology: ID as a Methodological Approach

Definition, Assumptions, and Objectives

ID has been developed as a qualitative approach for generating knowledge about phenomena for which deep, subjective, experiential, and contextual understanding have been lacking (Thorne, 2016). Quantitative approaches not informed by such understandings have risked rendering premature or misleading results (Thorne, 2016). Further, ID methodology has responded to the need to legitimize a reorientation of traditional qualitative approaches for greater relevance and impact for applied fields (Thorne, 2016). IDs design logic has required: a)

critical understanding of existing empirical knowledge and its influence on practice, and b) an extension of some of the rule structures of traditional qualitative standpoints and approaches to those which may be more relevant and logical for nursing as an applied discipline (Thorne, 2016). Notable for the phenomenon of interest in my study, knowledge to date has been largely informed by quantitative studies uninformed by qualitative understandings which may have not extended meaningfulness for potential practice responses.

ID has been developed for and grounded in shared assumptions and objectives with the nursing discipline, as discussed in greater detail in Chapter 1. Specifically, shared groundings have included use of diverse knowledge sources, review and critique of existing knowledge, development of new knowledge through dialectical frameworks of conceptualization and action. Knowledge has been assumed to be imperfect and in perpetual need of further understanding (Thorne, 2016) and have aligned with assumptions of narrative that every subjective account has an explicit interest or bias and that full access to all angles of vision cannot be achieved (Riessman, 2008). From such a perspective, knowledge development in ID and for nursing has been through shared themes particularized for individual clinical encounters (Risjord, 2010; Thorne, 2016). A key driver of ID and nursing has remained an imperative to problem-solve and take action for the benefit human health based on existing and developing understandings (Thorne, 2016).

As such, ID has defined an organizing logic for research inquiries generated from the field whereby researchers inductively develop understandings about complex, experiential, and clinical phenomena that would be optimally relevant and useful to the practice of nursing (Thorne, 2016). ID has offered a “theoretical scaffolding” (Thorne, 2016 p. 60) such that data analysis has not been guided by any explicit, pre-determined conceptual structure but rather has

emphasized the foregrounding and shaping of meaning and significance from its scholarly position within the nursing discipline (the assumptions and objectives of which were presented in Chapter 1). The methodological scaffolding has involved two elements including a literature review and a working out of what the researcher brings into the study (Thorne, 2016). ID has also offered a logical, credible sequence of intended intellectual and procedural activities expected through a research process. Using this methodology, researchers have sought to explore shared patterns, themes, and sources of variance, within subjective human experience, to understand what has been encountered in clinical practice in order to better inform the future healthcare of populations and individuals (Thorne). As Mottier (2005) has explained, ID has been "philosophically underpinned by the assumptions that there is no reality existing as an objective entity to be discovered, but rather the reality is more usefully understood as a social construction subjectively experienced…[and] approached using multiple angles of vision" (as cited in Thorne, p.55).

Location of Researcher

ID has explicitly recognized and capitalized on the instrumentalization of the researcher (Thorne, 2016). ID has assumed that researchers cannot be immune from influence and that integrity in the research process comes from the way in which this influence has been handled or exposed (Thorne, 2016). Further, ID has held that the prior understandings brought into the study by the researcher have served as a logical and useful resource (Thorne, 2016).

Throughout my research process, I have maintained regular reflexive documentation aligned with Thorne's (2016) ID. I have kept an electronic journal, in which I have noted, reflected on, and critically examined the substance, nature, and implications of personal, social, disciplinary, and empirical ideas as they have been developed and were generated in relation to

the phenomenon of interest. In the journal I also have recorded what was happening subjectively during my engagement in the research process. I have composed my own age autobiography for purposes of self-reflection and transparency for readers, some of which is included in the dissertation (See Appendix G). The aim of these strategies has been to: a) encourage reflexivity and transparency of the influence of such ideas through their acknowledgement; b) guide me to stay on track with the intended process; c) understand the implications of my role in data collection, analysis, and interpretation; and d) generate findings that were grounded in the data rather than preconceived understandings. The efforts to locate myself as researcher have assisted me in taking ownership over the potential meaning and impact of the outcomes that have been rendered as findings.

Methods and Techniques

Thorne (2016) has not formally prescribed sequential, circumscribed methods for conducting ID. Rather, she has described "conceptual maneuver[s]" (p. 38), an "operating logic" (p. 81), or an "organizing framework" (p. 81) which have encouraged and justified the application of a universe of available design techniques and procedures for an emergent research process, beyond their conventional contexts and rule structures. As such, researchers who have used ID have been 'informed' or 'inspired' by other established approaches.

Narrative Thematic Analysis

ID in my study has been informed by narrative approaches, with narrative as the data source and narrative techniques and procedures informing data collection and analysis, specifically drawing on Riessman's (2008) narrative thematic analysis. According to Riessman, narratives have recounted and reflected on contextually located events or ideas as shaped by their meaningfulness. Narratives may capture how identities have been constructed and deconstructed,

accepted and contested, and performed, which may be particularly key for the study of a phenomenon which may require disruptions of biographical expectations in order to develop new understandings. Narratives have been acknowledged as potentially strategic, functional, or purposeful in their use by an individual. They may have helped individuals to remember, argue, justify, persuade, engage, entertain, mislead, and/or mobilize an audience towards change. However, to be understood, personal constructions of identity must be meshed with a community of life stories. Further, identity and community groups may have constructed preferred narratives of experience to foster a sense of belonging and a shared call to action; for example, shared compelling stories of discrimination may ground a feminist resistance movement. Aligned with a narrative research process, my study has been designed to explore themes and patterns both within individual stories and across a group of critical feminist stories, and intended for the creation of meaning through collaborative revelations of researcher and audience.

Data Sources

The data source for this study has been critical feminist narratives on aging into later life as storied in published autobiographies and participant interviews. As Gubrium (1988) has stated "The ideal informants for an interpretive description study might well be those 'everyday philosophers' within the population who have a particular affinity for observing and thinking about the situations within which they find themselves rather than simply living them" (in Thorne, 2016, p. 100). For this reason, I have sought self-identified critical feminist narratives with the assumption that their efforts towards conscious and critical awareness may have escalated sensitivity and access to what, otherwise, may have been implicit experiences; for example, experiences of gendered ageism risk having been so normalized as to be subconsciously internalized.

Sampling

Published Autobiographies.

A literature search was designed in consultation with the University of Victoria, School of Nursing librarian to locate sources of critical feminist age autobiography. The databases AgeLine, CINAHL, Conferences First, Google Scholar, Papers First, Proceedings First, PsycInfo, Sociological Abstracts, Women's Studies International, and WorldCAT were searched using the search terms and boolean operators: feminis* AND (autobiograph* OR biograph* OR story OR narrative OR life history) AND (age* OR aging). Limiters included English language and publication date from 1980 to present. Reference lists of included sources were also searched for further results. As per the ID approach, the literature search was purposively and intentionally not comprehensive or systematic.

Inclusion criteria had required that the source be: autobiographical; focused on or inclusive of the topic of aging into later life; inclusive of some reference to any of the multiple domains of frailty; and narrated by someone who had identified as woman, critical feminist, experienced with aging in the sociocultural context of North America or Europe; and in the chronological age cohort of 65 years of age or older at the time of publication. The effort to delineate an age group, which could itself be construed as ageist, has been justified by recognition of how different cohorts or generations may be differentially aged by the society and culture of their time (Gullette, 2008), and in light of my aim to understand the experiences of old women today, specifying an age limit seemed reasonable. Exclusion criteria were comprised of narratives which contained: no autobiographical components or threads; no focus or content on aging or domains of frailty; no author identifying as a woman, a critical feminist, having

experienced aging within a North American or European sociocultural context, or having been within the target age cohort at the time of publication.

Interview Participants.

Snowball sampling technique was used to engage study participants for interviews (Polit & Beck, 2017). Potential study participants had needed to meet the same inclusion/exclusion criteria as delineated above for the literature search, with age identity determined at the time of the interview. The snowball sampling process began by emailing a request to University of Victoria School of Nursing faculty (whose areas of interest overlapped with this project) and critical feminist gerontology scholars (known through the public domain) to send a recruitment invitational script (Appendix C) to contacts who they had thought might potentially meet the inclusion criteria. This was the extent of the involvement of these academics. Invitees who were interested in receiving further information about participating in the study contacted me directly via my email address which had been included in the recruitment email. Their agreement or refusal to participate in the study had remained private from the referring person.

I then responded to requests for further information or involvement by sending them the information letter and consent form (Appendix D) via the email address they had used to contact me. I had allowed them time to review the materials and had responded to any questions they may have had via email or telephone based on their preference. This snowball sampling method has been well-aligned with the ID methodological approach (Thorne, 2016). It was feasible and eased establishing of trust in the researcher-participant relationship (Polit & Beck, 2017).

Sample Size

Samples of almost any size could have been appropriate for an ID study according to Thorne (2016). Engagement with a small sample was both appropriate and valuable for my

phenomenon of interest as it was common and in need of in-depth exploration of its subjectively experienced nature. A small study was deemed feasible for myself as a novice investigator while still capable of generating original findings.

Published autobiographies.

Sample size for autobiographers had depended on the literature available. Based on preliminary searches, it had appeared limited and, therefore, deemed manageable to include all materials found.

The literature search rendered 1340 results (Table 1) with 239 duplicates recognized and removed by the Covidence program, reducing the preliminary results to 1101. The subsequent title and author review identified 7 more duplicates, 1021 did not meet inclusion criteria, leaving 73 results for abstract or full-text review, of which only 5 results met inclusion criteria. One of these results, “Straight from the Heart” by Lamm (2020), was excluded as it could not be found despite an array of searches by myself and the librarian. Therefore, the initial results from the primary literature search was 4: Copper (1997), Gallop (2019), Juhasz (2017), and Kunin (2018). A search and review of their reference lists rendered 1 more result: MacDonald in MacDonald & Rich (2001).

In my endeavor to include a range of logically connected literature (Thorne, 2016), I also reviewed the reference lists of primary search results that led to 8 more sources: Bell (2012), Friedan (2006), Grumbach (1991), Heilbrun, (2006), Millett (2001), Segal (2013), Paley in Sewell (2004), and Steinem (2006). Thus, the total number of autobiographical sources for inclusion was 13.

Interviews. A sample size of 10 study participants, plus or minus 3, had been anticipated. Interviewee recruitment had resulted in 13 respondents. After they were provided with more

detailed information and had their questions answered, one respondent chose not to participate and twelve respondents decided to participate and were included in the study as interviewees.

Situating Participants

Autobiographers.

Autobiographical narratives had varied in their intentions and, as such, the demographic details offered in their stories could not be assumed to be of relevance to the topic of my study. As such, I have chosen to include only demographic details which interviewees had self-identified as potentially relevant to the topic of study (see Table 2). The frailty scores of the autobiographers were also not possible to glean from their texts and often they told of shifting health status over the course of their stories.

Interviewees.

The interviewees were intentionally not asked about their specific demographic details. Instead, demographics were gathered from what they spontaneously included in narratives or in responses to one particular question near the end of the interview when I asked if they had any context which they felt would be important to add to orient or enrich understandings of their perspectives. In this way, the demographic or contextual factors deemed relevant to the topic were self-identified by the participants (see Table 3), and not by myself as the researcher.

All interview participants had completed the Comprehensive Frailty Assessment Instrument-Plus (CFAI-Plus) (DeRoeck et al, 2018), the operationalization of the integral frailty model used in this study, to provide the context of interviewee frailty status to their narrative data (see Table 4) and inform them of the conception of frailty used in my study. Their scores were not collected or used as data. The range of their overall frailty scores was from 0.09 (no-low) to 0.58 (high). Mean score was 0.25 (mild) and median score was 0.28 (mild). By domain,

the mean frailty scores were as follows: physical domain (7.1, mild), psychological domain (5.5 mild), social domain (6.7, no-low), cognitive domain (4.3, no-low), and environmental domain (1.7, no-low). None of the participants had self-identified as frail. All had identified as living independently, though two had received some support.

Data Collection

Autobiographies.

The included literature sources were read between March 2022 and January 2023. The works were analyzed for contextual features and storied content relating to the phenomenon of gendered ageism and frailty. The stories were not exclusively about their own experiences, but often authors included their understandings or imaginings of the experiences of other women they've known, women in general, or women at various intersections of privilege and oppression. From each reading, textual data were flagged and, later, transcribed into a document form amenable for upload to Nvivo™.

Interviews.

Interviewees had engaged in in-depth, semi-structured, narrative interviews between March 2022 and July 2022 with one follow up interview for review and clarification of their story in November 2022. The length and schedule of the interview was based on the depth, detail, and complexity of each participant's story along with their preferred schedule. The format of the interview was varied based on each interviewee's preference and geographical location. Options had included the preferred naturalistic setting of the participant, a pre-booked private room at the University of Victoria, or the university's secure version of Zoom, a secure web-based conference technology. Ten participants had preferred a virtual interview format and 2 had preferred an in-person interview format. For the in-person interviews, I had informed my

supervisors of the times and locations, and checked in once finished, as safety measures. At the first interview of each participant, I had consistently introduced myself by identifying my name, location as researcher, and disciplinary affiliation. I clarified that I was not speaking with them as a healthcare provider offering services, but as a nursing PhD student researcher, inquirer and learner in the context of the interview process.

Interviewees were asked to first complete a subjective multi-domain frailty scale, the Comprehensive Frailty Assessment Instrument-Plus (CFAI-Plus) (Appendix A; De Roeck et al., 2018; De Witte et al., 2013b). The CFAI-Plus self-assessment had oriented the interviewees to the conceptualization of multidomain frailty being used for the study and provided context for the interpretation phase.

I had included interview questions for collaboration with the interviewee. Anticipated questions have included: What has been your experience of completing the frailty tool? What has been your perception of frailty risk in relation to your own life? What has been your experience with the frailty risk factors that are represented in the tool? How have you perceived of gendered ageism in society over your lifetime? How have you perceived of gendered ageism in the health domain over your lifetime? How have you experienced gendered ageism personally, over your lifetime, if at all? How have you perceived that these relate to frailty risk, if at all, over your lifetime? How have these perceptions and experiences related to frailty risk changed, if at all, as you've aged into later life? Have there been key moments or turning points during which you have perceived or experienced a shift in the relationship, if any, between gendered ageism and your frailty risk? What forms of gendered ageism have you perceived to be most significant in terms of their relationship, if any, to frailty risk? How have you perceived your critical feminist perspective to have influenced the relationship, if any, between gendered ageism and frailty risk

in your own life? How, without that perspective, would you imagine you might have perceived or experienced the relationship, if any, differently? How have you preferred to be addressed in terms of your gendered age group? In interviews I avoided directive questions and centered on the flow of talk of the interviewee, allowing participants to author their own narrative inquiry on the topic (Holloway & Freshwater, 2007).

As Riessman (2008) has suggested for the researcher, I took care to focus the questions on drawing out more depth and detail or responded to the larger data set, suspended the idea that any idea was ever complete by using 'hmmm' or 'say more', avoided judgment statements such as 'I agree' or 'I understand', and posed only a small number of questions. Their personal narratives further evolved and were framed over the course of the interview through conversational collaboration. We jointly constructed narrative accounts of some events, experiences, ideas, and meaning (Riessman, 2008); processes consistent with the intentions of concurrent data collection and analysis (Riessman, 2008). The stories were not exclusively about their own experiences, but included their understandings or imaginings of other women they've known, women in general, or women at various intersections of privilege and oppression. Interviews concluded with a summary of the key themes that I had heard and would reflect upon (Thorne, 2016).

All interviews were audio-recorded, with permission from the interviewees. Each recording was transcribed verbatim by myself within a few days of the interview. Transcriptions had included my presence in the conversation (Riessman, 2008). I then 'cleaned' the transcribed data within one week; that is, it was cleared of dysfluencies, breakoffs, and interview utterances to improve the readability of spoken language (Riessman, 2008). The cleaned transcriptions were

uploaded to NVivo, a data management and organization system software provided and supported by the University of Victoria for student and novice users.

These 'cleaned up' stories were taken back to each interviewee at the follow-up meeting for their reflection and review, elaboration or clarification of areas which I identified as sparse, unclear, or misrepresented (Thorne, 2016). These follow-up interviews were also audio-recorded, transcribed, cleaned, and uploaded.

Data collection, analysis and interpretation had proceeded strategically and iteratively over the period March 2022 to February 2024. Throughout, I had maintained an electronic journal of my process and ideas which I have referenced multiple times for orientation, organization, and reflection.

Analysis

Data analysis had proceeded concurrently with collection, consistent with the assumption that seeking knowledge about socially constructed aspects of reality "must be inductively generated from the data and developed within the context of the data" (Thorne, 2016, p. 109). As Thorne has suggested, the analytic process required strategic engagement and interaction with the data to explore and expand on conceptualizations of different manifestations of the constructions that begin to form upon entering the research field. I had ventured to enter the data collection and analytic process as open-mindedly as possible and employed self-reflection to improve conscious awareness of my hard-wiring or prior knowledge and avoid defaulting to these as orientations for the inquiry. Instead, I had assumed that pre-existing theory and knowledge, though valuable, represented only a partial understanding and I, instead, sought novel and different understandings.

ID had provided some analytical guidance (Thorne, 2016). The initial interaction with the data had allowed time to consider and reflect on what attracted me in the stories, how I reacted, and sensitized me to patterns which fit prototypical or were contrasting accounts. With time, I had developed an extended understanding, a sense of the whole, and explored how strands of data might variously fit together. Through this process, patterned or thematic insights and sources of variance were iteratively generated.

Narrative thematic analysis (Riessman, 2008) also informed some aspects of the analytic process. For the purposes of this study, 'narrative' included stories of the phenomenon which unfolded over the course of whole single written works or interviews. Reissman's (2008) narrative thematic analysis guided my ID analytic process in multiple ways. First, the content of the narrative was the exclusive focus, with scarce attention paid to the how, why, or for whom the narrative was told. Even so, I have hinted at complexities of language choices or metaphors when deemed useful. Second, detail contained in long sequences of narrative had been preserved and accumulated to capture a broader picture of the individual narrative. Third, the holistic sequential and structural features of narrative have been preserved, rather than fragmenting stories into non-sequential segments. Fourth, narrative accounts have been contextualized temporally, spatially, and historically.

Concordantly, one story at a time, I had organized accounts chronologically and identified acts, episodes, instances, or turning points in relation to the phenomenon of interest. I had read and re-read all of the interviews and autobiographies, reflecting on each as a whole. My first intention was to absorb the content of each personal story as an original perspective, and not in terms of how it may have served my own inquiry. I had wanted to ground my understandings more broadly in what study participants had wanted to convey. The narratives were then re-read

for perspectives, experiences, key moments, or metaphors which spoke to the phenomenon of interest. I initially wrote annotations on sections of text to capture the broad subject of its content, for example, ‘Perception of gendered ageism’ or ‘Association with physical frailty risk’, or ‘Sexism impacting women in old age’. As these broad topical annotations grew, patterns of commonalities and variances across narratives were understood and situated in relation to the research question of interest.

Coding

Coding was an inductive process in which different angles of gaze upon the whole and complicated collection of data were experimented with and appreciated, having considered the implications of each for handling, grouping, and reconstructing patterns (Thorne, 2016). Informed by narrative analysis (Riessman, 2008) and ID (Thorne, 2016), each story had initially been considered as a whole unit, with attention to avoid its fragmentation. Early coding was set up as broad ‘nodes’, as codes are called in NVivo, representative of commonalities with wide inclusion and space for recognition of distinctions and overlaps amongst data to gain clarity. This early process had continued until meaningful representations of thematic or patterned groupings and descriptors based on the evolving whole began to form and implications of these were sensed. Once far down this analytic path, the initial codes were narrowed down. This tempered process and holistic view had avoided potential errors of attempting to code too early (Thorne, 2016).

I inductively generated particular nodes based on what the narrative content conveyed to me about the phenomenon of interest. As I had organized sections of data into nodes, I had kept intact the longer sequences of narrative in the database, to include the context, sequence and structure of the broader story. Each particular node was then organized under its corresponding

broad node or commonality as a sub-node. For example, a section of data assigned a particular node of 'Assumptions of old women as complaintive meant that health concern was not taken seriously by provider' had been moved under the broad, commonality node of 'Healthcare inequity'. Layerings of nodes and sub-nodes were generated which then needed refinement. I had continued to regenerate and reorganize nodes iteratively over months, strategically interacting with the data to explore different manifestations, distinctions and overlaps, contrasting stories and sources of variance. Eventually, I had gained enough clarity to generate nodes and sub-nodes representative of themes.

Interpretation

The objective of my ID interpretation has been to "map the contours" (Thorne, 2016, p. 56) of a description and interpretation of the associations of gendered ageism and frailty in ways which reconfigure and extend how it has been customarily viewed by empirical findings and theorizations. The process has required me to use the intact stories of autobiographers and interviewees, context in which their stories have been embedded, and interpretive accounts I have developed from my own location. The interpretation had tilted the angles of vision and area of focus to align with the phenomenon of interest, which at times has been only indirectly addressed by the narrative accounts, particularly in reference to the autobiographers. Thus, I have created a story about stories by having selected particular narrative sections to illustrate common themes, patterns or variations (Riessman, 2008).

The data collection, analysis, and interpretation process had not been linear. Continuous reflexivity throughout the process had illuminated some of my disorientations and developed my ability to tilt the angles of vision toward my research intention (Reissman, 2008). For instance, I had realized the need to elevate conscious awareness of my focus on the research question,

openness to potential negative associations within the phenomena, and grounding in participant voices rather than pre-existing defaults. Repeated readings, reflections, organizations, and understandings of the data have been required.

The Thoughtful Practitioner Test

A 'thoughtful practitioner test' (Thorne, 2016) was organized after patterns and variances had been generated from the data collection, analysis, and interpretation process. NPs with more than five years clinical experience working in either seniors health specialty services and/or in primary care with a significant proportion of clients who are old women were recruited. As per ID (Thorne, 2016), NP experts were seen as potential 'collateral' information sources, beyond the reach of most other qualitative research designs. For example, if several interviewee and autobiographical narratives had been read, all from one perspective, the findings of common themes could have seemed quite convincing. However, testing those observations against a thoughtful, experienced practitioner group could reveal aspects of the data or interpretations which had not resonated with what is commonly seen in patient encounters and, thereby, may have illuminated relevant variances or analytic errors (Thorne, 2016). On the other hand, should the data and interpretations have aligned with the perspective of experienced practitioners, the generated findings may be strengthened. The content of the NP focus group discussion was not viewed as a way of contesting or countering of my own interpretations, but rather was a means to provide: a) diversity beyond what I had seen, b) stimulation and challenge of my interpretations, c) a point of triangulation for enhancement of trustworthiness by potentially highlighting limits of the research design, analytic errors, interpretive blind spots or misinterpretations, and d) a test of the resonance and usefulness of the interpretations for the intended audience of NPs (Thorne,

2016). This collateral information was not included as formal data in that it was neither analyzed nor viewed with the same critical reflection given to the data sources.

Recruitment.

NP thoughtful practitioner test members were recruited via the distribution of a recruitment letter (Appendix F) via email by two organizations to their members: the Island Health Nurse Practitioner Community of Practice (IH NP CoP) and the Nurses and Nurse Practitioners of British Columbia (NNPBC). Members who had wished to participate or receive more information were asked to contact me directly via email which was included in the recruitment email. Recruitment resulted in expressions of interest from seven NP's. Of these, four NP's had found it feasible to attend a session. Their areas of clinical NP practice had included two in Home and Community Care, one in complex care, and one in primary care. All NPs identified as working predominantly with persons of old age.

Participation had involved attendance at one 60-minute focus group. Focus groups were held via a secure Zoom link, in order to accommodate attendance from potentially diverse locations across the island or province. Attendance at the session had served as implied consent. Attendees had been presented with my emerging interpretations (i.e. preliminary themes and subthemes) and asked to discuss them based on their practice experience. The following questions were anticipated and asked: Do these resonate with what you have seen in your practice? What challenges to the data or interpretations would you put forward? What variances do you see in your practice? What might be missing or misleading? How might these ideas be useful in shifting practice? I had taken notes, recorded, and transcribed the sessions for my own review. Members' names and contact information had been stored in my locked electronic files

separate from the scripts and notes of the discussion. Upon completion of the study, all files had been destroyed.

As explained earlier, the NP focus group discussion was not used as formal data. As such, no quotes or identifying information have been used in the presentation of findings. Because no ethics review was required for this part of the research process, I have described below the ethical considerations I attended to in conducting the 'thoughtful practitioner test'. Participation was entirely voluntary. Those contacted were free to refuse and no inducements to participate were offered. A token of appreciation of less than $20 in value was given to participants at the completion of the group. There were no anticipated power-over relationship, however, the NP world is small, and some participants were known colleagues. There were no anticipated risks, though it had required a commitment of time. Members may have benefitted from enrichment of their professional development requirements and sensitization to the phenomenon of study.

The identity of the NP members was known by me. NP members were not identified or named to others in the focus group and their use of the camera was voluntary. However, indirect identifiability may have occurred since a member may have been recognizable to other NPs in attendance due to voice, appearance, and membership in the British Columbia NP community. No identifying information has been revealed in any presentation of the study.

The conversations were held in July 2023. There was consensus amongst the NPs that all the themes resonated as clinically present and relevant. One sub-theme that resonated more strongly than the others was 'inequities in healthcare'. Discussion of this sub-theme had brought up conversation about the potential stigmatization of gerontological nursing as an area of practice; inequitable and inadequate knowledge base informing healthcare for old women, particularly in terms of age-related change; and heavy assumptions of old women as vulnerable

and requiring intervention. Women's undermined self-confidence in health was viewed by the NPs as a potentially novel area worth exploring for meaningful practice change. They had readily connected with ideas of female gender as a social determinant of health and assumptions of frailty for old women.

NPs were also asked to discuss which results challenged their understanding. They challenged my use of the term 'old women', as they had found it offensive and uncomfortable. Age-related inequity in healthcare had resonated strongly. They had initially questioned its gendered nature, but then proceeded to spontaneously generate examples, such as less evidence base and differing health responses to presentations of osteoporosis and cardiovascular disease for 'old' women. The gendered nature of ageism's association with isolation was also questioned, though again they spontaneously thought of exceptions, such as in terms of sexuality and confidence which were also viewed as gendered.

NPs reported to me that none of the results were misleading or missing. They suggested that the experiences of ageism may not be exclusive to old women, but may also exist for old men, just as sexism may also be experienced by young women. They had clarified the need to emphasize the gendered nature of the ageism risks within each theme when presenting the findings. They expressed interest in future research on the topic with a sample of women who are chronologically older and more frail than the participants in this study. Overall, I considered the consensus amongst the NPs in the thoughtful practitioner test of resonance and their minor challenges to the themes as strengthening the trustworthiness of the generated findings.

Trustworthiness

I have been committed to key qualitative research quality criteria including thoroughness and diligence, reflexivity and transparency, participant-driven inquiry and insightful

interpretation (Polit & Beck, 2017), all carefully recorded to provide an auditable path (Thorne, 2016). More particular to ID, the trustworthiness of this research project should be assessed from the perspective of the nursing discipline, its grounding epistemology, and its moral and pragmatic mandate (Riessman, 2008; Thorne, 1997). More specifically, its trustworthiness should be assessed with an understanding of its assumptions that: a) there is always more to be learned and understood; b) all knowledge is partial; c) subjective knowledge is socially constructed; d) the subjective voice is essential for understanding health phenomena in their wholeness and complexity; e) any generalizations are tenuous; f) there may be dominant patterns upon which action must be based, but one must always be seeking particularities or nuances of diversity which are essential considerations for nursing care of individuals (Thorne, 2016). I have striven to establish trustworthiness with its readers by articulating, as authentically and transparently as possible, the methodological path that has been maneuvered and the process of discernment as to what may or may not reasonably become understood about the phenomenon of inquiry so that readers may view the findings as sufficiently well-developed to warrant learning and consideration for practice (Thorne, 2016). I have presented how this ID study has been approached and how it has been intended for evaluation of trustworthiness in terms of data sources and sampling, as above, and data analysis and interpretation, as below.

Trustworthiness in the analysis and interpretation process had been strengthened by presenting rich contextualized findings to the reader such that they will be enabled to construct their own interpretive account or story of the generated findings (Riessman, 2008) and reach their own informed decision about the relevancy of the findings to their situation (Lincoln & Guba, 1985, in Polit & Beck, 2017). There has intentionally been no attempt to demonstrate confirmability by ensuring that two or more independent, objective people agree that the data's

interpretations had not been invented or influenced by my perspectives or biases (Polit & Beck, 2017).

Generated understandings of the study had been strengthened through use of triangulation amongst the different sources: published age autobiographies, narrative interviews, and consultation with experienced Nurse Practitioners. Should triangulation have shown congruency, generated findings would be strengthened, whereas should triangulation have shown incongruency, relevant variances would have been illuminated. Either way, the triangulation process has contributed to enrichment of the trustworthiness of the study and expanded understanding of the phenomenon.

Ethical Considerations

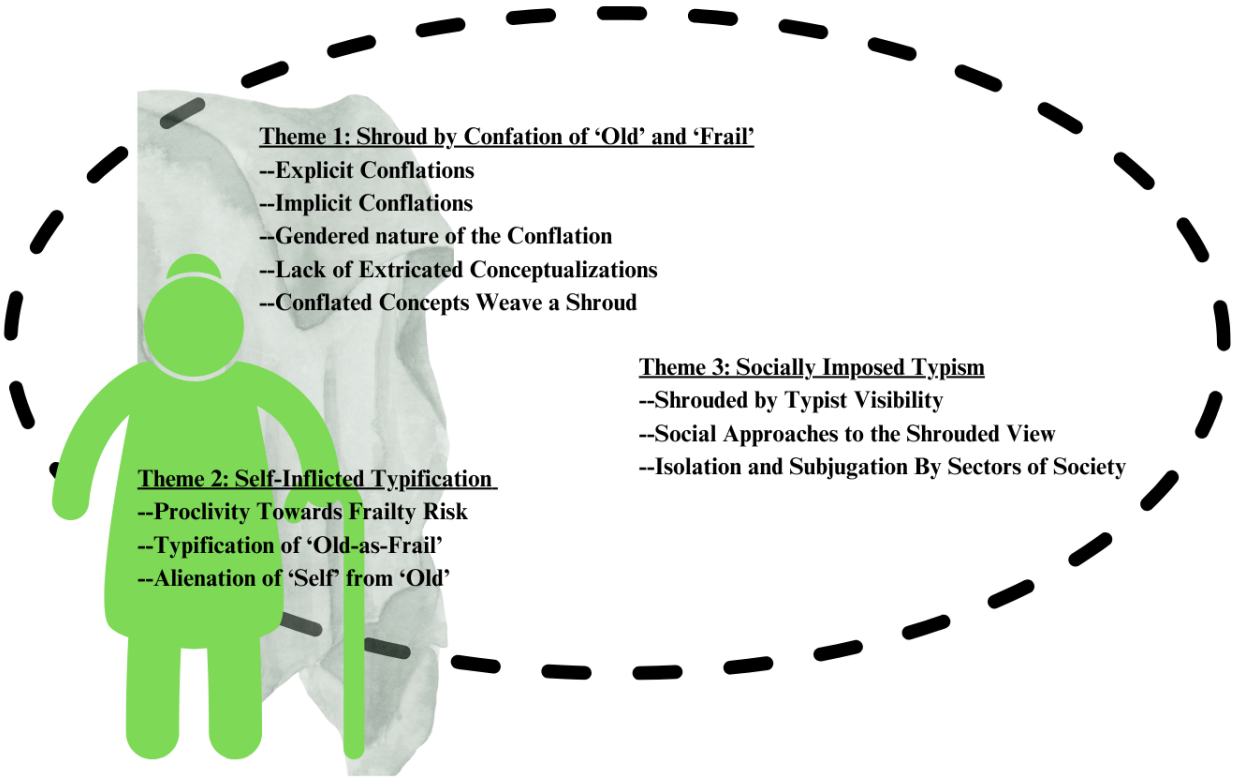
The research study had received ethics approval by the University of Victoria Human Research Ethics Board for the interviews. I have remained committed to the approved and consented-to scope, objectives and purpose of the study and have avoided diverting any product of research toward unsanctioned directions (Thorne, 2016). I have had no conflicts of interest to disclose.

Chapter Four: Generated Understandings

In Chapter 4 I have presented generated understandings of potential associations between perceptions and experiences of gendered ageism and multi-domain frailty risk for women. Three themes of understanding have been generated in relation to my research question: 1) shrouded by conceptual conflation of 'old' and 'frail'; 2) self-inflicted typification; and 3) socially-imposed typism. Each theme of generated understanding has been presented below with samples of exemplary participant narratives and its potential significance to the research question exploring the phenomenon.

Figure 1

Gendered Ageism's Associations with Frailty Risk for 'Old' Women



Theme One: Shrouded by Conflation of 'Old' and 'Frail'

"We were merging real issues of aging with ageist diseases of the imagination" [1]

Gendered ageist conceptualizations of 'old' women were commonly and potently understood by participants in terms of the language and concept of frailty, more particularly, the integral frailty model used in the study. To reiterate here, the integral frailty model has been conceived of as a multidimensional, "dynamic state affecting an individual who experiences losses in one or more domains of human functioning," separate from disease, comorbidity, disability, or age, and "caused by the influence of a range of variables and which increases the risk of adverse outcomes." (Gobbens et al., 2010b, p. 342) It has been operationalized as self-report measures of, in the physical domain: strength, nutrition, endurance, mobility, physical activity, balance, and sensory functions; in the psychological domain: mood, and coping; and in the social domain: social relations and social support (Gobbens et al., 2010c); inclusive of cognition (DeWitte et al., 2013); and immediate environment (Raphael et al., 1995), with an eye toward systemic factors.

Conceptions of 'old' women and integral frailty have been generated as conflated. I have used conflation to mean the "fusion of two concepts into a composite whole, by confusion or ingenuity" (Merriam-Webster, 2024) or the "combination of the features of two separate things" into one concept, "(intentionally), or in one's mind or thinking (unintentionally)" (Canadian Oxford Reference, 2005). These definitions have included understandings of both explicit and implicit processes, which may be distinctly significant in their associations with frailty risk. In this section, I have presented subthemes of (1) explicit conflation of 'old' and 'frail', (2) implicit conflation of 'old' and 'frail', (3) gendered nature of conflation, (4) lack of concepts of 'old' extricated from 'frail', and (5) conflated understandings have woven a shroud. For each subtheme, I have presented the generated understanding of the subtheme, samples of narrative

which exemplify it, and its significance to the research question of how gendered ageism and frailty risk may be associated for women.

Explicit Conflations

"I think…'old' is not as competent, not as capable, not as strong, not as sharp, not as…you know, things that have to do with decline, I'd say. Frail might be one of them" [2]

Participants have consistently storied explicit understandings of 'old' women using potent language of 'frailty', such that 'old' and 'frail' conjured the same conceptual imagining and lacked distinguishable features. I have used 'explicit' to mean, "fully revealed or expressed without vagueness, implication, or ambiguity**:** leaving no question as to meaning or intent" (Merriam-Webster, 2024). Interviewee participants, for example, understood the concept of 'old' women to mean:

> slow…slow to move and slow on the uptake. Maybe nothing more than that…Hansel and Gretel, you know…grandma's in bed for heaven's sake, and those are small children, I mean, this would be a grandmother in her prime time.

Another participant observed how literally "a lot of people see old women as frail". Likewise, autobiographer participant Friedan (2006) recalled how the 'old-as-frail' assumptions were held and perpetuated by a group of healthcare practitioners and researchers at a Harvard meeting: "Those experts on aging talk about 'them'-- the problems of those sick, helpless, senile, incontinent, childlike, dependent old people, all alone, or draining the finances of their families, a burden on the Social Security system and the hospitals" (p. 20). Further, Friedan has suggested a "focus on age solely as 'problem' or illness requiring 'care' as the crux of the mystique of inevitable decline" (p. 199). Similarly, autobiographer participant Segal (2013) has noted that signs of 'old' have become reproachable due to conflated associations with frailty:

> It is…those who cannot conceal their need for care, assistance and support who are seen as ageing badly, reinforcing notions of actual signs of ageing as indicative of seamless decline (p. 18) [due to] persisting cultural preconceptions insisting on their difficulties…and coupled with disability. (p. 65)

More particularly, I have wondered if such general conflation also existed more specifically within the particular frailty domains. From my analysis of stories from the women in this study, I heard a pervasive fusion of notions of 'old' and 'frail' as illustrated below.

In regard to the physical domain, 'old' and 'frail' for women have been commonly conceived of as comingled. For example, interviewee participants have shared descriptions of 'old' as, "The physical for sure…slowing down physically…That I'm feeble. I guess, it's the end of my independence, that I would be needing help", and "white, frail, bent over with a cane".

In the psychological domain, conceptions of 'old' as 'frail' have been perceived as merging. Interviewee participants have storied that, "You've heard it said, 'Oh, don't be such an old woman,' meaning don't be fussing, don't be nervous…unnecessarily, don't be…weak", and "fearful is another stereotype". Autobiographer participants have added that "The bias of the air we breathe is that…age is sad" (Steinem, 2006, p. xxi) and "You who are younger see us either as submissive and childlike or possessing some unidentified vague wisdom. As having more 'soul' than you or as being over emotional and slightly crazy" (MacDonald & Rich, 2001, p. 127).

Cognitively, conceptions of 'old' have been perceived by autobiographer participants as, at best, "highly conventional and becoming more so with the passing of years," (Heilbrun, 1997, p. 9). More troubling, Friedan (2006) has explored the reduction of 'wonder' to cognitive frailty when in reference to 'old' persons:

> The return of ‘wonder’ in old age is illustrated in ‘elder tales’ down through the ages, in all cultures, showing older people doing something apparently outrageous or foolish after years of being practical and predictable. This increase in ‘mythic awareness’ and ‘magical’ thinking in age was initially interpreted as regression--a senile reversion to childishness, the intellectual deterioration that was thought to be inevitable with old age. (p. 604-605)

More directly, Segal (2013) has oriented attention to the conflations of ‘old’ women with lacking or vilified thinking:

> The most frightening of images are implanted early on, along with language itself and all the affect-laden symbolic apparatus of fantasies, metaphor, condensation, accompanying our encounters with those witches of folktales, ghouls of horror movies, and the countless other versions of crones or dementing oldies, both male and--far more savagely--female. (p. 19)

In the environmental domain, more specifically in terms of social and economic power and status, autobiographer participant Copper (1997) has explored the conflations of ‘old’ women and diminished or distorted social power as, “The mythical prototypes of the Wicked Old Witch with unnatural powers, the Old Bad Mother with neurotic power needs, and the Little Old Lady, ludicrously powerless” (p. 14-15). Autobiographer participant Millett (2001) has shared her personal recognition of conflated assumptions of ‘old’ women as frail in the healthcare system as she advocated for her Mother:

> I hardly dare admit how scared I am…of Sal, Steven, the authorities at St. Anne's, the system, all the ‘grownups,’ all the big shots who talk about old people as if they were absent or objects or children, creatures rarely consulted over the decisions that govern

> their own lives. And I'm also part of the traitor generation, the managing bullies who have put Mother in this position. (p. 171)

Social frailty has also been conflated with ‘old’ women in participants’ stories. Autobiographer participant Copper (1997) abstracted her revelations about ‘old’ women’s frail social position after she witnessed a fairy tale being told to a class of school age children in which an old woman was blamed for the misfortunes of a young couple and then killed:

> I and other old women live with the social conditioning of that story in our lives, over and over again. Let me list some of the characteristics of the images which program people's responses to old women. The evil attributed to her is almost always gratuitous, without rational motivation. Care is taken to show that she is socially isolated, without friends even of her own kind. Not only is she ugly, but she causes ugliness in others—deformities, stupidities or criminal behavior. Her power to do evil is supernatural, unlike the strength or intelligence which others display in overcoming her. Above all the violent and often treacherous means of her defeat need no justification. (p. 61-62)

Interviewee participants have directly understood ‘old’ women as interchangeable with a frail social position as follows, “‘Little old lady’ is not someone to be taken seriously, kind of laughable, a bit pathetic” and “there's…the stereotype of the cranky old woman, and I think there's the stereotype of the cute old woman. ‘Isn’t she funny and doesn't she crack you up with what she does or what she says,’ which is a way of, sort of, socializing around her or over her without actually paying her any respect or attention.” Millett (2001), as an autobiographer participant, has spoken of her personal experience of how her children perceived and treated their Grandmother, her Mother:

> She has an authority both divine and funny for them, an exaggeration of that Mother I know at a daughter's closer range; for them the greater distance of yet another generation makes her something of a 'character,' harmless and sometimes amusing, never the devastating force she holds for me. (p. 10)

Further to the conflations of 'old' with particular domains of frailty, participants' narrations have oriented me to view 'old' as conflated with *multidomain* frailty, a key principle of the integral model constructed by Gobbens et al (2010c) as, "a combination of problems in different domains of human functioning…based on a holistic view of the person" (p. 340). An understanding of the inextricable nature of the concept of 'multidomain frailty' from 'old women' was storied by autobiographer participants Friedan (2006) as, "only…the *truly* helpless, dependent, sick, isolated, senile ones--are actually seen as 'old'" (p. 64-65) and Segal (2013) that "the idea of dependency has mutated into notions of psychological inadequacy, incapacity or ill health." (p. 65). Gallop (2019) agreed and has expanded that "There is…a wide swath where the categories of disability and aging bleed into each other" (p. 5).

The participants have perceived of themselves as being consciously aware of and resistant to the above *explicit* conceptual conflations of 'old-as-frail' for women in gendered ageist society. Though they have also expressed concern that less critically aware women may have been more vulnerable to the potential constraints arising from conflations of 'old' and 'frail'. This concern was exemplified by autobiographer participant Copper (1997):

> ageism is *not* the total experience of age for women. But only if we learn to recognize ageism--name it, resist it, refine our understanding of it, stop participating in it—only then can we separate growing old from the fog of ageism which diminishes us. (p. 4)

A lack of *explicit* critical awareness of conflation of 'old' and 'frail' has been understood as potentially *implicit* subconscious conflation, to which resistance may be less possible.

Implicit Conflations

"If I'm healthy, I'm not old. Am I?" [3]

I have noticed a strong pattern of seemingly implicit, uncritical conflations of 'old' as 'frail' in participants' narratives, despite their claims of being critically aware and actively resisting. Consequently, I have used 'implicit' here to mean, "present but not consciously held or recognized" (Merriam-Webster, 2024). The implicit, unconscious merging of 'old' and 'frail' have been particularly exemplified in the context of participants' personal attempts to reconcile their own subjective age with their health identities. As interviewee participants have explored, "I try not to identify as an old woman…as introverted or…cranky or don't want to learn anything", and "When my health is really poor, I am old. And that can change, that goes up and down." Autobiographer participant examples have included Kunin (2018) who, at age 85, has explored her own age identity amidst her implicit conflation of 'old-as-frail':

> Old age. The two words together shock me. Am I there yet? But I am not really old, not as old as she is, who needs help dressing, not as old as he is, rolling slowly past me in his wheelchair. I live independently. I don't need a walker. I can walk upstairs and down (okay, my knees hurt a little). I can hear (with the help of new hearing aids) and see (just reading glasses). I take pills, yes, but not that many. (p. 169)

Further, Millett (2001) has shared her Mother's distress at claiming 'old' as 'frail' for herself: "She will adjust to neither of these infirmities, hates the walker, was ashamed I should see it, warned me over the phone in a solemn voice that she was really old now" (p. 8).

Gendered Nature of the Conflations

"Weak, fragile and dependent--characteristics always attributed to the elderly and, not coincidentally, seen as prototypically 'feminine'." [4]

I have questioned and explored the extent of the gendered nature of the 'old-as-frail' conceptual conflation in participants' stories. Autobiographer participants were clear that assumptions of 'old-as-frail' were distinctly gendered experiences for women, grounded in sexism. Segal (2013) has captured that, "Many of the experiences and emotions of old age have been associated with the feminine all along; from its apparent fragilities and frequent humiliations to the laborious work of caring for those in need" (p. 26). Steinem (2006) has highlighted that women have received a "big dose of the feminine role" (p. 14) over their lifetimes which, as Copper (1997) has understood, may groom women to have frailty as their "negative default assumption…[their] toggle switch set to off to so many possibilities…preset to a constrained identity" (p. 53). Millett (2001) has reflected: "How I hate our vulnerability, our femininity and frailty" (p. 7). Further, Gallop's (2019) critique has expanded the conflation of 'femme' and 'old' to potentially include 'disabled' as a particularly potent discriminatory intersection and raised a question for me about the relationship of frailty to disability in terms of marginalizing intersections. It was these stories which have underpinned my understanding and assertion of conflation of 'old-as-frail' as gendered to the disadvantage of women.

Lack of Extricated Conceptualizations

"I want to be able to claim 'I am old and there's nothing wrong with that'." [5]

Overall, participants have perceived that an 'old-as-frail' conflation burdens women who are perceived as 'old' with assumptions of 'frailty', regardless of how they identify personally. I wondered whether participants had alternative ways of thinking about aging whereby women could claim an 'old' identity without 'frailty'. The most common alternative understanding has

been to deny 'old' by 'passing-as-young'. Autobiographer participant Segal (2013) has described an either 'old-as-frail' or 'passing-as-young' conceptions as "standard binary logic: stories of progress and stories of decline; of aging well and aging badly" (p. 17). An interviewee participant has described 'passing-as-young' as:

> It's like, if you're not feeble, aren't you great! You're superb suddenly! It's not like it would be taken for granted. If you're not frail…you're an exception and you're a great example, you're just special or something, but you're *not* just a regular 79-and-a-half-year-old person who just does a regular things.

Another alternative was to claim 'old', but in conjunction with qualifying language to counter the default assumptions of 'frail'. Interviewee participants gave examples of using such qualifiers as "vigorous old" or "functioning old". Another has explained:

> 'I'm eighty-two *but* I'm healthy,' as if you couldn't be eighty-two *and* healthy. Like, you don't say 'I'm sixty-four and healthy,' you just say 'I'm sixty-four.' And, so, I think that is a…very strong idea that there just isn't a language to talk about aging other than to almost correct the first impression.

As autobiographer participant Copper (1997) has narrated: "'Old' is never used authentically, even by the eighty year old" (p. 64) and she asked, "If I didn't want to accept [the frail] definition, how was I to speak of myself?" (p. 75). Also, autobiographer participant Paley (in Sewell, 2004) questioned, "What lady? Old?...my mirror seems to have reflected—correctly--a woman getting older, not a woman old" (p. 113).

For these 'old' women, current concepts and language have not captured the authenticity of their experience. In the words of interviewee participants, "things happen as you get older. You're not quite as bright and good as you were when you were younger….you're not the same,

but that doesn't necessarily mean that you're frail". Autobiographer participant Heilbrun (2006) has emphasized how old women "continue to find life precious, though disabilities accumulate" (p. 8). However, no conceptual language has been generated which could reconcile the concept or identity of 'old' and 'well' for women, despite this being how most participants have identified themselves.

Conflated Concepts Weave a Shroud

The image of age as inevitable decline and deterioration, I realized, was also a mystique of sorts, but one emanating not an aura of desirability, but a miasma of dread. I asked myself how this dread of age fitted or distorted reality. [6]

Earlier I have asserted that conflation of 'old-as-frail' has been both gendered and disadvantageous for women. Here, I have examined further the threat of frailty risk for 'old' women, personally and collectively. Conflated conceptualization of 'old-as-frail' has created a dense discriminatory shroud. I have selected the metaphor of 'shroud' intentionally as it conveyed "to cover or envelope so as to conceal [or obscure] from view" (Oxford dictionary online, retrieved August 24, 2024), to "put on a dead body for burial", and "to clothe, cover, protect" (etymonline.com/word/shroud Retrieved August 24, 2024). As a metaphor, the concept of 'shroud' captured the ideas that it has been imposed by others, applied to conceal, justified patronizingly as 'protection', and associated with death. Such shrouding has potentially groomed and constrained 'old' women into positions associated with frailty risk through self-infliction, generated in Theme #2, and social-imposition, generated in Theme #3.

As autobiographer participant MacDonald (MacDonald & Rich, 2001) has warned, old women may need to:

…let ourselves feel and experience our own aging now, so that we know some of its

> realities from our gut before we are deluged with the messages from the market place….At 69…I have had to learn ways of reacting to all the negative messages around me in order to survive. (pp. 90-91)

Similarly, the chief concern of autobiographer participant Segal (2013) has been:

> the stories we tell ourselves given the strange or bewildering predicament of not really knowing how to *be* our age, as we age. The confusion remains, even when we attempt, usually belatedly, to tackle the noxious flow of prejudice and inner fears most of us face in old age. (pp. 150-151)

Thus, these conflations, or messages (Segal) and mystiques (Friedan), have been understood as burdening women with a shroud of 'old-as-frail', so heavy that 'old' women themselves are pressured into its 'frail' forming (Theme 2) and so dense that others can no longer see through it to their full and diverse personhood underneath (Theme 3).

Theme Two: Self-Inflicted Typification

"Most would agree that the ageism is not the total experience of age for women. But only if we learn to recognize ageism—name it, resist it, refine our understanding of it, stop participating in it—only then can we separate growing old from the fog of ageism which diminishes us"[7]

The second generated theme of association between gendered ageism and frailty risk has been that conflated understandings of 'old-as-frail' have groomed women to have a proclivity towards frailty across domains. Such proclivities often led to self-inflicted constraints of health potentials, negative outcomes, and escalated typification. These key concepts of proclivity and typification have been explained in further detail below.

Proclivity has been used to describe "a strong inherent inclination toward something objectionable" (Merriam-Webster, 2024). As stated earlier, conflated understandings of 'old-as-frail' have inclined participants towards assuming and behaving as frail across domains. The pervasive stories of 'old-as-frail' were internalized by some participants with negative consequences. Autobiographer participant Copper (1997) has experienced such proclivities as "false assumptions about aging ingrained in my own psyche" (p. 3), as has Steinem (2006) "There is no such thing as being individually free in the face of collective bias" (p. 13). Such proclivities may potentially have particularly instilled low expectations and undermined self-confidence in relation to participants' perceptions and judgements about their own health and risks. Autobiographer participants, such as Copper, have storied that, "The irrational loathing and terror of female aging casts a long shadow, influencing the choices of women of all ages" (p. 55), and Bell (2012) conceived of old women continuing to be "bound by the need for approval--conforming to external models of how we should look, behave, be in the world" (p. 351).

On interpreting such stories in relation to the research question at hand, I have understood how proclivities toward frailty may have disoriented and misinformed old women into 'choices' which *typify* frailty risk. Typification has meant "to embody the essential or salient characteristics of" (Retrieved June 7, 2024, from https://www.merriam-webster.com/dictionary/typify**).** In this second theme, I have described proclivity and typification as potentially new and evocative ways to understand the phenomenon under study. Specifically, I have presented an understanding of: (1) 'proclivity towards frailty risk' generated from participant stories, followed by an introduction to: (2) a 'typification of 'old-as-frail' and (3) an alienation of 'self' from 'old', as core concepts in Theme 2.

Proclivity Towards Frailty Risk

"The old woman finds herself captured by stereotypes."[8]

Gendered ageist conflations of 'old-as-frail' have prepared the grounding for disoriented understandings of and undermined responses to women's own health by instilling proclivity towards decline and risk. The proclivity to 'old-as-frail' was not perceived of as inherent in 'old' women, but rather as society's gendered ageism self-inflicted. Interviewee participants have storied how 'old' women "do have the sense that the older you get, the more problems you're going to have. Physical, mental, whatever…emotional" and that "at seventy-five years old, I'm pretty certain that I'm going to suffer illness in the next few years, aren't I?...I'm pretty sure that that fear of being ill, in pain, having troubles, is likely realistic." These seem to exemplify what autobiographer participant Copper (1997) has suggested, that:

> …we were merging real issues of aging with ageist diseases of the imagination which we inflict upon ourselves. One of the things that women do when talking about these issues is to blur the distinction between aging and ageism. Aging is a real process which takes place differently in each individual. Ageism on the other hand is a constriction which rearranges power relationships, just like any other kind of discrimination or prejudice. When one ages, one may gain or lose. With ageism, one is shaped into something that is *always* less than what one really is. (p. 83)

The proclivity towards the 'old-as-frail' conflation, has been heard as having "captured" (Copper, 1997, p. 14) 'old' women through patterns of lowered expectations, undermined self-confidence, and fearfulness in regard to their own health. Other autobiographer participants have highlighted that "however we may feel on the inside, this has little impact on the abiding fears of ageing, that usually begin assaulting us from mid-life, seemingly from the outside" (Segal, 2013, p. 6). The assumption of the "decline story dominates our fears" (Gallop, 2019, p. 13), and has

become “perplexing and frightening for the many haunted by its presence” (MacDonald & Rich, 17). Its gendered nature has been highlighted by autobiographical participants including Copper who stated, its “‘brain-washing’ makes women fear the process of our own bodies within time” (p. 86-87) and Segal who shared, “it is women who have often reported a very specific horror of ageing” (p. 13). Thus, I have asserted that an ‘old-as-frail’ proclivity threatens to set low expectations, reductions in confidence, and escalation of fears for one’s own health, and provokes wonderings about a shaping of health risk in response. I have heard from participants how proclivities towards assumptions of ‘old-as-frail’ assumptions may manifest as typification, such that participants began—with or without awareness—to embody ‘old-as-frail’.

Typification of ‘Old-as-Frail’

“A self-fulfilling prophecy of isolation, passivity” [9]

A proclivity towards health decline, or ‘old-as-frail’, and away from potential has been generated as a disorientation and misguidance of women which has constrained participants’ efforts towards robustness and, thereby, self-inflicted greater frailty risk than what would have otherwise existed. Autobiographer participant Friedan (2006) has addressed this inclination throughout her book, including, “the view of aging as inevitable decline constrains…ideas about the limits of our own personal growth” (p. 222), and “can become mindless conformity to the victim—decline model of age” (p. 115). MacDonald (2001) also considered this process, “Our own panic about what's ahead leaves as undefended from such ageism” (p. 151). Understandings of the proclivity towards ‘old-as-frail’ assumptions being self-inflicted as typification have been embedded in the three subthemes of Theme 2: constrained physical fitness, function, and wellness; self-isolation from social engagement; and self-subjugation in relation to social power and influence.

Constrained Physical Fitness, Function, and Wellness.

"Become the victims of the low goals we then set for ourselves." [10]

Proclivity towards risk of decline and dependence, and its accompanying low expectations, undermined confidence, and fearfulness, have degraded participants' health goals to those of safety, acceptance, and maintenance. Autobiographer participant Grumbach (1991) pondered expectations of her health on her seventieth birthday: "Now I am old…this should be the age of…sedentary acceptance of what one has or is left with" (p. 147). In the words of an interviewee participant:

> What I do is I just try to maintain anything that is wrong with me. I look after it. I use all the appointments I'm supposed to. I take all the pills I'm supposed to take. I do the walks I'm supposed to do….cause I'm not interested in getting worse, so if can just maintain, you know, that would be good.

I wondered, if women who had focused only on maintaining "anything that is wrong with me", may have abandoned opportunities for improved strength, movement, and independence and, thereby, ended up typifying more physical frailty risk than they might have otherwise. Such potential typification was exemplified by participants' experiences of physical fitness, function, and wellness.

In terms of fitness, interviewee participants have storied how proclivities to decline altered their fitness pursuits in ways which may have rendered them less fit and more frail over time. One has storied of a friend withdrawing herself from a favorite fitness activity based on assumptions of 'old-as-frail':

> I think it would certainly make people more cautious and less…I mean, if you're told over and over that you can't do stuff or that you're going to hurt yourself…then you

> believe it, right? So that the messages we get…'you can't do that'…I think that just wears you down…I had a friend…who fell off her bike and broke her arm and I said to her 'well you're not going to not'… she was 68…she said 'well, I'm probably too old to be riding it' and I said 'I just went on a bike trip, you're not too old', and I'm older than she is, '…it's an arm, it's going to heal' and it did, it healed well and everything, but she sold her bike.

Another had found herself behaving less robustly than she otherwise would due to conflations of her 'old' age with her already difficult cancer recovery:

> age now is added to that deconditioning…I don't think it's necessarily age, but it's certainly always in the back of my mind. So,…I avoided situations where I would have to use strength to some extent, whereas before I would never have done that.

Further, another has extended understandings of a self-inflicted cycle of decline:

> If I pack extra weight on, I get sluggish, and I think, 'Oh, the older you get the more out of shape you're going to be.' So, that's just a downhill slide because then I think, 'Well,…let me have a little more comfort food, let me sit a little while longer here.' It does the opposite of whipping me into shape.

In relation to physical function, the priming for 'old' women's incapability and looming dependency have been seen as undermining their functional potential. Participants have spoken of a potential for irrational or anxiety-driven reluctance limiting their own function. As a result, I wondered, could they have escalated their own typification of 'old-as-frail'? To what degree has this been self-inflicted? As one interviewee participant evocatively pondered:

> My anxiety just takes over and I think it's quite unreasonable, like there's no reason why I shouldn't be as able to…you just hear all this stuff, and then you tell yourself this

ridiculous story…it just never crossed my mind that I was so vulnerable as I feel now…I'm not sure it's completely rational…I'm not sure I could defend it.

Other interview participants have shared similar thoughts and feelings having directly limited their own functioning: "Some people just stop. Like, a friend of mine down the hall said, 'I'm eighty now, so I'm not doing this, this, or this, anymore.' And I'm thinking, it's one day. You did it yesterday'." Driving has been a common example; for instance, one woman shared a personal story, "I did stop driving, and it…has nothing to do with my hip…I just lost my confidence…that's one of the things that makes me feel more vulnerable….I probably could have driven another few years, but I did have this anxiety." Similarly, autobiographer participant Millett (2001) has storied provocatively of the impact on her Mother's mobility, her "very infirmity a form of worry" (p. 70) as "tonight suddenly everything is difficult, Mother goes so slowly, is so afraid. Because, of course, it is not frailty; those legs are still good, she even uses a stationary bicycle... It is fear that motivates her" (p. 12).

In regard to wellness potential, I have heard how irrational presumptions that health changes were signs of inevitable and expected health deterioration (disproportionate to actual risk) have left 'old' women with blind spots, or even resistance, to otherwise benign or reversible possibilities. Further, their default response of resignation and apathy, rather than problem-solving, treatment, and resiliency have been normalized. The meaning to their frailty status was seen as embodying more physical limitations and frailty than what had been pathologically or biologically determined. As autobiographer participant Friedan (2006) has identified: "Any actual physical disability or mistake or temporary failure (no matter how irrelevant to the ability to carry on the work or career) is exaggerated by this process" (pp. 211-212). She has shared a personal example:

> I literally double up under the pack. It keeps slipping down. I can't seem to get myself upright enough to climb at all. What's wrong with me? Age, after all?...He helps me adjust the shoulder strap and the belt tight around my waist. I stand upright easily enough. The weight seems to be carried by my hip bones now. So, it wasn't the feebleness of age, after all, but a matter of engineering! (pp. 310-311)

I have wondered how often such self-doubt guides women to disengage from their desired, robust endeavors. An interviewee participant had storied how 'old' women may lack a vision for their potential resilience: "women, in particular, really felt that they were at the end…like, the broken hip thing…once that happened, women didn't really see themselves coming back from that."

Self-Isolation from Social Opportunities.

"Trapped by our own resignation from continued risks in love and work." [11]

Social inhibitions have been seen to be created by proclivities to an 'old-as-frail' social undesirability and risked self-inflicting social isolation and frailty. Participants' stories have included descriptions of 'old' women feeling fearful, self-conscious, ashamed or burdensome and, thus, they "retreat" (Friedan, p. 614) and "collude in [their] own exile" (Friedan, pp. 211-212). I have wondered if such experiences also potentially increased their typification of a 'lonely old lady' and its accompanying risks of frailty. Similarly, autobiographer participant Bell (2012) has questioned:

> Why is it deemed such a compliment to be told that we look younger than we are, or that we don't look our age? It feels like yet another way of making ageing shameful and not fit to be seen. (pp. 23-24)

One interviewee participant has empathized:

> It's really, really, really difficult, especially if you're someone who feels that you have to look a certain way and then you no longer do…the toll on them is terrible, I mean, the whole self esteem issues, and they hide in their apartments or just feel really lousy about themselves.

Other interviewees broadened this understanding of social isolation to not wanting to expose or burden others with their oldness or age-related changes. One person has shared:

> Once your hearing starts to diminish…you miss parts of a conversation…so then I got more into doubting myself and hating checking….it takes a lot of guts to say, 'What? I missed that. Could you repeat that'. I think I'm quite courageous…and so I wonder about people who are quite shy…how that is for them? I suspect some people just don't say anything.

Another has summarized, "I think that's partly what happens with seniors is that we…don't want help…and then you isolate."

Understanding social isolation has been extended by participants to include withdrawal from or denial of intimate and sexual relationships. Autobiographer participant Heilbrun (2006) has suggested "that the 'elderly' leave romance to the young and welcome friendship….Like happiness, or beauty in a work of art, sex after sixty cannot be the object of any undertaking" (pp. 112-113). There was a strong pattern of shared experience from the autobiographer participants. Copper (1997) has narrated:

> I have met old women who did not want to be touched. I do not know whether they never liked exchanging touch, or whether, out of a sense of shame, that refusal came with age into their vocabulary of self-inflicted deprivations. (p. 46)

Others have offered personal accounts, including Roberts Giordan (in participant Sewell, 2004):

> My husband of fifty-five years kissed my hand. I withdrew it in embarrassment. After all, he was never that demonstrative even in our courting days. 'It's not a very pretty hand,' I explained, passing the fruit bowl. 'To me it is,' he insisted. I looked at my hand with candor. No, it wasn't at all pretty. (pp. 23-24)

Likewise, MacDonald (2001) wrote:

> I wondered how to feel proud and strong when women around me were telling me I was weak. I wondered how I looked to other people…I wondered what Cynthia was feeling and I wondered if I would ever have the confidence to make love to her again. (p. 31)

Gallop (2019), with her use of a queer lens on sexuality for the 'old' and/or 'disabled', has expanded understandings of such social disconnections to the psychological realm:

> I am overcome with the fear that we are inevitably moving toward castration. I would want to note that it is my castration anxiety, my fear that I will be castrated (that I will never get aroused again), that is at stake in my depression. (p. 75)

While Segal (2013) explored, "the likelihood of many women's self-protective renunciation of sexual desire in old age" (p. 268), equally jarring, has been the generation of self-inflicted subjugation of 'old' women's rights to equitably hold space and receive attention and care. As autobiographer participant Friedan (2006) speculated, by "underestimating our potential for further participation in society, we narrow our own perception of choice, and gradually restrict our exercise of autonomy" (pp. 211-2).

Participants' stories have revealed a pattern of having removed themselves from social relationships and engagements due to their perception that 'old' age or age-related changes are

too burdensome to expect accommodation or care from others. For example, as autobiographer participant Juhasz (2017) has written: "I know that as I have aged, living with my arthritis, I am less easy to have around. I have trouble sitting in many chairs; don't engage in most sports anymore" (p. 133). Friedan has extended this theme to opting oneself into institutional care:

> With increasing uneasiness, I began to wonder if the people I interviewed who had bought into these facilities to save their children from 'having to put me in a nursing home' weren't defining themselves, too soon, as objects of such ultimate 'care.' Were they, in fact, somehow *colluding* in the process of denying their own personhood by withdrawing from the community into that 'care' ghetto? (italics in original, p. 374)…The voluntary embrace of an identity as a 'care object' was indeed short changing their autonomy, their independent personhood, their active participation in the community. (p. 378)

Even from within care institutions, women have continued self-subjugation of their own care needs and autonomy, to the privilege of others. Autobiographical participant Millett (2001) has poignantly told of her Mother's self-subjugation of her basic care needs:

> I surrendered a bit, didn't buy the wheelchair…Mother put the kibosh on the whole project. It would be a nuisance for Joannie to load and unload into a car, too heavy, another imposition and burden. She will not be a burden, she will not inconvenience these two younger people who are her lifeline here, who do her favors, visit her at the Wellington, take her out sometimes. They must not be stretched further. (p. 123)

Also, she has described that after her Mother's care conference:

> I overhear her with Steven [her nephew, a lawyer], fascinated to know what she will say to him after her great occasion, but I only catch her asking him, "What have <u>they</u>

> decided?" The helplessness of it all. She sinks further, telling him that she will abide by his judgment "Whatever you decide," she says, humbly. I grit my teeth: it's what she said in the University hospital, it's how she got to this lousy visitor's parlor in St. Anne's Catholic Home to begin with. It's surrendering to youth or masculinity or a law degree." (pp. 219-220)

I have wondered if this represented self-subjugation of one's right to social presence. Autobiographer participant MacDonald (2001) has summarized this phenomenon and alluded to its cost to old women:

> Our own panic about what's ahead leaves us undefended from such ageism. In that panic lies the power we give to the younger professional lesbians to take control of our lives. In that panic we can be tamed into asking nothing for ourselves in the present--not making demands to be seen and heard and valued right now. (pp. 151-152)

As one interviewee participant has evocatively perceived, to safeguard connections with others, "we damn well better comply with the narrowest version of what an acceptable [old] woman is". Thus, participants' perceptions have been that 'old' women may self-subjugate as 'frail' in order to assure the meeting of their social needs, but, ironically, such typification of frailty may render them at greater social vulnerability.

Self-Subjugation of Socioeconomic Status.

"The habit of exempting myself won out" [12]

Gendered ageism self-inflicted has been seen as potentially misguiding 'old' women to self-subjugate in terms of socioeconomic status, potentially elevating frailty risk in social and environmental domains. More specifically, 'old' women may have self-subjugated their positions of social presence and influence, as well as career and income, each of which have been

presented in more detail below. Autobiographer participants have storied of this proclivity, "the careless and pejorative dismissal of the Baby Boomers…is espoused as much by the old themselves" (Segal, 2013, p. 50) and that "all old women, regardless of their differences, share a common burden: the prejudice and stereotyping ageism brings. Ageism, not aging oppresses us. We are oppressed by other women and we oppress ourselves" (Copper, 1997, p. 3).

The self-subjugation of social presence, and the typification of 'old-as-frail' which it may result in, was generated from stories of multiple autobiographer participants. Copper (1997) has offered an example in terms of social influence, "Conforming to the Little Old Lady stereotype of absolute powerlessness should not be a goal for any lesbian, yet the pressure I feel going 'over the hill' is to behave less assertively--to be 'appropriately' submissive" (p. 20). Other autobiographical participants have narrated their experience as "a dread that holds us back from taking charge of our lesbian [social] power" (MacDonald, 2001, p. 150) or a "fall into indifference" (Heilbrun, 2001, p. 206). A personal account was offered by Steinem (2006):

> At sixty, I was thinking about aging and leaving the center of life" (p. xi) "I would have been delighted to think that I, too, could grow more radical and rebellious with age but the habit of exempting myself won out. With few role models of daring, take-no-shit older women in my history books or my family history as transmitted to me (though both had held many in reality)-- and with even the rebellious older woman I had written about consigned to the category of 'other' prescribed my reporters role--my own future remained a hazy screen. (p. 26)

I had pondered if this self-subjugation of social status may have associations with frailty risk, as it had for one interviewee participant:

> I would say that maybe power is…one of the differentials between whether women end up being frail or not so frail. And maybe the amount of power that they feel comfortable taking on and exerting and how they use that power or, if they have any power, maybe that's a missing thing.

In terms of education and work pursuits and socioeconomic status, common patterns were noted of self-directed gendered ageism having potentially groomed 'old' women with an inclination to typify positions of lower social influence and socioeconomic status. For example, they may have 'chosen' to not pursue advanced education believing they were too old, as autobiographer participant Juhasz (2017) storied about her mother:

> [She] had 'chosen' to be a teacher. But when she went back to school to earn that MA in special education after my sister and I grew up, she told me, 'What I really want to study is psychology, but I'm too old.' (p. 65)

Even participants who pursued learning and engagement, have often repositioned themselves as subjugate to others. As one interviewee had described, "I used to take modern dance classes and sometimes there'd be an older woman in the class...they would always, kind of, stand in the background." Likewise, autobiographer participant MacDonald (2001) had questioned her right to partake in advocacy work at a feminist march and whether it would be better to exclude herself:

> We continued to wait in the darkness but nothing was the same. I felt the old caution I used to feel entering a bar not knowing whether or not it was a men's only bar--the dread of being told I did not belong there. With the same furtiveness, I now glanced at the women around me, at the six women in the rank ahead of me. We had been laughing together earlier at the man who wanted to convince us that capitalism was our oppressor;

> at least, I had thought we were laughing together--now I wondered. I looked at the women in the row and in the row behind me. I wondered how I looked to them. My short stature, my grey hair, my wrinkled face--I wondered how sixty-five years looked to them. And finally I looked at the four other women who were to walk beside me. I wondered how they felt about being with me. I wondered if I should take the arm of the woman next to me and tried to remember the instructions, but all I could recall was my shock and shame, hearing the monitor's words, "If you can't keep up, go to the head of the march." Hearing once more that I was a problem and did not fit. All my life in a man's world, I was a problem because I was a woman; now I'm a problem in a woman's world because I'm a sixty-five year old woman. Hearing once more that I was not in the right place and thinking, 'If not here, where?' (pp. 29-30)

Extending to work potential, interviewee participants have storied of self-directed gendered ageism casting doubt on their own capabilities and distancing themselves from opportunities:

> when I first saw that 'Help wanted' sign in my favorite hardware store where I really like the people, I thought 'Well, maybe I can work with these people,' and it would be lovely to have some more income, but one machine that I've never operated is a cash register…I guess I don't have total confidence that I would do a good job with that….And then I think, 'Hmm, I'd be so self-conscious about my hearing, and all that'. So, you know, I kind of rule myself out.

Further, 'old' women have also storied feeling better-suited for volunteer work, rather than expecting paid work. One interviewee participant had narrated:

> I'm still feeling that I can help my writer partner solve problems with her text and I've been told that I'm a good writer so that people appreciate what I do as a volunteer for the website that I work on, but it's all volunteer. I don't see myself getting paid for it, you know?

Another pattern has illustrated how 'old' women have felt compelled to step aside from involvement and leadership. Their stories have conveyed how, despite not having any tangible reason to not continue or advance their work and influence, they subjugated themselves, relinquishing their own power by knowingly "passing the torch" (Kunin, 2018, p. 8) to the 'young' and diminishing themselves in the process. Interviewee participants had planned to "leave the future to those who will inhabit it", and "step aside…and allow young people to flourish and to take leadership roles". As examples, two women have described their 'choice' to step away from their potential in political roles of leadership and influence. Autobiographer participant Kunin has said "My priorities remained similar to what they were at a younger age, but now they take a different form. Instead of running for office myself, I pass the torch to a new generation of women" (p. 8). Also, an interviewee participant has storied:

> I've been very politically active all my adult life, and I often find myself thinking I should leave it. You know, I mean partly it's just I don't have the same amount of mental energy and physical energy to go out and be organizing demonstrations….but I do tend to think…I have to listen. The young people, it's their world that they're coming into. I'm happy to support whatever they're doing, but really it is, in a way, you're sort of giving over the knowledge to younger people.

Further, the self-subjugation in 'passing of the torch' or 'stepping aside' has been justified and honoured by its framing as 'altruism'. As autobiographer participant MacDonald

(2001) wrote:

> The old woman is at the other end of that motherhood myth. She has no personhood, no desires, or values of her own. She must not fight for her own issues--if she fights it all, it must be for 'future generations.' Her greatest joy is seen as giving all to her grandchildren. (p. 126)

Alienation of 'Old' from 'Self'

"By denying the real infirmities of age, we become its passive victims, forfeiting choice" [13]

Self-inflicted gendered ageism has encouraged women to alienate their sense of 'self' from their 'old' age. Autobiographer participants have identified how women find themselves in "the strange or bewildering predicament of not really knowing how to *be* our age, as we age" (Segal, 2013, p. 151), not having prepared or planned for old age (Gallop, 2019; Millett, 2001), and starting "belatedly to tackle the noxious flow of prejudice and inner fears most of us face in old age" (Segal, 151). Gallop has labelled this experience "an identity crisis" (p. 15). From this perspective, women have found themselves unattuned to their age-related health changes. They were at times disengaged from healthcare and supports which might otherwise have been beneficial and, without which, they incurred more frailty risk. As autobiographer participant Friedan (2006) has storied:

> The slowing down of normal aging, which usually does not occur before the eighties, can be compensated for by people who actively identify with their own aging. It is cause for panic only among those who deny age…it is those who so fear their own aging that they must repress and deny all thought of it--those who are *alienated from their own experience* as they continue to try to pass as young-- who may be at highest risk of depression. (pp. 61-62)

Denying one's 'old' age has also risked not attending to healthy parameters, as exemplified by one interviewee participant:

> 'We're not there yet. We're not there yet.' In some ways, I understand it. I've had this conversation with a friend of mine who hurt her back recently doing something stupid, but we do things until our bodies rebel, and then we feel foolish because we've done it. But…of course we will do it until we can't. But we don't talk amongst each other about those kinds of things, you know, 'How do you manage when you get old?'

An alienation of 'old' 'self' has been understood as having misdirected efforts to resist age rather than resist ageism. Autobiographer participants have suggested that women who accept their own 'old' age may be better able to critically and actively resist ageism, potentially leaving them less vulnerable to its proclivities. As MacDonald (2001) has described:

> I do think we will face the experience with a clearer vision if we let ourselves feel and experience our own aging now, so that we know some of its realities from our gut before we are deluged with the messages from the market place that tell us…that old is ugly, old is powerless, old is the end, and therefore that old is what no one could possibly want to be. At 69, I take in these messages from the outside every day, and I have had to learn ways of reacting to all the negative messages around me in order to survive. (MacDonald & Rich, pp. 90-91)

Theme 3: Socially Imposed Typism

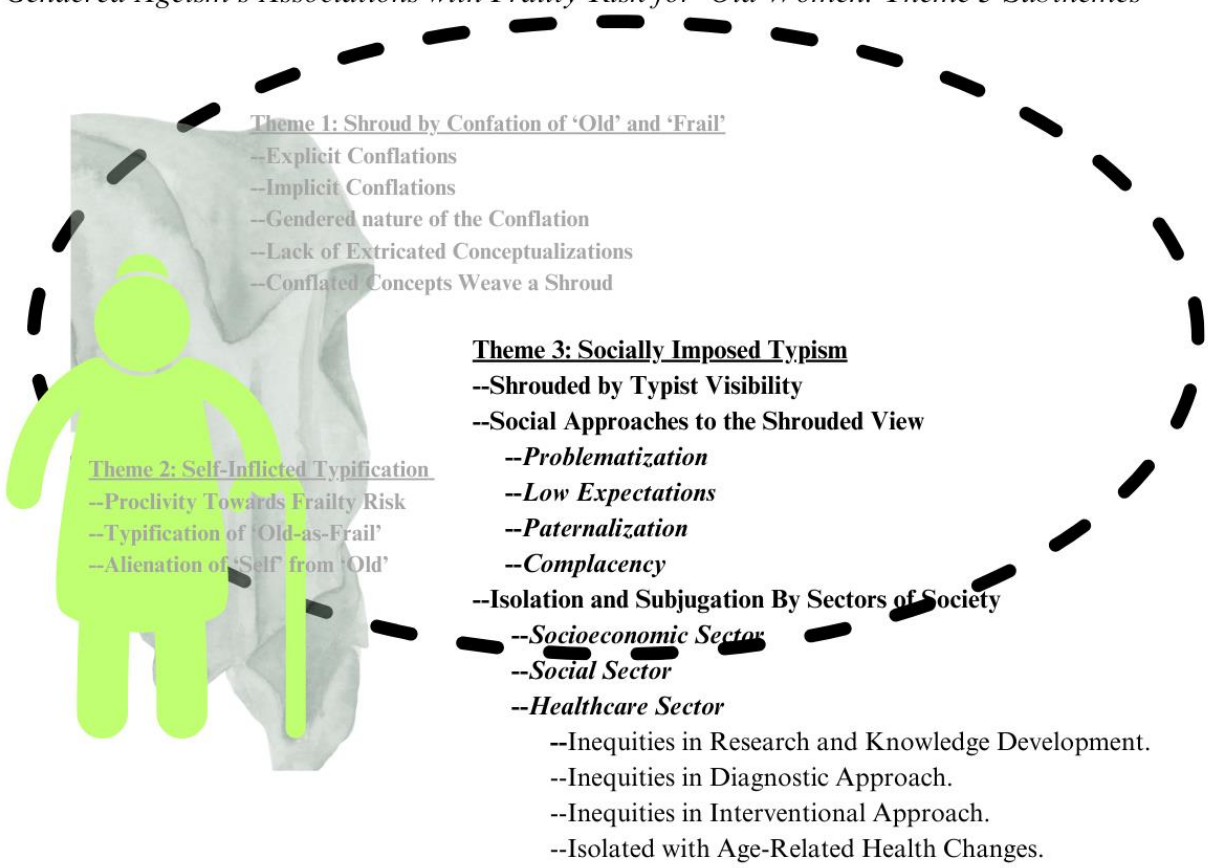
"It is not physiological aging or psychological aging that is troubling me. I am experiencing societal aging—ageism." [14]

Conflations of 'old-as-frail' have generated a typist social shrouding of 'old' women which has imposed constraints on how they have been viewed, approached, and positioned by

society in ways aligned with frailty risk. ‘Typist’ has been a term that refers to discrimination grounded in the social construction of what is typical based on standard assumptions (Oesterdiekhoff, 2009). A typist shroud applied to ‘old’ women by society has rendered only their ‘old-as-frail’ features visible, even disproportionately conspicuous, and their personhood invisible to those externally gazing upon the shrouded person. Such typist visibility may have informed social approaches and repositioning of old’ women to subjugated and isolated social locations, particularly in socioeconomic, social, and healthcare sectors, more strongly associated with frailty risk. As the insights of autobiographer participants have explained, “Aging [is] still the most impoverishing and disempowering event for women” (Steinem, 2006, p. 23), but, “Many of my struggles were not only happening in but significantly defined by the space itself” (Juhasz, 2017, p. xi), potentially because, “Ageism rationalizes the discarding of old women--as workers, friends, lovers, relatives” (Copper, 1997, p. 14). In this third theme, I have presented three subthemes: (1) typist visibility which has rendered frailty hyper visible and personhood invisible; (2) a diminishing social response provoked by such limited visibility; and (3) an imposition of social repositioning in socioeconomic, social, and healthcare sectors to locations of potentially stronger associations with frailty risk (Figure 2).

Figure 2

Gendered Ageism's Associations with Frailty Risk for 'Old' Women: Theme 3 Subthemes



Shrouded by Typist Visibility

Participants storied how typism had socially imposed a metaphorical shroud over them, distorting how others in society viewed them in ways which both illuminated their frailty and concealed their personhood. Below I have presented each of these constrained views of understandings with illustrative examples.

The shroud represents the typist view which others in society impose when they 'see' who they perceive to be 'old' women. That is, 'old-as-frail' has become a discriminatory lens based on typical social construction of standard assumptions (Oesterdiekhoff, 2009) which make frailty conspicuous in 'old' women. An interviewee participant has described, "I think,

people…just have more of a sense of an older person's vulnerability. Now, do I feel vulnerable too? I don't really." Autobiographer participant MacDonald (MacDonald & Rich, 2001) has described:

> …old women are already stereotyped as powerless and pathetic. We are already seen, ad nauseam, as the embodiment of younger people's fears and shames around sickness, need, physical weakness, death, and loss of loved ones--as if these were our principal attributes, and as if they were unique to us. (p. 133)

Interviewee participants demonstrated an imposition of typist shrouding on 'old' women collectively by its representation and promotion by media. For example, "All the images on TV, anywhere, are…,if it's an old person it's to do with…some medical discovery or some new medication they can take", "There's so many articles about dementia…and I'm not saying that it shouldn't be read about…but it needs a context, right?...it becomes a blanket thing for all older people, very easily", and "the images of old people having to be in care homes is often a female image". As a personal experience of the imposition of typist shrouding, one interviewee participant has evocatively described:

> Appearing in public with two canes, and being quite awkward with them…attracts a gaze which is quite painful, which is people looking at you quite differently…Even just the lack of ability, things like clumsiness, that comes with lack of mobility, really is, in the eyes of the public…that you're still frail when, in fact, in your mind, you don't see yourself as frail at all. You just see yourself as clumsy…I'm more noticing this kind of inability for people to just act like they're dealing with a normal adult and just completely focusing on the frailty…What I'm not sure, is if it's worse for a woman. I suspect it might be, and somehow men are kind of expected to be more competent even if they have a

cane.

The density of an 'old-as-frail' shroud was also understood to impose an invisibility of personhood, explained by an interviewee participant as, "You're not just a regular person anymore, you're a little old lady." As autobiographer participants have conveyed, "Age prejudice encourages substitution of these manufactured realities for the real human being" (Copper, 1997, p. 14), "Old women suddenly become invisible to the whole world", and "She has no personhood, no desires, or values of her own" (MacDonald & Rich, 2001, pp. 125-126). Further, typist views may have been even more potent at intersections with disability. According to one interviewee participant, "the assumption is, I believe, especially if combined with obesity or a physical… mobility disability, I think people make the assumption that there's less than a whole person there." As an autobiographer participant living with a disability, Gallop has quoted from Lehrer (2019), "'Old women disappear into a slow molasses of obscurity, even when they fight to be seen. I can see the day coming when the shape of my body will be chalked up to age and I will join the ranks of the Invisible Women'" (p. 6). I had wondered whether the potency of such an intersection may have extended to 'old' women with visibly substantiated frailty, particularly inspired by autobiographer participant Millett's (2001) potent description of her Mother's dehumanization: "a little woman's body, that frail and vulnerable being. That figure habitually ignored or derided and passed over, incarnate in human flesh" (p. 307). In terms of significance, the shrouding of personhood to associations with frailty risk, MacDonald (2001) has perceived that, "By their omission. they leave [old women] with even greater vulnerability" (p. 160).

Social Approaches to the Shrouded View

'Don't call me old,' 'don't let me tell myself I'm old,' because, with that, comes an identity of being frail and vulnerable, or being treated as though I am… I'll reject the label of old, not

because there's anything really wrong with old, but because it comes with all these other strings, all these other labels. [15]

This typist shrouded view has informed my understanding of various social approaches to 'old' women which assume their frailty and disregard their personhood. Participants commonly exemplified these social responses as problematization, low expectations, paternalization, and complacency. Such approaches risk diminishment, isolation, and undermining of 'old' women's health potential, thereby imposing frailty risk.

Problematization.

As a discriminatory process, typism may have shrouded 'old' women as social problems, concealing any counterbalance of their social contributions. As one interviewee participant has described:

> Unfortunately, there are two things happening that drive me mad. One is that, suddenly, older people are being, whether it's deliberate or not, are being portrayed as problematic. We're all going to take so much resources as we get older. We're all going to get dementia as we get older. We're all going to be a drag on society and cost so much as we get older. And there's nothing said about, anything about, the contribution we have made throughout our lives.

Further, associations with frailty risk have been imposed by subjugation and exclusion of those viewed as 'problems', as autobiographer participant (Friedan (2006) has declared:

> the more guilty and 'compassionate' people are made to feel about the 'problem' and 'plight' of the elderly, the more they want to avoid them and actively resist personal identification with them. The more people over sixty-five become unfamiliar 'others,' like any segregated minority group, the more they make the rest of us uncomfortable and

> the older we get ourselves, the more we exaggerate their 'problems,' and deepen that aura of guilt and pity, to keep ourselves as distant as possible from the contamination of age. (pp. 64-65)

Advancing the understanding of problematization, autobiographer participant Segal (2013) has highlighted its connection to 'burden', "For those in need of care, there are often deep levels of shame, guilt and resentment if they find themselves in situations of extreme dependence on partners or children, when they may feel simply a burden" (p. 261).

Low expectations.

The shroud, having illuminated 'frail' and concealed other aspects of personhood, has rendered low expectations for 'old' women in society. As one interviewee participant has explained, "I'm actually amazed…They talk about women of 70, and they will name that age, and they talk about them as if they were 102. Their expectations of them are stunningly awful." The fitness domain has been commonly storied by interviewee participants to illustrate their discouraged participation and diminished potential:

> At my gym, there's a guy who's a personal trainer and I've seen him work with some older women and I don't think he pushes them hard enough…I think he's got low expectations…he's a bit condescending. If you show up at all, then it's like 'Bravo', but you don't have to really work at it.

And,

> I am criticized on most fronts for my determination to be engaged in physical activities….people's attitudes towards women, I don't even know after what age, it definitely attributes this negative slant…it's as if you're insulting people…they kind of look at you like 'Come on, get over yourself and not be so frisky.'

Expectations in the social domain have been no less effected, as autobiographer participant Friedan (2006) has illustrated:

> I was nearly fifty before I was liberated enough to discover that I could dance. Now I love to dance!...But in recent years, on a dance floor where most of the people were young, when, whirling around, I saw them smiling—suddenly, I felt funny dancing. (p. 64)

Also, MacDonald (MacDonald & Rich, 2001) has shared how just her social presence has been perceived to lower the social status of those around her:

> I went to San Diego State University last month to do some research for this talk. When I stepped on the library elevator, two young men were there. I got off on the third floor, and as the elevator door closed, I heard guffaws of laughter. One man was saying, "My God, this is a school for old ladies and grandmothers." And I knew I had seen this before in the eyes of students I passed--the message that very presence of an old woman diminishes the status of their institution and so diminishes them. (pp. 167-168)

Such a pattern of low expectations has potentially undermined the opportunities and efforts of these 'old' women to optimize health potential across domains, constraining them to positions of greater frailty risk.

Paternalization.

The discriminatory process of typism has also triggered paternalistic approaches. As MacDonald (MacDonald & Rich, 2001) has claimed, "I know of no other group in our community who is so blatantly patronized, made the subject of others' revulsion, pity or sentimentality" (p. 151). Presumptive 'relieving' or 'helping' of 'old' women with functional or challenging activities may have risked diminishment of their own agency and function across

domains. For example, autobiographer participant Millett (2001) has spoken about herself defaulting to patronizing her Mother's cognition, "We did find Patrick. Just where mother said he was, though we doubted, thought her forgetful, vague, dared to patronize if only in the inner recesses of our minds, mine anyways. (p. 75). From the receiving end of cognitive patronization, an interviewee participant has shared:

> I see it in the supermarket,…a young person is counting out their money and everybody just waits, an older person they want to jump in there and do it for them. They don't have the same respect to let them just figure out their money.

In the physical domain, autobiographer participant Paley (2004) has experienced that, "Some young people will grab your elbow annoyingly to help you off and on the curb at least fifteen years before you'd want them to. Just tell them, 'Hands off kiddy'" (pp. 118-119). An interviewee participant also echoed that, "People take heavy things away from you, without even checking to see if you could manage that weight, like just the assumption is you can't." Such patronization has been potentially associated with frailty risk, as highlighted by an interviewee participant:

> It kind of takes your confidence away…a good example is that I dropped my canes and, of course I can pick them up, but it just causes a big flurry in the room to see who's going to pick them up first…it is kind of undermining…it doesn't feel good. Like I could get them if you would just be comfortable with the fact that I'm awkward getting them….and it's actually good for me to move…but it's hard to convince people of that and I suspect that's gendered. I really do.

Such stories have led me to wonder if these women's opportunities to use, maintain, and improve their strength and function may have been undermined by paternalistic treatment? And

further, what might have been the cumulative toll in terms of lost opportunities over, potentially, years or decades? Might such losses have been associated with frailty risk? An interviewee participant has wrestled with similar questions personally:

> What am I unwilling to accept because I don't want to be seen as dependent or as needing help? And…what is something I should be sensibly wary about because it's going to make me lose some of my capacity if I give up doing those things for myself too soon or too often?

Complacency.

The typist shroud, though illuminating 'frailty', has ironically manifested in a social approach of complacency towards health challenges and the gendered ageist discrimination which 'old' women face. Autobiographer participants have represented complacent social responses as, "This graying of society has not only been largely either disregarded or deplored, it has also amplified rather than diminished social antipathy towards the elderly" (Segal, 2013, p. 2) and "The world outside neither cares nor offers attentiveness, except occasionally" (Heilbrun, p. 58).

Such complacency has particularly existed in terms of health challenges. For example, one interviewee participant has remarked that, "People will say, 'Oh well, yeah, she's got that problem now with her leg, but nice she didn't have it when she was younger, because she's old now it doesn't matter.' Well, it does matter very much to the person with the leg". Another interviewee participant has offered a personal experience:

> I sometimes need to talk about the greater pain I feel…Unless I insist, my [middle-aged] friends do not accommodate themselves to my slower gate when they walk with me.

Another interviewee participant has evocatively summarized how her experience of social complacency was experienced personally, “To me, that all comes down, in a way, to a lack of compassion”.

Yet, despite having been explicitly understood, it was surprising to me that there has been little resistance against such complacency amongst these women. As has been captured by an interviewee participant, “If I’m going to live in this type of situation, as in the world, I don’t expect them to accommodate me, I’ve got to change or get along, you know?”

Social complacency has also existed in terms of resistance to the gendered ageism which ‘old’ women face. Autobiographer participants have described the isolation ‘old’ women endure in their resistance to gendered ageism as a “social malaise under which all women suffer” (Copper, 1997, p. 3) and that “not once have I read of any group of younger women enraged or marching or organizing legal support because of anything that happened to an old woman” (MacDonald & Rich, 2001, p. 122).

Isolation and Subjugation BY Sectors of Society

The typist, shrouded views and approaches presented above have been seen to reposition ‘old’ women to more isolated and subjugated social locations, more aligned with frailty risk. As autobiographer participant Friedan (2006) has considered, there have been “so many elements of society seeming to conspire to prevent [‘old’ women] from continuing to use their human abilities after sixty-five” (p. 70). Three social sectors have commonly exemplified the phenomenon: the socioeconomic sector, the social sector, and the healthcare sector. Each of these are presented below as sub-subthemes (Figure 2).

Socioeconomic Sector.

"The circling of the economic and social wagons around [the age mystique] deny us new possibilities." [16]

The socioeconomic sector, potentially informed by the shrouded view, has been perceived by participants to have undermined and subjugated 'old' women's representation, opportunity and credibility, and roles in the sector, each of which have been presented below as sub-subthemes of this third and final theme. Such socioeconomic repositioning may have rendered 'old' women at lower socioeconomic status which, when understood as a social determinant of health, may align them with greater frailty risk.

Under-representation of 'old' women in positions of socioeconomic influence has been perceived by an interviewee participant as "There's not anybody out there telling you that older people are interesting and valuable and talented. You kind of have to find out for yourself". As autobiographer participant Heilbrun (2006) has described, "The aging…do not seem to play a very large role in this country's affairs-aging women even less than men" (p. 159). Autobiographical participant Copper (1997) has critiqued such under-representation as subjugation: "there is reason to be alarmed by the ageist content or lack of content" (p. 10) as it has rendered 'old' women "powerless" (p. 75) and "*One of the primary definitions of patriarchy is the absence of old women of power"* (italics in original, p. 14).

Opportunity and credibility for 'old' women in the socioeconomic sector have been suppressed by the imposition of typism. In the words of autobiographer participants, "The view of aging as inevitable decline…constrains employers' ideas about the age limits of productive work" (Friedan, 2006, p. 222) and these constrained ideas have been "at least as much about ageism as sexism…strongly linked with many of the feminist issues around misogyny and continuing gender inequality" (Bell, 2012, p. 6). One interviewee participant has perceived that

sexism and ageism "sort of scrunches us at both ends, so that the window in which…we're afforded maximum contributions status, is a pretty little window there in the span and of an adult life". A personal example of typist undermining of credibility has been described by autobiographer participant and professor Juhasz (2017):

> [The students] did not like my age, even as older wom[e]n occupy a tenuous position in society at large. This was the final stage of my gendered position in the classroom. When I started, I was a young woman and had to prove myself as a person who could stand in front of the class. Then I was a middle-aged woman, whom students frequently understood as more like a mother figure than a professor. Then I was an older woman, and my classroom status as 'professor' dropped accordingly. So different from the white-haired gentlemen who automatically were authorities. (p. 197)

The imposition of such discrimination in workplaces has potentially rendered early retirement an inequitably appealing option for 'old' women, despite its potential socioeconomic restrictions. Autobiographer participant Friedan (2006) has considered:

> Only people pretty sure of themselves, firm in their own authentic identity, can resist the overt pressures to retirement, and the denigration of their own abilities implicit in the stereotypes of age bombarding them from the media, not to mention the glances and tone of voice of coworkers and bosses…given the *pain* involved in meeting those stares and tones of contempt where there used to be respect, small wonder that so many seize on the dream of "retirement" if pension makes it possible. (p. 201)

Retirement has been experienced as frailty risk, for example, by Juhasz (2017) who found herself "frequently confused, anxious, and then depressed", "not secured by the clear guidelines of a job, a definite social position in life, and the sense of self that accompanies it" (p. x).

The typist shroud has been perceived as sustaining and deepening exploitative role expectations of ‘old’ women as in-service to others. Autobiographer participant MacDonald (MacDonald & Rich, 2001) has offered that:

> Youth is bonded with the patriarchy in the enslavement of the older woman…The older woman is who the younger women are better than--who they are more powerful than and who is compelled to serve them. This is not true of men; older men still have power…Men are not the servants of youth; older women are. (p. 39)

Autobiographer participant Copper (1997) has furthered its associations with lowered socioeconomic status:

> Old women do much of the undesirable or unpaid labor designated in the culture as female work…When younger women escape this work into the cash economy of factory or office jobs, it is largely old women who inherit the work which the younger woman can no longer perform. If women are the mules of the world, the grandmother is the mule’s mule. (pp. 78-79)

Such repositioning of ‘old’ women, as an interviewee participant has narrated, have often been justified as:

> forms of self-sacrifice…Continuing to support their kids financially, emotionally, materially; then their grandkids, their husbands’ health…who's usually older…Then there's volunteering…helping.

The potential frailty risk from stress and isolation in such roles has been highlighted by autobiographer participant Kunin (2018) in her role as caregiver to her husband:

> John became more prone to losing his balance. A fall, I feared, could kill him. My arm was in a constant state of readiness. A low level of anxiety permeated our partnership. If

> he fell when I was with him, it would be my fault. If he fell when I was not with him, it would also be my fault, only more so. I found myself, as an old woman, reliving the tension I'd experienced as a young woman. Should I give myself to the children, or should I venture out to my own life?...Should I go to my office and write, have lunch with friends, feed my own soul? Bad mother, neglectful wife., selfish woman. (p. 40)

The story has been brought full-circle by MacDonald (MacDonald & Rich, 2001) “Like all who serve, the older woman soon becomes invisible” (p. 40) and Copper (1997) “as women age,…their services [become] ‘convenient but expendable’” (p. 31).

Social Sector.

“The consequence for older people is being dismissed more and more often…or overrun.” [17]

The typist shroud has imposed social isolation on ‘old’ women by instilling a social response which unaffirms their social presence and provokes others to distance from and exclude them. Autobiographer participant Friedan (2006) has captured her experience:

> When my friends threw a surprise party on my sixtieth birthday, I could have killed them all. Their toasts seemed hostile, insisting as they did that I publicly acknowledge reaching sixty, pushing me out of life, as it seemed, out of the race. Professionally, politically, personally, sexually. Distancing me from their fifty-, forty-, thirty-year old selves. Even my own kids, though they loved me, seemed determined to be a part of the torture…I was depressed for weeks after that birthday party, felt removed from them all. (p. 13)

Potential associations of isolation with frailty risk have landed as familiar, though the reorientation of responsibility for the isolation from individual ‘old’ women to societal discrimination seemed novel.

‘Old’ women’s social presence has often gone unaffirmed, as their personhood has been shrouded. Interviewee participants have experienced a lack of social affirmation as: “people who used to smile or acknowledge in a sense your presence, stop doing so in many cases”, “I do find it a rare thing to, for example, be greeted by my name”, “People literally walk into you in the streets…if you didn't step out of the way they’d careen into you”, and “They tend to talk to each other more than they do to me, or they'll listen to me for 10 seconds and that's it…my time is up…Rather than a follow up question, they'll tell you a story about themselves. That’s a thing men do all the time…it's kind of ‘young-splaining’”. The sentiment has been shared by autobiographer participant MacDonald (MacDonald & Rich, 2001):

> No one seems to be expecting me anywhere. Even if I go into a local shop to buy clothes, I am always greeted with the question, “Is this for yourself?” as though I must be buying for someone else, as though I didn't buy clothes for myself; as though I must have some supply somewhere in an old trunk, left me by my mother, there waiting for me to wear when I reached the right age. (pp. 17-18).

Troublingly, the potency of unaffirmed social presence has been perceived as amplified according to the extent of ‘old’ and ‘frail’ that are perceived by others, as an interviewee participant described, “If I was older and frailer it would probably be assumed that I wouldn't question and I probably wouldn't be given the space to question”.

People in society have socially distanced themselves from shrouded ‘old’ women. The shrouded view has misguided intergenerational, peer, and sexual relations by informing assumptions that there are no shared interests, no value in time spent together, and fearfulness. Thus, frailty risk has been socially imposed, as an interviewee participant has experienced, “‘When you are eighty not so many people come by’…You managed loneliness when it became

that".

An assumption of no shared interests has been a barrier to intergenerational relationships. As autobiographer participant Copper (1997) has said, "ageism wipes the conversational slate clean. Other than asking me about my children, most ageist strangers assume that there can be no overlapping interest. Small talk becomes my burden of initiation and maintenance" (p. 43).

Devaluation of time spent with 'old' women has been perceived by interviewee participants. One has noticed that:

> There is just a willingness to leave behind. You know, that, 'Oh, she can't keep up with us anymore,' or 'we used to still do things together, but that she seems to have suddenly gotten old'…it's not that they give them a hard time, they just leave them behind…just kind of race on.

and another has reflected that:

> the societal attitude that…it's too time consuming to visit and pay attention. It's not productive. It's not a good use of time…generally, there's not an expectation that it's your role to spend time with that person and that you would enjoy it and feel good about yourself for doing that.

The Covid-19 pandemic has been perceived by an interviewee participant as exacerbating such distancing, "I think Covid threw a major wrench in it. Young people had to decide whether they cared enough to see you to isolate for days."

Beyond devaluation, it has been commonly understood that the typist shroud informs assumptions that 'old' women carry threats of dependency which encourage distancing by those avoiding any potential burden of responsibility. Segal (2013) has storied, "It is just those ties of dependence that we tend to repudiate entering adulthood in cultures such as ours, where what we

are taught to value is the notion of autonomy and self-sufficiency above all else" (p. 260).

Such threatening views of 'old' age and frailty have also stoked distancing out of fearfulness. An interviewee participant has perceived, "We don't really want to be hanging out with older people…I guess, it's a fear, a fear of aging, isn't it? Or denial? Well, I guess, in the end, it's a fear of death, isn't it?" Autobiographer participant Friedan (2006) has described the distancing from the 'old-and-frail' out of fear as, "those over sixty-five who can no longer 'pass' as young are its carriers and must be quarantined lest they contaminate, in mind or body, the rest of society" (p. 50).

The scope of typist social distancing has included age and gender peers. Autobiographer participant Segal (2013) has shared her surprise in regard to this, "What is perhaps most startling about the careless and pejorative dismissal of the Baby Boomers is that…the critique is espoused as much by the old themselves" (p. 50). MacDonald (MacDonald & Rich, 2001) has described:

> From the beginning of this wave of the women's movement, from the beginning of Women's Studies, the message has gone out to those of us over sixty that your "sisterhood" does not include us, that those of you who are younger see us as men see us--that is, as women who used to be women but aren't anymore. You do not see us in our present lives. You do not identify with our issues. You exploit us; you patronize us; you stereotype us. But most of all, you ignore us. (p. 123)

Desexualization of 'old' women has constrained their potential for intimate relationships, which may be particularly sensitive to isolation and associated frailty risk. As autobiographer participants have evocatively described, "Invisibility needs to be described in all its subjective horror. It takes many forms, the most searing being its sexual form" (Copper, 1997, p. 29), and "The fear and denial of age itself…reaches its apex in sex" (Friedan, 2006, p. 255). The

particularly gendered nature of the desexualization of the ‘old’ has been emphasized. An interviewee participant has perceived, “We don't have that concept of sexy and old woman. We just don't…But, you know, George Clooney can be sexy, even though he's grey and wrinkled. Harrison Ford? Come on.” Kunin (2018) has personally highlighted the differing gendered experiences of late life intimate relationship potentials between herself and her brother:

> I had watched my older brother court of variety of girlfriends after his wife had moved to Washington and he was virtually single. He was a successful seducer; women fell for him regardless of their age or his. [NP] He confided in me, ‘It's much harder for women,’ and I soberly agreed while feeling envious of his ability to behave like an old rooster. (p. 49)

The potential manifestations of such isolation of ‘old’ women from even gestures of intimacy were provocatively storied by Copper (1997) “A woman's casual touch experience changes with age. Men and most lesbians don't touch old women because they are afraid of being misunderstood. The language of touch carries complex messages of sexuality as well as friendship” (p. 46). Segal (2013) has elaborated, “It is a fear that any expression of love coming from those seen as old, however platonic, will be perceived as inappropriate” (p. 259). In terms of associations with frailty risk, autobiographer Friedan (2006) has asked, “Can one long deny that need for intimacy without paying a deep emotional, physical, and spiritual price?” (p. 267). One interviewee participant summarized:

> I'd actually like to have a little fling. And it's harder to find people who think that that would be a fun thing. Or people are surprised that I still have a sex drive…It's the kind of thing you want control over. You want to be able to say, ‘I'm the one who decides if I'm still sexy or sexual.’

Healthcare Sector.

Healthcare has been a social sector in which typism may potentiate associations with frailty risk for 'old' women in terms of inequitable knowledge development, diagnostics, and interventions. As one interviewee participant has identified, "In the last few years, as I've had a lot more to do with the medical system as a patient…the ageism is quite profound." Not surprisingly, but less familiar, has been these misguided approaches to 'old' women's concerns may be experienced as isolating, rather than supportive, of their health changes and needs.

Inequities in Research and Knowledge Development.

There has been a paucity of knowledge development in regard to 'old' women's health. Further, that which has existed, has often been misinformed by biased research designs which privilege a young/male norm and serve the interests of healthcare professionals.

The knowledge which has existed has been accused of telling a story *about*, rather than *by*, 'old' women. Autobiographers have questioned "how people in their thirties and forties could identify the crucial questions and ethical issues for people over sixty-five. 'Them.' Wasn't it like having a bunch of men define the problems of women*?"* (Friedan, 2006, p. 21) and, "what questions would we like to ask or be asked? …What stories do we do we have to tell, rather than have told for us?" (Bell, 2012, p. 9).

Health research inquiries, measures, and sampling have been biased by their grounding in youth and/or male privilege, constraining understandings of 'old' women to 'other' or 'frail' in comparison. Interviewee participants illustrated this in relation to heart attacks for which, "You have to ask about different symptoms [in women]…a lot of the studies were done on male hearts, and not female ones", and orthopedics, "I had a [mis]interpretation of x-rays…an orthopedic surgeon said women's hips are often not read properly."

In terms of healthcare knowledge about 'old' women having been constructed to serve

the interests of healthcare professions via disproportionate alignment with frailty in need of their services, autobiographer participant Friedan (2006) has noticed:

> The gerontologists and geriatricians, the gerobiologists and geropsychiatrists. There were conferences…research money…careers…But the questions most of them were dealing with-- incontinence in nursing homes, senile dementia of the Alzheimer's syndrome, the effect of age on insulin dosage for diabetics, precise quantitative measurements of memory loss--were not the questions that interested me. (p. 17)

Concerns have extended to the potential role of profitability in such knowledge constructions. For example, autobiographer participant Copper (1997) has noted that "Old women's bodies subsidize the nursing-home industry" (p. 62). Thus, it has been generated that the sparsity and biases which have existed in knowledge development risked misinforming and misguiding diagnostics and interventions in alignment with frailty.

Inequities in Diagnostic Approach.

Impositions of typist diagnostic approaches have been understood to occur as misattribution of pathological symptoms as inevitable signs of *being* 'old' women or, contrastingly, misattribution of health changes as chronic pathology, both of which have held associations with frailty risk from either missed diagnoses or hasty, unjustified diagnoses. Interviewee participants have perceived that their reporting of symptoms to healthcare providers were often met with, "'Well, you're getting older what do you expect'." Personal examples were provocative. For example, one interviewee participant has storied:

> I said to [my doctor], 'I'm having trouble walking up hills…I get terribly, terribly breathless.' And he said, 'Well you are getting older.' And I said 'Yes, but it's not that kind of breathless. This is a whole other level.' And I had to insist on that…I just want to

> be listened to the first time. The fact that…I can't do what I could do last month matters to me. I want an explanation. And if the explanation is 'Well, you've just deteriorated a bit,' I could accept that. But I want to know that it's not from something new that I should be taking care of…And I don't know that you should have to say that to your doctor!

Also, autobiographer participant Millett (2001) has told of her mother:

> The doctor has just given her a checkup and proclaimed her to be sound as a dollar. 'He says I'm just about perfect,' she laughs. 'He forgets to mention that I can hardly walk even though they can't find anything wrong with my legs.' (p. 8) [Only much later had it been found that] What was killing our mother: a benign tumor pressing upon the brain, paralyzing her mobile capacity…she had been right all along about her growing infirmity and her regular physician wrong and arrogant-even culpable in dismissing her condition as mere age. (pp. 1-2)

Potential frailty risk of this typist diagnostic approach has been summarized by Friedan (2006), "as long as age itself is defined as sickness, doctors may not diagnose or even treat ailments in people over sixty-five that can be cured" (p. 67). Contrastingly, the ready pathologization of health changes has also been perceived by participants, with its associated risks from hasty and unjustifiable tests and treatments. Interviewees have shared these experiences. For example:

> I broke my wrist [and] the doctor would have liked to see me as frail… every time I went to see the surgeon and get an x-ray, he'd say 'you're going to have other fractures within the next few years'…I might have been 70…and I said to him 'why would you say that? Why would you tell people that?' I said, 'do you tell men that?' He wasn't that impressed

with that. Because I just thought it was because he saw me as an old lady, right? And I said, 'I was cycling. That's not a frailty fall and my GP says it's not a frailty fall.'

And another shared:

When I got pulmonary infections…they go testing for late onset this and late onset….I didn't have any of that stuff. I had a viral non-covid pulmonary infection and then I had a bacterial infection on top of it. That's all I had…but they had to investigate this, that, my heart, blah, blah, blah. And, so, they didn't really pay much attention to the actual problem…to me it just meant that I was…sick for three months, instead of three weeks.

Inequitable Interventional Approach.

Typism in healthcare has inequitably imposed constraints on intervention options for participants including less opportunity for health promotion and rehabilitation or, contrastingly, more hasty relegation to intensive interventions. These interventional disorientations have been experienced by participants as associated with frailty risk. In terms of health promotion, an interviewee participant has described "I could imagine that going in as a young man and saying 'I can't play soccer anymore' that you would get a bit more something than going in as an older woman and saying, 'Walking is getting difficult now'." Another has storied about her parents:

In the medical profession the expectation for them was very low. Like, if they were eating and dressing themselves, that seemed to be all that was expected…they weren't really getting much encouragement to keep up doing the things that they loved.

Limited options for recovery and rehabilitation were experienced by interviewee participants as: "I tore my anterior cruciate ligament…I had been told that I was too old to have that surgery…So, I went for a second opinion…and he said 'That's nonsense'", "I asked him about exercises…he said 'Oh, just like washing dishes and rolling pastry' and I said 'And what

do you tell your male clients?' and he didn't respond and his nurse started to laugh", and "They didn't even tell [my friend] about cardiac rehab. I told her…I also wasn't…I understand from research that women are often not." In contrast, a perceived hastiness towards unnecessarily intensive medical and nursing interventions have been exemplified in terms of over prescribing, efforts towards longevity, and residential care. As autobiographer participant Millett (2001) has understood, prescriptions for her Mother were inappropriate, even harmful:

> I deeply resent his [the doctor] responding…by prescribing antidepressants for Mother when she was discouraged after surgery, gloomy over how slowly she was mending, how weak she was. I even suspect some drug of bringing on the hypercalcemia. Surely drugs weakened her further both in mind and body and made her dopey. (p. 148)

Autobiographer Friedan (2006) has challenged intensive medical interventions which prioritize longevity over quality of life:

> Specialists prescribing new, esoteric, high-tech procedures and pharmaceutical cures for…terminal illnesses—or disabilities…where the cure is more disabling than the condition…that is what far too many older people get as depersonalized, passive objects of 'care,' instead of whatever it takes to keep them functioning actively in the community, in charge of their own lives, doing the things that give them pleasure, partaking in the fountain of age. (p. 426)

And, the presumption of the only option as, "the nursing home specter, focusing our attention on no-win alternatives that assume a medical model of dependence for our later years." (p. 517). An interviewee participant has summed it up as:

> Getting the best remedy or getting the best intervention agreed to, even considered, is something that's not even on the table. It's kind of like, 'Well, how much of a future do

you have left? So, we'll just make you comfortable.'…even if you have two weeks or two years left, you might want to live that as fully as possible, it's still your future.

Isolated with Age-Related Health Changes.

Participants have been learning to live with authentic age-related health changes despite a vacuum of affirmative healthcare space. They felt isolated from healthcare due to its lack of meaningful support and relegation of responsibility to self-management. 'Authentic age-related health changes' has been used to convey personal health experiences which participants have associated with being 'old', but have held as distinct from typist, binaried constructions of 'passing-as-young' or being 'old-as-frail'. As has been described by an interviewee participant as, "We slow down, whether we like it or not. We have this illusion that if we do things, we can all just go on doing them forever and it just isn't the case", and by autobiographer participant Friedan (2006) as "the reality, the actual possibility of the frailties, disabilities, chronic or sudden mishaps which age can entail" (p. 415). Despite this recognition amongst 'old' women, societal typism has involved a "dedicated refusal to admit any *necessary* impediments in people's lives as they grow older that remains at the heart of many narratives of ageing well…to imagine that we can remain ageless" (Segal, 2013, p. 177), where 'necessary' has been a key concept, implying that 'old' women have a choice between 'passing-as-young' without age-related health changes or being 'old-and-frail'. Such an approach in healthcare essentially blames age-related health changes on individuals, assigning them self-management to 'choose' to age better and problem-solve their own way out becoming 'frail'. Thus, it offers no affirmation of experiences of aging authentically as neither 'young' nor 'frail'. Without affirmative healthcare support, 'old' women experience isolation with their age-related health conditions or seeking out peer support. For example, interviewee participants have described, "To me it seems like normal aging…I mean, I

don't know. I don't have experience…I have no idea what's age and what's something actually going wrong", "The real question is--how are we to live our lives?", "the whole self-management thing is just ludicrous", and autobiographer participant Juhasz (2017) has explained "When I looked around me for guidelines and models, I found little help….I was plunged into severe depression. It was in fact worsened by the world telling me how good I should be feeling...What about the aging part of aging?" (p. xi-xiii). By default, responsibility for health guidance has been relegated to interview participants themselves or their peers: "a lot of people…just don't go to the doctor…because they think they won't get any help, right?...I mean, I do it myself", "If nobody's going to help me, I'd better be…not only my best advocate, but my best resource". At the same time, there has been risk in the absence of evidence-informed care for interviewee participants; for example, "I haven't told [the doctor]…but I'm going to go off the medication". Autobiographer participant Copper (1997) has provocatively summarized the isolation with age-related health changes and its risk:

> The single strongest social message an old woman receives is to 'grow old gracefully'--*not to burden others* with complaints. By complaining, an elder will only increase her isolation--or so the saying goes. This threat obscures for old women the importance of naming our experience honestly. (italicized in original, p. 19)

Conclusion

In conclusion, three main patterns of potential associations between gendered ageism and frailty risk for women have been generated. The first has suggested that the phenomenon have been associated with conceptual conflation of 'old' and 'frail' for women which has been woven into a shroud of assumptions. The second has suggested associations that conflated understandings of 'old-as-frail' groom women with a proclivity to frailty which risks self-

infliction of typification. The third has suggested that associations of typism have socially-imposed subjugation of ‘old’ women to social locations of escalated frailty risk. To explore meaning for NP practice, in the next chapter, I have discussed generated understandings which need to be explored in relation to their situatedness within existing literature and their potential re-orientations for NP actions.

Footnotes

[1] See Copper, 1997, p. 83 for context of this quotation

[2] Interviewee participant

[3] Interviewee participant

[4] See Segal, 2013, p. 6 for context of this quotation

[5] Interviewee participant

[6] See Friedan, 2006, p. 41 for context of this quotation

[7]See Copper, 1997, p. 4 for context of this quotation

[8] See Copper, 1997, p. 14 for context of this quotation

[9] See Friedan, 2006, p. 59 for context of this quotation

[10] See Friedan, 2006, p. 211-212 for context of this quotation

[11] See Friedan, 2006, p. 536 for context of this quotation

[12] See Steinem, 2006, p. 26 for context of this quotation

[13] See Copper, 1997, p. 80 for context of this quotation

[14] See Copper, 1997, p. 80 for context of this quotation

[15] Interviewee participant

[16] See Friedan, 2006, p. 614 for context of this quotation

[17] Interviewee participant

Chapter Five: Discussion

My study has been informed by a literature review which highlighted 1) the importance of ageism's potential associations with health risks and 2) gaps in understandings of the phenomenon at intersections of age and gender, in association with 'frailty' risk specifically, and from qualitative and nursing angles of vision. I have used a critical feminist gerontology lens to explore associations between perceptions and experiences of gendered ageism and multidomain frailty risk through narratives of 'old' women who self-identify as critical feminists. Generated understandings of associations between gendered ageism and frailty risk include three themes: 1) shrouded by conceptual conflation of 'old' and 'frail'; 2) self-inflicted typification; and 3) social imposed typism. Within each of these themes I have discussed priorities for further discussion alongside potentially novel, key, or unexpected associations arising from this research question. Each theme is considered in relation to existing literature that is important for new interpretive breadth and applicability (Thorne, 2016). The strength of using interpretative description approach is that it allows for pragmatic application of the generated understandings for NP and nursing practice. The chapter ends with concluding considerations for future conceptual, research, and practice shifts which serve as pragmatic examples that can be applied in clinical practice, and the limitations of my study.

Theme One: Shrouded by Conflation of 'Old' and 'Frail'

The first key understanding of associations between gendered ageism and frailty risk was that the concepts and language of 'old' and 'frail' for women are conflated, both explicitly and implicitly, even in the language of critical feminist women in my study. That is, the language threads of 'old' and 'frail' for women are woven by gendered ageism into one fabric so as to be indistinguishable. Metaphorically, the fabric's weave is such that if a woman is perceived as

'old' she is thereby understood as at risk of 'frailty' and, similarly, if a woman is perceived as 'well' she is understood as not 'old'. Further to this key understanding is that the fabric of 'old-as-frail' contains few to no threads of 'wellness,' or other diverse possibilities. So, for women, such as those in my study, who self-identify as experiencing wellness with oldness and frailty, there lacks a language representative of a concept or identity of 'old-as-well'. I wondered how this constrained and conflated understanding might be situated in relation to existing literature. There have been hundreds of theories of aging, so I considered the general categories of biologic, sociologic, psychologic, and successful aging theories and a few specific fundamental examples within each. I considered whether theories of aging supported or challenged an 'old-as-frail' conflated fabrication. I explored whether they offered 'well' or diverse conceptions of aging, and how these related to concepts of 'passing-as-young' or 'successful' aging, or distinguished gendered experience particularly for women.

I looked particularly toward feminist literature to explore feminist concepts of aging and 'old' women. Interestingly, academic feminists have paid scant attention to old age or ageism (Calasant et al., 2006; Cruikshank, 2013; Freixas et al., 2012; King, 2013; Twigg, 2004) and, where they have, their foci are not on aspects of health or frailty, but rather the social, political, demographic, and economic. Feminist contributions to aging theory have mainly been in the form of critiques. Critical feminists in gerontology (a field etymologically rooted in the Greek work 'geron', meaning 'old man') highlighted a paucity of aging theories with a perspective on women's experiences at the intersection of sexism and ageism (Cruikshank, 2013). Once again, key understandings from my study continue to show that conceptual conflation of 'old-as-frail' is a significantly gendered experience.

Critiques of aging theories, particularly successful aging theories (Rowe & Kahn, 1997), also resonate with concerns raised in my study that theories risk conflating 'old' and 'frail, particularly for women. Thus, the discussion that follows is structured around the common threads of feminist critique that support and at times extend the understandings generated in my study. These include a use of constructs and language which support conflating of 'old' and 'frail', lack understandings of 'old' and 'well', creation of a binary of 'old-and-frail' or 'well-and-passing-as-young', foster inequity of opportunity for women to age 'successfully', and justify gendered ageist shrouding.

My finding of conceptual conflations of 'old-as-frail' was not only shared by study participants but is evident in constructions of aging in existing theories. For example, biologic theories of aging have aimed to explain age as physiologic changes due to an accumulation of random cell damage from episodic events over a lifetime and/or a predetermined, timed series of events (Hirst et al., 2015; Jin, 2010; Lange & Grossman, 2018). Based on biologic theories, Kohn (1982) proposed that 'old' age is in itself a "syndrome" or "an ultimately fatal disease" (p. 2797). Expanding this line of understanding, Vasto et al. (2010) claimed that measures of this biologic syndrome (which overlap with those of physical frailty including declines in functional capacity and increased susceptibility to disease and death) could more accurately determine age than chronology. Though biologic theory scholars distinguish between the conceptual and language threads of 'frail', 'syndrome', 'disease' and 'senescence', and such differences are poorly understood by those outside of the field (Richardson et al., 2011), as illustrated by the self-identified critical feminist participants in my study. Further, these biologic concepts of 'old' have been accepted and uncritically given prominence because of biomedicine's power, rather than the intrinsic merit of the ideas (Cruikshank, 2013).

Next, I explored sociologic theories which can be viewed as explaining expectations of social frailty. For example, disengagement theory (Cumming & Henry, 1961) has explained aging as a "mutual withdrawal or disengagement, resulting in decreased interaction between the aging person and others in the social system" (p. 227). A reformation of disengagement theory has been the theory of gerotranscendence (Tornstam, 1996) which, though more recent, persists with an aim to explain and justify withdrawal from pragmatic and social activities with age (Wadensten, 2005). Rowe and Kahn's (1997) theory of successful aging posits 'old-as-frail' as a 'usual aging syndrome' associated with decline. Similar to findings in my study, such constructions homogenize the 'old' experience with that of frailty. Though varied in their specific explanations of age, existing theories generally weave threads of 'old' and 'frail' into a homogenous conceptual fabric, the density of which is tightened through language such as intrinsic, determined, inevitable, progressive, irreversible, and vulnerable (Cumming & Henry, 1961; Kohn, 1982). These examples demonstrate how social constructions of 'old' which are mired in meanings of decline, loss, and relatedly, frailty, support the understanding of conceptual conflation generated in my study.

Another key concern is how existing theoretical weavings of understanding 'old' age have not included many threads of wellness, leaving a paucity of vision and language for women's experience of 'old-as-well'. As Holstein and Minkler (2003) critiqued, "The equation of good health with success in successful aging theories (and by extension, disability and poor health with failure), fails to honor the many ways in which individual face changes that accompany aging" (p. 794). For instance, Pickard (2024) reported that successful aging theories "cannot by themselves account for the fact that *flourishing and frailty* are often found together, whilst conversely successful ageing may not bring satisfaction" (p. 2, italics added). Further,

conceptions of ‘wellness’ or ‘success’ in theories of ‘old’ age hold low expectations or, in Holstein and Minkler’s (2003) critique, have reduced “old age to the most basic norms, less than we would accept at other times of our lives” (p. 795). Specifically, and with italics added to exemplify key language, Erikson’s (1982) psychological theory constrains ‘wellness’ to ‘integrity’ based on satisfaction with one’s *past* and *acceptance of death*, Rowe and Kahn’s (1997) theory of successful aging conceived of ‘success’ as *low probability of disease and disability*, cognitively and physically *functional*, and actively socially *engaged* (Lange & Grossman, 2018; Wadensten, 2003), and Tornstam’s (1996) theory of gerotranscendence considers meaningful development in old age to be found in an *appreciation of solitude*, *greater attachment to fewer relationships* (Krause, 2009), and *less material or practical interests* (Blanchard-Fields & Kalinauskas, 2009). Even theories of adaptation (Carstensen et al., 1999) and accommodation (Brandtstadter, 2008) explain effective regulation in old age as a buffering of emotional well-being in the context of awareness of limited time and experience of loss by deemphasizing knowledge and information-seeking pursuits and reducing the breadth of social networks (Labouvie-Vief, 2009). These constrained theories of aging persist in current biased views of aging as highlighted in my study. Holstein and Minkler (2003) went on to question whether the setting of such a low bar for success wouldn’t work against the health promotion and maintenance activities for which it advocates, and what potentials and possibilities for ‘old’ age remain suppressed by their exclusion.

More recently, theoretical developments of ‘successful aging’ as ‘passing-as-young’ parallel those of frailty (Gullette, 2004; Langmann & WeBel, 2023; Pickard, 2024). This has led to a dichotomy of understandings between ‘old-as-frail’ signifying failure (Pickard, 2024) and the extent to which one is not ‘old’ signifying success (Holstein & Minkler, 2003). Between

these binaries remains a void of understanding of experience somewhere between these two positions, an experience which likely encompasses ‘authentic’ old age, as it was called by the women in my study. Authenticity discourse, as argued by Lacelle (2018), may “be capable of, on the one hand, acknowledging the positive potentials of growth and development that later life may harbor, which, on the other hand, provide support for recognizing and integrating the inevitable existential vulnerability and finitude that old age also confronts” (p. 970).

Theories of successful aging have been critiqued as selecting criteria for success which are, at least somewhat, determined by privilege. As such, they position marginalized groups, including ‘old’ women, at inequitable disadvantage in terms of opportunities for ‘success’ (Langmann & WeBel, 2023) and greater risk of ‘usual’ or ‘frail’ aging. In this way gendered ageism’s associations with frailty risk are strengthened. The underlying values of ‘success’, as described by Richardson et al. (2011), are those of “the ultimate American myth of the self-made man” (p. 24): ambition, competition, competence, and independence. But these are inadequate as models of aging, particularly for women (Cruikshank, 2013). Feminists point out that many other possible indicators of success, those primary to the lives of women, had not been selected, such as nurturing, caring, friendship, love, social activism (Holstein & Minkler, 2003), or power and agency (Jones, 2022). Expanding this feminist critique, Langmann and WeBel (2023) found conventional ‘successful ageing’ concepts to be particularly limited in their ability to account for experiences of people facing intersectional discriminations, such as sexism and ableism with ageism. For example, Rowe and Kahn’s (1998) theory of successful aging has lacked a view to the influences of genetics, life’s contingencies, and marginalization and oppression; instead, it assumed that everyone has the same position of privilege from which to self-care (Holstein & Minkler, 2003; Langmann and WeBel, 2023). If ‘successful ageing’ is not feasible for all, or

most, people, then "it serves to further privilege the already privileged, a danger that a feminist perspective identifies" (Holstein & Minkler, 2023, p. 792).

Furthermore, theories of aging which conflate conceptions of 'old' and 'frail' and ground conceptions of 'successful' aging as not 'old' both serve to justify ageism and gendered ageism (Langmann & WeBel, 2023). The negative perception of 'usual' aging as decline and frailty reinforces ageism and ableism, especially when chronic illness, disability, or frailty co-exists (Langmann & WeBel, 2023).

I have argued that the conceptual and linguistic threads of 'old' and 'frail' have been indistinguishably woven into theories of aging rendering a fabric of conflated understanding. This fabric of misunderstanding shrouds 'old' women in gendered ageist oppressions. The shroud, as explained in Chapter Four, is selected as the metaphor for gendered ageism which serves as both an action and object. A shroud is used "to cover or envelope so as to conceal [or obscure] from view" (Oxford dictionary online, retrieved August 24, 2024), to "put on a dead body for burial", and "to clothe, cover, protect" (etymonline.com/word/shroud Retrieved August 24, 2024). As a metaphor, the concept of 'shroud' as gendered ageism captures the ideas that it has been imposed by others, applied to conceal, justified patronizingly as 'protection', and is associated with death. In summary, to be shrouded in these ways potentially grooms and constrains 'old' women into positions associated with frailty risk as women conform under its weight, identified as Theme Two (self-inflicted typification), and through society being unable to see the personhood of 'old' women through its densely visible pattern of 'old-as-frail, identified as Theme Three (socially imposed typism).

Concluding Considerations

Conceptually, existing understandings of ‘old’ are narrow in their predominant focus on ‘frailty’ and their denial of possibilities of ‘wellness’. There is a need for concept and language development in the gap beyond existing binary constructs, particularly for representations of co-existence of well, old, and frail, and of health in ‘old’ age beyond maintenance and coping. There are continued calls for aging theories focused on the aging experience of women and the intersections of sexism and ageism (Calasanti, 2010).

Future research could pursue new angles of vision to develop more meaningful aging theories to inform healthcare of ‘old’ women. Existing understandings could be enriched by expanding its largely objective, biologic grounding towards that of subjective experiences (Pickard, 2024). Intersectional approaches would allow for development of understandings of the diversity of experiences of ageing and ageism at intersections with sexism and ableism (Langmann & WeBel, 2023). Langmann and WeBel (2023) illuminated that ableism may have a greater impact on health than sexism or ageism, as alluded to by women in my study, which highlights the importance of development of understandings of what this means in terms of marginalization and health risk for ‘old’, ‘frail’ women.

Nurse practitioner practice must consider the theoretical basis grounding its gerontological practice. Nursing theories have addressed aging vaguely, if at all. Wadensten and Carlsson (2003) reviewed 17 well-known nursing theories originating between the early 1960’s to 1990’s in order to delineate their views on aging and to what extent those descriptions could organize nursing care for older people. Of these, 4 did not discuss aging at all and 13 discussed aging from developmental perspective, “however, none of them has shown what this development leads to” (Wadensten & Carlsson, 2003, p. 122). Thus, general nursing theories arguably lack the particularity and holism required to guide gerontological nursing practice

(Lange & Grossman, 2018). Gerontological nursing theory has attempted to fill this void by explaining unique care needs of 'old' adults, often grounded on existing biologic, sociologic, and psychologic theories (Lange & Grossman, 2018). Nurse practitioners must maintain critical awareness of these theories' gendered ageist biases, limitations, and potential contributions to and justifications of associated marginalizations and risks to health. As Richardson et al (2011) have highlighted, "the language and theories of social scientists can be poorly understood by those outside of their field, yet biomedical clinicians and researchers should be aware of this literature so that unnecessary suffering is not unintentionally inflicted on our patients and our future selves" (p. 24).

Theme Two: Self-Inflicted Typification

The second key understanding of association between gendered ageism in the health domain and frailty risk is that gendered ageism may be self-inflicted as risk through individual typification of 'old-as-frail woman'. That is, 'old-as-frail' may self-inflict health risks from existing in the constrained space beneath the shroud, its weight exerting pressure to embody typification. I wondered how the understanding of typification of gender and age might be situated in existing literature and found that others have spoken of such a phenomenon using language of 'doing' or 'accomplishing' gender (West & Zimmerman, 1987) and 'age' (Laz, 1998). More specifically, I wondered about a phenomenon of 'doing' discriminatory constructs involving poor health, such as a gendered ageist 'old-as-frail' construct for women. Here I discuss key turning points of self-identification (Eisenhandler, 1991; Fillit & Butler, 2009; Gernier & Hanley, 2007; Laz, 1998; Warmouth et al., 2015) and self-relevancy (Levy, 2009), 'doing' a sick role (Cuikshank, 2013), and stereotype embodiment theory (SET) (Levy, 2009), which most directly supports my theme 'self-inflicted typification'. Further, I review recent

studies which have specifically explored health or frailty risks of self-inflicted gendered ageism. Lastly, I discuss how 'doing' gender and age, or performing 'old-as-frail' such as self-subjugation to meet immediate needs, might ultimately relate to reinforcement of the shroud. This second theme discussion concludes with considerations for reconceptualization, future research, and NP practice.

Scholars writing about typification of gender and age constructs have spoken of the phenomenon as 'doing'. West and Zimmerman (1987) have proposed 'doing' gender as a socially guided, unavoidable, "routine accomplishment embedded in everyday…perceptual, interactional, and micropolitical activities" (p. 126). They position it as "an accomplishment" in that the competence of one's "performance" of gender "can be subjected to evaluation" (p. 145) and "is hostage to its production" (p. 126). Laz (1998) extended this angle of vision to 'age', claiming that, like gender, age "normalcy is accomplished" (p. 101) in that "we create and maintain selves, roles, and identities…in all interactions…in predictable ways" (p. 100). Laz (1998) supported the understanding of typification in her explanation that:

> "we act with an eye toward accountability; that is, we anticipate how our actions may be characterized, understood or misunderstood, excused, condemned, etc., and act in ways that will minimize the need for accounting (since accounting holds the possibilities of being misunderstood, discounted, or contradicted). As a result, we often conform to dominant norms and conceptualizations, including those related to age and gender, even if we question or reject those norms." (p. 99)

Closer to my research question, my generated understandings suggest a self-infliction of discriminatory constructs of poor health for old women such as 'old-as-frail', which are manifested as risk through typification. I wondered what existing literature would say about how

identities or relevancies of health risk are self-inflicted as “something unpleasant to be endured” (Merriam-Webster, 2025). Current literature supports and explains such a phenomenon through perspectives of self-identification or relevancy, ‘doing’ a ‘sick role’, and embodying discriminatory health constructs, as discussed and illustrated below.

‘Doing’ or self-inflicting gendered ageist typifications are understood in my generated understandings and in existing literature as being triggered by key turning points of subjective identity with or relevancy of discriminatory characteristics, moreso than gender or age themselves. Laz (1998) described that “occasionally [age] comes to the forefront of our consciousness and we must deliberately make sense of [it], often in the context of certain events or milestones, changes in our physical appearance or physical conditions, or social roles and norms” (p. 100). She explained these as proxies for age, which decenter and render less explicit age and ageism. Levy’s (2009) stereotype embodiment theory uses the language of self-relevance of discriminatory constructs. Levy positions self-relevance as central to stereotype embodiment, in tension with my generated understandings which position subjective turning points or triggers as sources of variance. The phenomenon of turning points for self-identification or relevancy extend to frailty identity crisis (Fillit & Butler, 2009), a process or turning point of assuming a frail identity which is distinct from the authentic self and negative in nature (Grenier & Hanley, 2007; Warmoth et al, 2015). The congruencies between literature on self-identity as ‘old’ women, frailty identity crisis, and age stereotype self-relevancy raise possibilities yet to be explored that these distinct discourses may be exploring the same phenomenon of self-infliction of discriminatory constructs from different perspectives.

A ‘sick role’ has been explored by Cruikshank (2013) in which “old people may perform sickness when their environment gives them the appropriate cues. If they assume their illnesses

are natural concomitants of their age, they may feel fatalistic about their health" (p. 42). She argues that 'doing' a 'sick role,' or conforming to existing in the space beneath the 'old-as-frail' shroud, may insidiously create and normalize illness, or frailty, while suffocating imaginings of recovery or improved health and overshadowing accurate assessment of one's abilities, coping strategies, resilience, or alternative roles. A 'sick role' for 'old' women involves typification of increasingly dependent and powerless positions across frailty domains (Cruikshank, 2013).

My understandings in Theme Two are most directly supported by Levy's (2009) stereotype embodiment theory (SET) which has dominated the literature on ageism embodiment and health risk. Generated understandings from my study of self-inflicted associations between gendered ageism and frailty risk via typification, share support with SET literature in understandings of ageist discrimination as internalized over a lifetime; explicit and implicit in nature; escalated in salience with self-relevancy; occurring via psychological, behavioural, and physiological pathways; and embodied by individuals biologically and psychosocially (Levy, 2009). Tensions between understandings from my study and SET also provoke new wonderings. For example, in terms of the directionality of associations, SET has theorized a unidirectional pathway from ageism to internalization and embodiment; however, my generated understandings suggest the possibilities of bidirectional or cyclical associations in which, not only does ageism become internalized and embodied, but embodiment of stereotypical 'old' or 'frail' imaginings, such as a change in appearance or health, may trigger gendered ageism.

Warmoth et al. (2015) have supported my understandings in their assertion that not only has self-identification as 'old' or 'frail' potentially *led to* ageism embodiment, but also that self-identification as 'old' or 'frail' *stemmed from* declines in health domains. Warmoth et al. (2015) have explained self-identification as 'frail' as willing or resigned acceptance of the label and

embodiment of the assumed characteristics and behaviours, including poor health and functioning, disengagement from physical and social activities, depressive thoughts, negative affect, stigmatization and discrimination. This literature supports my generated understanding that gendered ageist constructs may be self-inflicted as typification of 'old-as-frail' risk.

I wondered what recent research could tell us about particular impacts on frailty risk of self-inflicted or embodied gendered ageism. Studies have found that, among the three types of ageism, self-directed ageism has been the most common and most strongly associated with increases in health risk (Ishikawa, 2023), and poor outcomes in relation to physical, mental, and chronic health (Allen et al., 2022). Factoring in gender, Ishikawa's (2023) study found stronger relationships to self-directed negativity and fears about ageing amongst women and, thus concluded that being a woman may be a "risk factor for detrimental health effects from ageism" (p. 10).

More particular to frailty risk, Vanleerberghe et al.'s (2023) study found "a positive correlation between self-directed ageism and frailty" (p. 11) in that "frailty increases self-directed ageism, while self-directed ageism reduces quality of life" (p. 11). Provocatively, they have suggested that frail persons may be more susceptible to associations between self-directed or inflicted ageism and health risk, though no gender differences were found (Vanleerberghe et al.). Another study by (Horst, 2019), focusing on the issue of retirement age and socioeconomic risk, found that "health pessimism is indeed related to a lower preferred retirement age" (p. 34) and that for women "considering oneself to be old was negatively related to the preferred retirement age" (p. 34).

Further, I discuss existing literature on generated understandings that 'doing,' identifying, or embodying gendered ageist constructs of 'old', frail, woman over the long-term serves to add

weight to the discriminatory shroud, despite their occasional beneficial uses for prompting social affirmation or securing assistance. West and Zimmerman (1987) have explained that 'doing' gender creates differences between women and men, which are not natural or biological but, rather, are constructed to reinforce gender distinctions as 'essential'. They offer Goffman's (1977) example of men 'doing' dominance and women 'doing' deference as differences justified as 'natural' but, ultimately, reinforcing of hierarchical power arrangements. Laz (1998) has added that, likewise, 'old' women participate in and constitute the impartment of meaning of age in society. While these sources are dated, they provide greater interpretation on participants experiences over their lifetimes.

Concluding Considerations

Critical feminist gerontological reconceptualization could serve to mitigate risks from self-inflicting gendered ageist assumptions of frailty in 'old' women. As Laz (1998) has described, how folks do their 'old' age and woman gender in any given situation is "the product of the interpretations and choices (often unconscious) we make among available individual, cultural, and institutional resources" (p. 102). As such, a critical feminist gerontology perspective could serve as alternative resource tool. Laz has offered examples which continue to be relevant today including that taking a "view of age-as-accomplished can deflect attention away from 'success' in aging…in order to devote more attention to diversity and the appreciation of variability" (p. 109) and extend consideration of the phenomenon to agency, choice, resistance, and recognition that the 'problem' is the situation in which 'old' women exist, rather than their age or gender. As such, critical feminist gerontological reconceptualization may offer protective benefits through highlighting that critical thinking may prevent internalization of oppressive

cultural messages, collective action may promote self-reliance, and decision-making that follows self-interest rather than a cultural imperative focused on their bodies (Cruikshank, 2013).

Future research should inform NPs about how individuals authentically experience and perform their age, a shift away from the focus to date on beliefs about aging, objective measures, and societal trends which have offered only clues. Laz's (1998) calls to examine how "chronology is *made* 'factual'," "the consequences of our acting *as if* chronology were natural" (p. 101), and "how, in particular contexts, individuals constitute and respond to the meaning of available resources" (p. 109) continue to be relevant. Further, as Horst (2019) has recognized, "Ageism will not be uniformly experienced by everyone of the same or similar age, nor will the consequences be the same" (p. 34), highlighting a call for intersectional knowledge development, particularly in relation to sexism.

A focus in NP education and practice on individual internalization and self-infliction assumes that this form of gendered ageism is most accessible for intervention in clinical encounters with 'old' women. However, a shift in approach to one which recognizes and intervenes with the societal source of gendered ageist discrimination could effectively reorient and 'situationalize' gender and age for 'old' women clients. Cruikshank (2013) has described how women need to unlearn gendered ageism and learn to be 'old' women. She has explained that:

> Learning to be old, then, means knowing that late-life illness has both cultural and biological origins. It means believing in one's capacity to recover completely from illness, accident, or disease in the face of skepticism or insensitivity from families and doctors. It means knowing that political and economic institutions are structured to offer

> some support for the sick old but very little for health maintenance or improvement (p. 42).

This extends to needing to unlearn gendered ageist assumptions of 'old-as-frail' internalized over a lifetime. "Many old women feel ashamed of their age. This is the most insidious form ageism takes. Consciously working through the negative associations with age that are nearly universal in this society requires effort" (Cruikshank, 2013, p. 152). Vanleerberghe et al. (2023) have concluded that "every effort should be made to prevent frailty, ageism, and self-directed ageism as they impact community-dwelling older people's quality of life" (p. 1). NPs have an opportunity and a responsibility to pursue such efforts in their own education and in healthcare encounters with individual clients through education and support to disrupt gendered ageism and offer a critical feminist gerontology view of gender and age as an alternative resource for intervention to mitigate 'old' women's frailty risk.

Theme Three: Socially Imposed Typism

The third theme of generated understanding suggests that 'old' women embody frailty risk associated with the imposition of societal typist shrouding. In existing literature, there is support for this theme in explorations of embodiment of 'old-as-frail' gendered ageism as occurring through the typism of others, and not solely from individual internalization and typification (Warmoth et al., 2015). Exploring associations between social and systemic gendered ageist shrouding and frailty risk emphasizes shifts from a focus on the symptom of individual internalization toward its underlying cause of objective activators in society (Chrisler et al., 2016). West and Zimmerman (1987) have explained it as:

> a situated doing, carried out in the virtual or real presence of others who are presumed to be oriented to its production…an emergent feature of social situations: both as an

> outcome of and a rationale for various social arrangements and as a means of legitimating one of the most fundamental divisions of society. (p. 126)

In this way, society's interactions with 'old' women are more about assigning, or shrouding in, socially constructed categories and associated typist assumptions which deeply oppress and produce social divisions and inequities, than they are about individual characteristics of age or gender (Harbison, 2015; Krekula et al., 2018), which is consistent with a key understanding generated from my study. Feminist scholars have described a phenomenon akin to typist shrouding; that is, a targeting of the 'old' with prejudicial social attitudes, discriminatory practices, and institutional structures and policies (Butler, 1980). As such, a 'doing' of age and gender may also be a 'doing' of gendered ageism (Krekula et al., 2018), an embodiment of frailty risk rendered via interpersonal and institutional interactions and constraints (Harbison, 2015).

Existing literature has explored several potential explanations as to how societal shrouding of 'old' people, most intensively 'old' women (Gullette, 2004; Meridio, 2024), may manifest as "barriers…in achieving health equity and wellbeing" (Meridio, 2024, p. 149) which harm "their health, quality of life, and social participation" (Meridio, 2024, p. 146). These barriers have included stigma (Link & Phelan, 2001), stereotype threat, microaggressions (Levy, 2009; Chrisler et al., 2016), minority stress, hostility (Chrisler et al., 2016), perceived unfairness (Jackson et al., 2006), structural discrimination (Hand & Ihara, 2024), social exclusion (Galabuzi, 2016), and positions of dependency (Townsend, 2007).

Associations with Frailty Risk

Existing literature has explored associations between manifestations of societal gendered ageist shrouding and embodiment of increased frailty risk. For instance, a targeting and

shrouding of persons as ‘old-and-frail’ has been associated as “pivotal” (Levy & Apriceno, 2019, p. 1) in an embodiment of “cumulative burdens” (Hand & Ihara, 2024, p. 32) and resulting negative health consequences. Numerous studies have illuminated associations with frailty risk particulars. For example, Link & Phelan (2001) have highlighted how stigma has a “dramatic and probably a highly underestimated impact on multiple life chances and health outcomes” (p. 381) and has been linked to negative outcomes across domains of health (Lebel and Devins, 2008). Lamont et al (2015) have found that age-based stereotype threat significantly affects women’s performance in physical, functional, and cognitive domains. Specific to domains of frailty risk, in the physical domain, associations have included stress response (Jackson et al., 2006; Levy et al., 2000; Taylor, 2012), weakness (Swift et al., 2012), poorer hearing (Barber & Lee, 2016), decreased function and increased dependency (Coudin & Alexopoulos, 2010; Joanisse et al., 2013). Psychological associations have been found in terms of poorer mental health in general (Hu et al., 2021; National Poll on Healthy Aging, 2020); increases in anxiety (Barrett & Toothman, 2016), fearfulness (Coudin & Alexopoulos, 2010), and depression (Lyons et al., 2018); and, decreases in cognitive performance (Abrams et al., 2006; Desrichard & Kopetz, 2005; Hess et al., 2003; Lamont et al., 2015). Socially, associations exist in terms of increased loneliness (Coudin & Alexopoulos, 2010). Environmentally, socioeconomic associations have been found associated with inequities in employment and income (Krekula, 2018; MacDonald & Levy, 2016; Office of the High Commissioner for Human Rights, 2019, in Meridio, 2024; Townsend, 2007).

Shrouding within the Healthcare Sector

The imposition of an ‘old-as-frail’ shroud on ‘old’ women within the healthcare sector is supported in current literature. Ageist discrimination in healthcare has been described as

"pervasive" (Meridio et al., 2024, p. 151), widespread and normalized (Ben-Harush et al., 2017), and, institutionalized, particularly in terms of gendered ageism (Chrisler et al., 2016). Shrouding in this sector is associated with 'old' women's frailty risk both directly, through reductive and marginalizing disparities and, indirectly, through a resultant isolation from healthcare (Chrisler et al., 2016; Meridio et al., 2024).

Direct typist shrouding of 'old' women in healthcare manifests as barriers, biases, and discriminations which result in worse healthcare, and health outcomes (Ben-Harush et al., 2017; Chrisler et al., 2016; Meridio et al., 2024). McFarland and Taylor (2021) have explained gendered ageist constructs of frailty in healthcare as "a product of powerful discourses of surveillance, individualism, risk, care, and safety" (p. 56) which have shifted the focus away from providing advocacy and services to *meet* their needs and, instead, towards *managing* their needs to *minimize* their impact on systems (Harbison, 2015). It has manifested in tendencies to group the 'old-and-well' in with the 'old-as-sick'; use patronizing, condescending, or dismissive approaches (Hummert et al., 1998; Macrae, 2018); offer less assessment, diagnoses, and treatment options (Chrisler et al., 2016; Macrae, 2018), and more ready medication prescriptions (Macrae, 2018). Levy and Apriceno (2019) have explained that:

> the misconception that ageing leads to illness and frailty leads doctors, nurses, and other medical professionals to attribute treatable illnesses and impairments of older adults to old age, resulting in less thorough examinations and diagnoses and reluctance to recommend aggressive treatments in older patients. (p. 7)

As older women are doubly stereotyped as frail, they are impacted more than older men (Chrisler et al., 2016; Levy & Apriceno, 2019). Common examples in existing literature of associations between gendered ageist healthcare approaches and escalated frailty risk have included

cardiovascular disease (an example commonly generated in my study also) (Chrisler et al., 2016; Vitale et al., 2016), disability (Reyes-Ortiz, 1997), breast cancer (Di Rosa et al., 2018; Pritchard, 2007) and incontinence (Griebling, 2011). These latter two, with their greater prevalence in 'old' women, are particularly provocative when considered from the angle of vision of gendered ageism. Recent literature on the Covid-19 pandemic has examined gendered ageism in healthcare and its imposition of undue frailty risk on 'old' women. Higgs and Gilleard (2021) have highlighted tensions between two patterns of ageist responses to the Covid-19 pandemic: lock-downs which disproportionately confined 'old' people to their homes based on chronological demarcations of those deemed automatically vulnerable and frail, and failure of systemic responses to value and preserve the health of 'old' people, particularly those in nursing homes, predominantly women. They highlighted that:

> The high death rates of older people in nursing homes, in particular, has been one of the most noteworthy internationally reported features of the pandemic…There was an implicit assumptions that this group (the care home population) constituted a less important category for policymakers than other groups when decisions about their needs were being made. (p. 3)

This has included inequitable access to healthcare (Mikton et al., 2021) and treatment within healthcare (Rodriguez-Rodriguez, 2022; Settels & Leist, 2022). Further, Rochon et al. (2021) has highlighted that "The dearth of sex and age disaggregated data masks the excess burden of morbidity and mortality experienced by older women", thus, "the disproportionate impact of Covid-19 on older women remains largely unrecognized and exposes the general lack of consideration give to older women." (p. 2).

Indirectly, healthcare sector discriminations and microaggressions impose escalated frailty risk through withdrawal and isolation of 'old' women from provider and service relationships (Chrisler et al., 2016). Clarke et al. (2014) have found that 'old' patients strategically employ self-subjugation, emphasize their frailty risk, and perform compliance in order to garner adequate attention from and reduce perceived burden on physician providers. Further they often seek alternate sources of information and support outside of the formal healthcare system. In Cruikshank's (2013) words:

> The old woman…who frequents doctor's offices performs subordination. …her infirmities receive far more attention than strengths and innate healing powers. Rarely will a doctor view an old patient as capable of returning to full vigor. Rarely does a patient have the opportunity to tell the whole story of…her illness in a way that emphasizes not only its severity but also …her coping strategies and resilience. An old woman may escape the most blatant forms of gender bias in her medical care—being diagnosed as demented if she expresses anger, for example—but gender may determine how seriously her symptoms are taken and whether or not a psychotropic drug is prescribed. (p. 42)

The consequence for 'old' women may be an encouraged disengagement from or underutilization of healthcare, forgoing its potential benefits as a means to avoid stigmatization and its associated harms, as explored in relation to mental health (Corrigan and Anderson, 2004) and cancer (Lebel & Devins, 2008). Thus, my generated understanding builds on existing research reporting that associations between gendered ageism and frailty risk may have had some grounding in 'old' women's isolation with their health concerns due to discriminatory healthcare,

which adds tension to a more common assumption of ‘old’ women’s supposed disproportionately greater use of and dependency on healthcare.

Concluding Considerations

A systemic social-imposition of gendered ageism has been a potentially novel and unexpectedly strong association with frailty risk for ‘old’ women. Existing biomedical theories of ageing have been limited by their focus on chronological age (Harbison, 2015) in isolation from ageism (Krekula et al, 2018; Levy & Apriceno, 2019). An expanded view of age and ageism as social determinants of health, consistent with gender and sexism (Public Health Agency of Canada, 2024), would allow crucial understandings of their health impacts as a reflection of inadequacies and inequities in the system, rather than as individual failures within that system (Mikton et al., 2021; Travers, 1996). Significant knowledge development has suggested that social determinants of health have far more potent influences on risk and outcomes than biomedical and behavioural factors (Raphael, 2016).

Further, the imposition of discriminatory shrouding of ‘old’ women and its associated frailty risk may be compounded for those at additional intersections of social determinants of health. Conceptual development of understandings of intersecting age, gender and disability is of particular interest in relation to frailty and has been considered a particularly potent discriminatory location in healthcare (Higgs & Gilleard, 2021; Krekula et al., 2018; Meridio, et al., 2024; Rogers et al., 2015), as consistent with my generated findings that ‘old’ women with visible disabilities are significantly more burdened with discrimination.

Generated understandings and existing literature call for a broadening of knowledge development of associations of gendered ageism with frailty risk from the view of individual

internalization to its social and systemic source. For example, Levy and Apriceno (2019) has called for a stop to isolating *age* research from *ageism* research. Laz (1998) has offered:

> The effort to counter the dominant assumptions may be a guide for research into age-as-accomplished. The refusal to take chronological age as fixed or determinate and focus on group process (in contrast to individual attributes) generates a variety of research possibilities. (p. 109).

Krekula et al. (2018) have concurred, suggesting an intentional dismantling of understandings of chronological age from discriminatory temporally-based life course assumptions. They have understood gendered ageism as consisting of differentiating practices which demarcate age and gender groups, give age-based meaning to bodies, and apply these codings to marginalization, subordination, and inequitable division of resources for the demarcated group. They highlight that the perspective of power has not so far been explicitly applied in work on the concept of gendered ageism and suggest interactional approaches for future research stressing that, “the need to understand the powerful alongside the powerless and opens a discourse of mutual shaping while recognizing the flexibility and the unfinished projects of creating differences” (p. 36).

A strengthening of research approaching intersections of age and gender have been suggested as key to knowledge development of health and healthcare inequities (Chrisler et al., 2016; Meridio et al., 2024). There have been specific calls for equitable inclusion of ‘old’ women in clinical trials (Bowling, 1999) and for gender and age disaggregated data in order to make possible an exploration of the burden of frailty risk experienced at those intersections (Rochon et al., 2021).

For education, practice, and policy, generated understandings and existing literature call on NPs in practice to apply their social justice mandate to critically confront gendered ageism as a means to decrease associated frailty risk, promote more multi-faceted understandings of 'old' women, and strengthen healthcare relationships and equity (Ayalon & Tesch-Romer, 2017; Chrisler, et al., 2016; Hand & Ihara, 2024; Levy & Apriceno, 2019; Meridio et al., 2024; Rochon et al., 2021). As Mikton et al. (2021) have announced, "Changing how we think, feel, and act towards age and ageing is a prerequisite for successful action on healthy ageing" (p. 1333). Various approaches have been suggested in existing literature to guide such a shift, for example, Human Rights Framework (Townsend, 2007), intersectional approaches (Hand & Ihara, 2024), social determinants of health lens (Mikton et al., 2021; Raphael, 2016), Positive Education about Aging and Contact Experiences Model (PEACE) (Levy, 2018), and trauma-informed approaches (Hand & Ihara, 2024). Specific suggested actions to mitigate gendered ageism include reflective practice to explore one's own internalized gendered ageist biases and prejudice within and across healthcare professions and systems (Ayalon & Tesch-Romer, 2017; Chrisler et al., 2016), disruption of myths and stereotypes of 'old' women (Hand & Ihara, 2024; Mikton et al., 2021), use of respectful communication with 'old' women (Ayalon & Tesch-Romer, 2017), and redesign programs and services led by, or in consultation with, 'old' women (Chrisler et al., 2016). Practice shifts can work towards conscious removal of threatening and burdensome discriminations for 'old' women in healthcare and enhancement of safe spaces where they feel freedom to choose authentic ways of being with which they self-identify (Calasanti et al., 2006, p. 26).

Study Limitations

In terms of the literature search to collect autobiographical participant sources, the small number of published age autobiographies written by ‘old’ women may be viewed as a limitation; however, the paucity of available sources has highlighted the potential need for these voices to be heard. Further, autobiographers’ ages were found to be limited to the late middle years and, thus, they have written on the process of aging; whereas, few if any were in the range of deep old age to write on the experience of old age itself (Twiggs, 2004). The context of autobiographers’ status in relation to frailty risk could not be known. There was a narrow range of diversity in the autobiographer sample (see Table 3). Understandings, therefore, may have less applicability to women living and aging in diverse social contexts and intersections.

In terms of the interviewee participant sampling, it is noted that the sample was dominated by well-educated, white, cis, heterosexual women (see Table 4) and there has been a need to acknowledge the positions of privilege and oppression of those being heard and consequent limitations to the relevancy for women in diverse contexts or intersections (McFarland & Taylor, 2021). As noted with autobiographers, the sample of interviewee participants, as per the sample of autobiographer participants, shared a narrow range of diversity. Thus, drawing on the work of McFarland and Taylor (2021), it is important that generated understandings be viewed in light of participant social positions and acknowledgement of voices not heard (McFarland & Taylor, 2021). Shared themes or patterns amongst a more diverse group may have strengthened findings, though it may also have risked rendering invisible the distinctiveness of voices at varying intersections (McFarland & Taylor, 2021).

Conclusion

The key generated understandings discussed above warrant prioritization for NP knowledge development and practice shifts, with consideration that their credibility is

particularly situated and intended to be tentative and non-generalizable. (Thorne, 2016). Considerations for NP knowledge development and practice community shifts are concluded below.

Knowledge Development

Conclusions for knowledge development have considered what my generated understandings may contribute to informing next logical steps for understanding associations between gendered ageism and frailty risk, in the context of study limitations, existing literature and practice interests (Thorne, 2016). Future questions and approaches could aim to develop understandings of potentially new dimensions of gendered ageism and frailty risk in an effort to inform clinical reorientations in directions advantageous to 'old' women (Thorne, 2016). To reiterate, the practice premises underlying my research question were that 'old' women may have resisted preventative or remediating interventions for 'frailty' risk and that there was a call to understand how gendered ageism may be associated. Generated understandings from my study have shifted the focus of my question from what's happening for individual 'old' women who resist such interventions, to what's happening in society and healthcare that 'old' women have disengaged, and there remain expectations of meaningless and marginalizing responses. Conclusions for future research have been oriented by this shift in understanding. As an angle of vision not yet explored, future research is invited to extend understandings of associations between gendered ageism and frailty risk to a systemic realm, explore operationalizations of extended conceptual dimensions for reliability and validity, and apply a critical feminist gerontology lens to explore gender differences.

Practice Community Shifts

A practice mandate underlies my generated understandings. It orients me to consider and report what might come as reorientations for NP practice, education, and policy development to be increasingly informed and thoughtful about potential associations between gendered ageism and frailty risk. The phenomenon has been insufficiently explored to-date to support such sensitivities. Recommendations are ventured as collaborations in an ongoing conversation about the phenomenon, within a context of nursing disciplinary logic and practice, and tempered by assumptions of the incomplete nature of general knowledge and particular limitations of my study (Thorne, 2016). Attention to two main shifts are suggested, including a broadened angle of vision on gendered ageism embodiment and frailty risk from the individualistic towards the systemic and a creation of safer spaces for women to claim 'old' and 'frail' free from discriminatory assumptions and responses.

Broadened Angle of Vision from Individualistic Towards Systemic.

Generated understandings for practice suggest a shift in the angle of vision on associations between gendered ageism and frailty risk from the individualistic, which has been the clinical focus, to the systemic. Expansion to a systemic view may inform and sensitize practice shifts to ease the burden of responsibility for gendered ageism embodiment and associated frailty risk from individual 'old' women towards that of social responsibility, particularly in healthcare. For example, new understandings have called into question practice emphases on self-management of individual psychological, behavioural, and stress responses to gendered ageism as a solution to potentially associated frailty risk. Such approaches seem to, metaphorically, 'treat the symptom and not the disease' and hold individual 'old' women to blame for systemically imposed proclivities to typification and constraints of typist shrouding. Generated understandings suggest instead an approach which emphasizes disruption of

underlying discrimination and marginalization as another effective means of mitigating disproportionate frailty risk. Further, generated understandings encourage a recognition that holding individuals responsible for inequitable risk from gendered ageism may be serving to distract and relieve social and healthcare responsibility for harmful oppressions and leave unaddressed the need for critical self-reflection and community action to disrupt gendered ageist harms. Critical shifts in ourselves and our communities of practice are surely accessible and attainable interventions to reduce inequitable frailty risk.

Creation of Safer Spaces for Women to Claim 'Old' and 'Frail'.

Generated understandings call for creation of safer healthcare spaces in which women feel safe to claim 'old', age-related health changes, or 'frailty', and engage supports, without a threat of inequitable responses grounded in gendered ageist 'old-as-frail' assumptions. Such shifts may be informed and sensitized by improved understandings of the meaningfulness of women being able to reclaim 'old' or 'frail' as particularly and diversely experienced. This calls for criticality and sensitivity in NP's use of the concepts and language of 'old', woman, and 'frail'.

Age-related health concerns could be approached with equitable attention and efforts to optimization of health and minimization of risk to those afforded to pathology-related concerns. Age-related health changes may be discussed with 'old' women clients more resonantly and less threateningly by framing them in terms of the issue they pose or the body part affected; and avoiding their attribution to 'old' or 'frail' labels which may be perceived as burdened with diminishing assumptions which may risk triggering of typification or threatening typist shrouding. NP practice may improve safety by holding space for 'old' women to self-identify their age and health as diversely experienced. Evidence, guidelines, and policy may be critically

reviewed from a feminist gerontology perspective and discussed with ‘old’ women in terms of gaps, biases, and limitations to improve transparency, informed healthcare decision-making, trust building, and conscious raising about gendered ageism’s associations with harms and the benefits of resistance.

NPs are called on to critically self-reflect, unpack, disrupt, and actively resist personal and professional gendered ageist assumptions, the explicit and the implicit. Active resistance and advocacy in healthcare practice communities, and society at large, are required to create shifts towards social justice and health equity for ‘old’ women. NP practice, viewed as holding community, social justice and health equity as core principles, may be strongly situated to lead shifts in healthcare to potentially disrupt negative health consequences of gendered ageist discrimination.

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Table 1: Autobiography Literature Search Results

Database	Results	Duplicates Removed	Total Dupicates Removed	Results Added For Screening	Total Results For Screening
WSI	452	29	29	423	423
AgeLine	78	3	32	75	498
CINAHL	187	25	57	162	660
PsycInfo	326	85	142	241	901
SS Abstracts	232	86	228	146	1047
MLA International Bibliography	17	0	228	17	1064
WorldCAT	48	11	239	37	1101

Table 2: Autobiographer Demographics

Author	Year of Pub	Author age	Religious Back-ground	Edu Work	Sexuality	Mother-hood	Countries of Residence
Bell	2012						
Copper	1997	68		Writer	Homo		
Friedan	2006	72	Jewish Agnostic	Journal	Hetero	Y	USA
Gallop	2019	67		PhD Professor	Hetero		USA
Grumbach	1991	70		MA Writer	Hetero Homo	Y	USA
Heilbrun	2006	80		PhD Professor	Hetero	Y	USA
Juhasz	2017	75		PhD Professor	Hetero	Y	USA
Kunin	2018	85	Jewish	MA Journalist	Hetero	Y	Switzerland USA
MacDonald	2001 ed.	70		MA Social Work	Hetero Homo		USA
Millett	2001	67	Irish Catholic	PhD Professor	Bi		USA
Paley			Jewish Agnostic	College Writer	Hetero	Y	USA
Segal	2013	69	Jewish	PhD Professor	Hetero	Y	UK
Sewell ed							
Steinem	2006	72	Protestant Jewish	Journalist	Hetero	N	USA

All autobiographers self-identified as white, woman/she/her, housed, SES safe/secure, non-frail.

Blank=Did not identify.

Table 3: Interview Participant Demographics

Pseudonym	Functional (In)dependence	Age	Religious Background	Education Work	Sexuality	Mother-hood
Viola	I	69			Homo	
Anna	I c support	79		PhD Professor	Homo	
Maya	I	78		Writer	Homo	
Ava	I	77		Manager Writer	Homo	
Nola	I c support	90+	Catholic	College Nurses aide	Hetero	Y
Ruth	I	79	Jewish	PhD Professor	Homo	Y
Estelle	I	76			Hetero	N
Vivienne	I	76			Hetero Homo	
Nancy	I	65		PhD Professor		
Olga	I			PhD Professor	Hetero	
Laura	I					
Lisa	I	69			Homo	

All participants self-identified as white, woman/she/her, housed, SES safe/secure, non-frail.

Blank=Did not identify.

Table 4: Interview Participant CFAI-Plus Scores

Pseudo-nym	Frailty score	Physical	Psych	Psyc Emotion	Social	Social Network	Enviro	Cognitive
Viola	.58 high	10 mild	12 mild	7 19 high	12 mild	4 16 mild	5 no-low	8 no-low
Anna	.38 mild	7.5 mild	3.3 mild	4.16 mild	2.5 no-low	8 10.5 mild	4 mild	8.75 high
Maya	.17 no-low	7.5 mild	.83 no-low	0 .83 no-low	0 no-low	6 6 no-low	1 no-low	1.25 no-low
Ava	.15 no-low	0 no-low	1.67 no-low	.83 2.5 no-low	2.5 no-low	2.5 5 no-low	0 no-low	7.5 no-low
Nola	.27 mild	15 mild	3.33 no-low	0 no-low	1.67 no-low	4.17 5.84 no-low	0 no-low	2.5 mild
Ruth	.125 no-low	0 no-low	2.5 no-low	1.67 4.17 no-low	0 no-low	3.33 3.33 no-low	0 no-low	5 no-low
Estelle	.30 mild	20 high	2.5 no-low	.83 3.33 no-low	.83 no-low	2.5 3.33 no-low	1 no-low	2.5 no-low
Vivienne	.30 no-low	5 no-low	5 mild	5.83 10.83 mild	4.17 no-low	4.17 8.34 no-low	0 no-low	6.25 no-low
Nancy	.16 no-low	0 no-low	2.5 no-low	4.17 6.67 mild	4.17 no-low	0 4.17 no-low	0 no-low	5 no-low
Olga	.09 no-low	0 no-low	.83 no-low	.83 1.66 no-low	0 no-low	4.17 no-low	3 mid	0 no-low
Laura	.22 mid	10 mid	1.67 no-low	3.33 5 no-low	2.5 no-low	3.33 5.83 no-low	0 no-low	1.56 no-low
Lisa	.29 mid	10 mid	2.5 no-low	5 7.5 mild	4.17 no-low	4.17 8.34 no-low	0 no-low	3.13 no-low

Appendix A

Comprehensive Frailty Assessment Instrument-Plus (CFAI)

PHYSICAL

Have the following activities been hampered by your state of health, if so, for how long?

	1. Not at all	2. 3 months or less	3. More than 3 months
1. Less demanding activities, like carrying a shopping bag			
2. Walking up a hill or some stairs			
3. Bending or lifting			
4. Going for a walk			

PSYCHOLOGICAL

Considering the last few weeks, to what extent do you agree with the following?

	1. Not at all	2. Not more than usual	3. More than usual	4. Considerably more than usual
1. I feel unhappy and depressed				
2. I feel like I'm losing my self-confidence				
3. I feel like I cannot cope with the problems				
4. I feel like I'm under				

constant pressure				

EMOTIONAL

To what extent do you agree with the following statements?

	1. I completely disagree	2. I disagree	3. Neither	4. I agree	5. I totally agree
1. I experience a general sense of emptiness					
2. I miss having people around me					
3. I often feel rejected					

SOCIAL

To what extent do you agree with the following statements?

	1. I completely disagree	2. I disagree	3. Neither	4. I agree	5. I completely agree
1. There are enough people whom I can rely on when I am in trouble					
2. I know many people whom I can totally trust					
3. There are enough people with whom I feel a bond					

SOCIAL SUPPORT NETWORK

Suppose you are unable to carry out the activities you usually do in the housekeeping for a certain while, whom would you be able to appeal to?

Partner		Grandchild	
Son		Sister (in-law) or brother (in-law)	
Daughter-in-law		Family	
Daughter		Neighbours	
Son-in-law		Friends	

ENVIRONMENTAL

Which statements are applicable to your house?

	1. Not applicable at all	2. Rather not applicable	3. Neither applicable nor non-applicable	4. Rather applicable	5. Completely applicable
1. House is in bad condition/poorly kept					
2. House is not very comfortable					
3. It is difficult to heat the house					
4. Insufficient comfort in the house					
5. I do not like the					

neighbourhood					

COGNITIVE

To what extent do you agree with the following statements?

	1. Totally disagree	2. Disagree	3. Neither disagree nor agree	4. Agree	5. Totally agree
1. I have trouble with remembering things that have happened recently?					
2.I experience difficulty with learning new things in general					
3. I experience difficulty with handling financial matters, eg. the pension, dealing with the bank					
4. I have trouble with following a story in a book or on TV					

De Roeck, E. E., Dury, S., De Witte, N., De Donder, L., Bjerke, M., De Deyn, P. P., Engelborghs, S., Dierckx, E. (2018). CFAI-Plus: Adding cognitive frailty as a new domain to the CFAI. *International Journal of Geriatric Psychiatry, 33*, 941-947. https://doi.org/10.1002/gps.4875

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Appendix B

Sample interview questions

What was your experience of completing the frailty tool?

What is your perception of frailty risk in relation to your own life?

What has been your experience with the frailty risk factors that are represented in the tool?

How have you perceived of gendered ageism in society over your lifetime?

How have you perceived of gendered ageism in the health domain over your lifetime?

How have you experienced gendered ageism personally, over your lifetime, if at all?

How do you perceive that these relate to frailty risk, if at all, over your lifetime?

How do these perceptions and experiences relate to frailty risk, if at all, as you've aged into later life?

What is your perception of how this may differ from earlier in life?

Can you tell me about key moments or turning points where you perceived or experienced a shift in the relationship, if any, between gendered ageism and your frailty risk?

What forms of gendered ageism do you perceive to be the most significant in terms of their relationship, if any, to frailty risk?

How do you perceive your critical feminist perspective to have influenced the relationship, if any, between gendered ageism and frailty risk in your own life?

How, without that perspective, do you perceive you may have experienced the relationship, if any, differently?

Can you tell me how you prefer to be addressed in terms of your gendered age group?

Appendix C

Participant Recruitment Email Script

Gendered Ageism and Its Potential Relationship to Frailty Risk:

A Critical Feminist Gerontology-Informed Understanding to

Reorient a Nurse Practitioner Approach

[Date]

Hello,

You are being contacted to inform you of an opportunity to voluntarily participate in a research study about critical feminist perceptions and experiences of gendered ageism and its relationship, or not, to frailty risk for older women. This study, titled "Gendered Ageism and Its Potential Relationship to Frailty Risk: A Critical Feminist Gerontology-Informed Understanding to Reorient a Nurse Practitioner Approach", is being conducted by Jinelle Woodley, a PhD student working under the supervision of Dr. Anne Bruce and Dr. Lorelei Newton in the School of Nursing at the University of Victoria. I am forwarding this to you subsequent to receiving my own invitation to participate, which was accompanied by the request that I forward it to contacts who may potentially meet the inclusion criteria.

The researcher is seeking individuals who identify as women and critical feminists, who have experience of aging in North America or Europe, and who are in the chronological age group of over 65 years. Your participation will involve completion of a self-rated comprehensive frailty scale and semi-structured, in-depth interviews with the researcher. The length, timing and location of the interviews will be based on the time required for your story and your preferences. Interview questions will ask for your stories of experiences and perceptions of gendered ageism

over your lifetime and into later life and how, if at all, these may be related to frailty risk. There will be one follow up meeting to review your story to ensure that it is represented as you intended. There may also be brief follow up interviews in response to the need for further clarifications or questions which may have emerged as the research progressed. Your story will serve as data for the study.

Your identity will be known to the researcher conducting the interview, however, data collected from you will be anonymized prior to its viewing by supervisors and presentation of the research. However, it is possible that your identity may be inferred or guessed at. Confidentiality of the data will be protected.

Participation in this study may cause some inconvenience to you, including the time required for participation, and there is the possibility of mild harms to you, including fatigue or emotional discomfort.

Potential benefits of your participation include raised consciousness, strengthening of social identity and group belonging, liberation from social forces, and empowerment to take action in your own life and for old women as a group. Your participation may also contribute to practice change recommendations for Nurse Practitioners, and other healthcare clinicians, to raise sensitivity and attention on these issues.

The study has been reviewed and received ethics clearance through the University of Victoria Human Research Ethics Board.

If you would like more information, have questions, or are interested in participating, please contact jinellew@uvic.ca directly and she will then send you a detailed information letter and consent form for your review.

Sincerely, Jinelle Woodley

Appendix D

Participant Information Letter and Consent Form

Gendered Ageism and its Potential Relationship to Frailty Risk for Women: A Critical Feminist Gerontology-Informed Understanding to Reorient a Nurse Practitioner Approach

You are invited to participate in a study entitled "Gendered Ageism and its Potential Relationship to Frailty Risk for Women: A Critical Feminist Gerontology-Informed Understanding to Re-Orient a Nurse Practitioner Approach" that is being conducted by myself, Jinelle Woodley.

I am a PhD student in the School of Nursing, Department of Human and Social Development, University of Victoria. You may contact me if you have further questions by calling xxx-xxx-xx53 or emailing jinellew@uvic.ca

As a graduate student, I am required to conduct research as part of the requirements for a PhD in Nursing degree. It is being conducted under the supervision of Dr. L. Newton and Dr. A. Bruce. You may contact them at: Dr. L. Newton, xxx-xxx-xxxx, lorelei@uvic.ca or Dr. A. Bruce, xxx-xxx-xxxx, abruce@uvic.ca;

Purpose and Objectives

The purpose of the research project is to improve understanding of gendered ageism and its potential relationship to frailty risk for women to inform Nurse Practitioner practice. The objectives are to 1) hear, describe, analyze, and interpret stories of how gendered ageism relates to frailty risk, as told by women with a critical feminist perspective and experience of aging into later life; 2) to collect and examine across many stories to inform commonalities and variances;

3) to suggest ways for Nurse Practitioner practice to respond; and 4) to raise conscious awareness of gendered ageism and any potential relationship with frailty risk for women as they age, as a prelude to change.

Importance of this Research

Frailty in older adults and its related healthcare implications are an increasing priority. Ageism is emerging as having a relationship with decline and poor outcomes as individuals age, and ageism in the health domain may be particularly negative for women. Gendered ageism may play an as-of-yet unexplored role in the risk of multidomain frailty. Nurse Practitioners (NP) are often the most appropriate healthcare providers for older adults living with complex health conditions and have a social mandate to address health inequities. NP practice thus requires an increased understanding of this phenomenon to inform a response to improve care and health equity.

Participant Selection

You are being asked to participate in this study because you were previously contacted by either a faculty member at the University of Victoria School of Nursing or a previous invitee, to whom you responded and confirmed an interest in receiving more information or participating. The referring person also identified you as an individual who identifies as a woman, with a critical feminist perspective, experience of aging in Western countries, and being in the chronological age group of over 65 years.

What is involved

If you consent to voluntarily participate in this research, your participation will include completion of a brief frailty self-assessment tool; engagement in semi-structured, in-depth, narrative interviews; and one follow up meeting for review of your story. There may also be

brief follow-up conversations with me for clarification and questions which might emerge as the research progresses. The interview length and schedule will be based on the depth, detail, and complexity of your story and will accommodate your preferred schedule. The location may vary based on your preference and geographical location, but options may include a pre-booked private room at the University of Victoria, or a secure web-based conference technology, such as the university's secure version of Zoom. Zoom servers are located outside Canada and Zoom stores users' names and usage data outside Canada. No other information is stored outside of Canada and recordings of Zoom meetings are not stored on Zoom servers.

At the first interview, you will first be asked to complete a brief self-rated comprehensive frailty scale. This will orient you to the definition of frailty being used for the study and will be used by me as a contextual aspect of your interview. Anticipated interview questions may include: What was your experience of completing the frailty tool? Can you tell me how you have perceived of frailty risk in relation to your own life? Can you tell me about your own experiences of the frailty risks that are represented in that tool? Can you tell me about how you have perceived of gendered ageism in society over your lifetime? How have you perceived of gendered ageism relating to the health domain over your lifetime? Can you tell me how you have experienced gendered ageism personally, over your lifetime, if at all? How, if at all, did these relate to your health? What is your perception of how, if at all, these perceptions and experiences relate to frailty risk as you've aged into late life? How has the relationship, if any, between gendered ageism and frailty risk changed as you've aged into late life? Can you tell me about key moments or turning points through which a shift in the relationship between gendered ageism and your frailty risk in your life was experienced? If you perceived of a relation between gendered ageism in the health domain and frailty risks, what forms of gendered ageism do you

perceive to have been the most significant? How do you perceive your critical feminist perspective has influenced the relationship, if any, in your own life, if at all? And how, without that perspective, do you perceive you may have experienced the relationship differently? Can you tell me how you prefer to be addressed or identified in terms of your gendered age group? The interview will center on your story and my focus will be on drawing out depth and detail through conversation. The interview will end with a summary of key themes that I heard.

The interview will be audio-recorded, with your permission or, should you prefer, detailed notes will be taken. Then the recording will be transcribed verbatim and then rewritten to be readable and sequenced.

Inconvenience and Risks

Your participation may cause some inconvenience to you, including the time required. There are some potential risks to you by participating in this research including the possible risk of fatigue or emotional discomfort from conversation which draws attention to your body, your health, or content not usually highlighted in your daily life.

To prevent or deal with these risks, I will use strategies to not take advantage of your emotional states, check in with you that you are revealing only what you are comfortable with, and confirm your continued free consent to proceed with the research process.

Health risks are associated with possible exposure to COVID-19 for in-person interviews. To minimize such a risk, you will have the option of virtual interviews. Should you choose in-person interviews, the University of Victoria Communicable Disease plan will be followed; specifically, you and I will share our proof of vaccination, sanitize our hands immediately prior meeting, and wear masks throughout the interview. You will be advised if you were potentially exposed to an individual who has tested positive for COVID-19. Your contact information will

be stored in a separate file from research data in the event that follow up for contact tracing related to this exposure is needed.

Benefits

The potential benefits of your participation in this research include raised consciousness, strengthening of social identity and group belonging, liberation from social forces, and empowerment to take action in your own life and for old women as a group. Your participation may also contribute to practice change recommendations for Nurse Practitioners and other healthcare disciplines, to promote health and prevent frailty for old women.

Compensation

No incentives will be offered for your participation. Should expenses related to transportation or parking be incurred for attendance at in-person interviews, reimbursement will be offered. A thank-you gift worth less than $30 will be provided after your involvement in the study has ended.

Voluntary Participation

Your participation in this research must be completely voluntary. If you decide to participate, you may withdraw at any time without any consequence or any explanation. If you do withdraw from the study having partially completed an interview, you will be asked whether data collected to that point may or may not be used. Should you wish for none of the data to be used, any notes or recordings will be destroyed.

Anonymity

During the interview, you will not be anonymous to me as I will be interviewing you. The data collected from you will be anonymized prior to its viewing by my supervisors. Efforts will be made to maintain your anonymity in any presentation of the research and, at the follow up

meeting, I will confirm with you that you agree that your anonymity is adequately preserved in the story. However, it is possible that your identity may be inferred or guessed at, particularly if you were referred to the project by persons at the University of Victoria School of Nursing, are within a certain age range, and whose identity as feminist may not have been held privately amongst the field of scholars.

Confidentiality

Your confidentiality and the confidentiality of the data will be protected. Data will be held as audiotapes, transcriptions of interviews, and my reflective journals as researcher. These will all be protected and stored in password protected computer files or a locked file cabinet by myself. Data collected will only be used for this project.

Dissemination of Results

It is anticipated that the results of this study will be shared with others in the following ways: publication of results in a peer-reviewed journal and presentation of findings at professional conferences. The dissertation will be publicly available on the UVic Library website "UVic Space." The findings will be made available to participants via email. I commit to align the direction and presentation of findings with the approved and consented to scope, objectives and purpose of the study and avoid diverting any product of research toward unsanctioned directions.

Storage and Disposal of Data

Data collected will be stored in the University Systems network storage, hosted solely in Canada, and will be stored for no longer than 5 years. At that point, data from this study will be destroyed; specifically, erasure of electronic data and shredding of paper notes. It will not be

available, now or in the future, to other persons for other purposes, including commercial purposes.

Contacts

|You may contact myself or my supervisors in regards to this study. You will find our contact information at the beginning of this letter.

In addition, you may verify the ethical approval of this study, or raise any concerns you may have, by contacting the Human Research Ethics Office at the University of Victoria (250-472-4545 or ethics@uvic.ca).

Your signature below indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have your questions answered, and that you consent to participate in this research project.

Name of Participant _____

Signature _____

Date _____

Please retain your original signed copy of this consent, and send or scan a copy to myself.

Appendix E

Sample Letter Of Request to the *[Name of Organization]* for Assistance in Recruiting Nurse Practitioners for a Thoughtful Practitioner Test

Gendered Ageism and Its Potential Relationship to Frailty Risk:

A Critical Feminist Gerontology-Informed Understanding to

Reorient a Nurse Practitioner Approach

School of Nursing

University of Victoria

[Date]

Dear

This letter is a request for *[name of organization]* assistance in recruiting Nurse Practitioner (NP) experts for a research project I am conducting for my PhD in the School of Nursing at the University of Victoria under the supervision of Dr. Anne Bruce and Dr. Lorelei Newton. The title of my project is "Gendered Ageism and Its Potential Relationship to Frailty Risk: A Critical Feminist Gerontology-Informed Understanding to Reorient a Nurse Practitioner Approach"**.** I would like to provide you with more information about this project and NP involvement.

The purpose of this study is to describe and interpret how women with a critical feminist perspective and experience of aging into later life perceive of and experience gendered ageism and its potential relationship, if any, to frailty risk for older women. Knowledge generated from this study may inform directions for NP practice change and social action.

It is my hope to connect with NPs who have more than 5 years experience working in seniors health specialty services or primary care with a significant proportion of clients who are women in later life to invite them to participate as members of a focus group. The content of the focus group conversation will serve as collateral information which will potentially provide diversity beyond what I have seen, stimulate and challenge my interpretations, enhance the study's trustworthiness, and test the usefulness of the interpretations for the intended audience of NPs. All notes, recordings and transcriptions of the focus group content will be held securely and separate from participant identifiers and will be destroyed upon completion of the project.

To respect the privacy and rights of your organization, I would not contact members directly, but rather I would provide your organization with a recruitment email script to be distributed to your members, at your discretion. Should a member be interested in participating, they would contact me directly via my contact information which will be included in the email script.

Participation of any NP is completely voluntary. The focus group discussion is not considered data for the study and, as such, no quotes or identifying information of any members would be included in the presentation of findings. No ethics approval is required for the conduction of the NP focus groups. There are no anticipated risks to members, though a time commitment is required. There may be benefits to participants, including professional development and sensitization to the phenomenon under study. The study itself has been reviewed and received ethics clearance through the University of Victoria Human Research Ethics Board.

If you have any questions regarding this study or would like additional information to assist you in reaching a decision about participating in the distribution of recruitment emails to

your members, please contact me by email at jinellew@uvic.ca. You may also contact my supervisors, Dr. Anne Bruce at abruce@uvic.ca and Dr. Lorelei Newton at lorelei@uvic.ca.

I hope that the results of my study will be beneficial to the NPs in your organization and older women receiving their healthcare. I very much look forward to hearing from you and thank you in advance for your consideration of assisting with this project.

Sincerely,

Jinelle Woodley, MN-NP, PhD in nursing student

School of Nursing

University of Victoria

Dr. Anne Bruce

Professor

School of Nursing

University of Victoria

Dr. Lorelei Newton

Associate Professor

School of Nursing

University of Victoria

We agree to help the researcher recruit participants for this focus group from among the members of or organization: Yes: _____ No: _____

We agree to the use of the name of the organization in any dissertation or publication that comes of this research: Yes: _____ No: _____

Director name: _____

Director signature: _____

Board of Directors Representative Name: _____

Board of Directors Representative Signature: _____

Witness Name: _____

Witness Signature: _____

Date: _____

Appendix F

Recruitment Letter for Nurse Practitioners for a Thoughtful Practitioner Test

Gendered Ageism and Its Potential Relationship to Frailty Risk: A Critical Feminist Gerontology-Informed Understanding to Reorient a Nurse Practitioner Approach

[Date]

Dear fellow Nurse Practitioners (NP)

Hello,

You are being contacted to let you know about an opportunity to serve as a voluntary expert NP for a research study about gendered ageism and its potential relationship to frailty risk of older women. This study is being conducted by myself, Jinelle Woodley, a PhD student working under the supervision of Dr. Anne Bruce and Dr. Lorelei Newton in the School of Nursing at the University of Victoria. You are being contacted as a member of the *[Name of Organization],* who agreed to distribute this invitation to their members.

I am seeking Nurse Practitioners with more than 5 years experience working in seniors health specialty services or primary care with a significant proportion of clients who are women in later life. Participation will involve attendance at focus groups of one hour duration. The number of focus groups will be determined by the amount of time required for you and the other members of the group to feel that they have nothing else to contribute. Two to three sessions are anticipated. The scheduling of the focus groups will be planned based on feedback about your availability. Focus groups will be held via a secure Zoom link, in order to accommodate attendance from potentially diverse locations across the province. Your attendance at the session will serve as implied consent. You will be presented with emerging interpretations based on the

data. You will then be asked to discuss them based on their practice experience. The following questions are anticipated: Do these resonate with what you have seen in your practice? What challenges to the data or interpretations would you put forward? What variances do you see in your practice? What might be missing or misleading? How might these ideas be useful in shifting practice? I will be taking notes and the discussion will be recorded and transcribed for my review. Your name and contact information, and that of the other members, will be stored in my locked electronic file and separate from the notes, recordings and transcriptions of the discussion. Upon completion of the study, all files will be destroyed.

The NP focus group discussion will not be used as data. As such, no quotes or identifying information will be used in the presentation of findings. No ethics review is required for this part of the research process. Participation is entirely voluntary. You are free to refuse and no inducements to participate will be offered. A token of appreciation of less than $20 in value will be given to you at the completion of the focus group. There is no power-over relationship, as we are colleagues and I am consulting you. There are no anticipated risks, though it will require a commitment of time. Members may benefit from the enrichment of their professional development and competency portfolio in the area of research. Participation may also sensitize NPs to the phenomenon under study.

The identity of the NP members will be known by me. It is possible that there may be a collegial familiarity between myself and some of the members due to our common professional community. NP members will not be identified or named to others in the focus group and use of the camera will be voluntary. However, indirect identifiability may occur since a member may be recognizable to other NPs in attendance due to voice, appearance, and membership in the British

Columbia NP community. No identifying information will be revealed in any presentation of the study.

If you are interested in participating, or would like more information, please contact me at jinellew@uvic.ca. Should you confirm your intent to attend, I will send a confirmation email and begin negotiating the specific time of the focus group along with the connection information for the virtual group meeting. If you have to cancel or reschedule your attendance, please email me at jinellew@uvic.ca.

Sincerely,

Jinelle Woodley

Appendix G: Excerpts from Researcher's Own Age Autobiography

I acknowledge the privileges and oppressions of my identity as:

-57 years old

-she-they; prefer to opt-out of gender

-pansexual living in a heterosexual partnership

-white, of colonial settler heritage

-healthy with invisible disability

-middle-class

-gerontological nursing professional

*****

"That's no way for a young lady to act!", said my mom…often! With the best of intentions, she squashed me and my sister into her singular mold of how to be properly successful 'ladies'….be chosen for marriage, mother children, have a 'feminine' profession, earn an income sufficient for independence if needed. I never thought about what was past those goals likely achieved by the age of 35. My life beyond was a void, seemingly meaningless in its comparative importance to what I would do as a 'young lady'. I can't recall any aspirational encouragement, or even chit-chat, about later life….even middle life….with the exception of being financially comfortable enough to retire after decades of work. I had very few old women in my family and can't recall any iconic old women in the world around me as potential role models. The only images of old women I recall are ridiculous, vulnerable, and wicked characters from fairytales and movies.

*****

I make a conscious effort to exude pride in stating that I nurse in Seniors Health or Geriatrics. Nonetheless, the most frequent response is “how depressing”, “working with dying people who can’t be helped”, or “no one gets better”. Acute care nursing always seems regarded as more glamorous and heroic. I’ve never seen a TV show about long term care! Even amongst nurses, geriatrics seems to be delegated to the lowest rung: the spot where nursing students in first year learn their basic skills (bedpans, bed changes, transferring). I wonder why caring for the ‘old’ has been so devalued? Caring relationships seem celebrated in art and media….parents caring for children, colleagues supporting each other, teachers caring for the disabled…but few, if any, images come to mind of persons cherishing or finding reward in their care for the old. It exists, buts as a burden to relatives or a profit for business. I have found it beautiful to care for those who surpass us in life experience and knowledge….what an honour, but not as a ‘favour’ to the ‘old’, but as part of a long-term reciprocity, an equity of care for all of us when its needed. Not “Poor you, you have to go care for your dad this weekend”, but “How rewarding to have your dad and share care across your lifetimes?

*****

My coach circulates the gym encouraging those around me with “Why not try pushing a little more weight today?” and “Come on, you slacking off today? He turns to me “How does that weight feel? Ease up a little.” I am ‘excused’ from not investing the intensity of work that others do. No one notices when I back off on a tired day. They expect little from me, aren’t expecting my goals.

*****

“She’s amazing for her age” my mom would state after every visit with my great auntie. I agreed. She was healthy, bright, happy, sweet. A perfect hostess to family and her husband’s

army friends, serving drinks and baking. She reminded me constantly of Disney's Snow White with her jet black dyed curls, red lipstick and shrill cheerful voice, which I felt sure must attract the birds and the butterflies when she was alone. She surely felt bolstered by the praises of her 'loveliness'.

Lately, I've wondered, who was she *really*? If not accomplishing the 'sweet, little old lady" role, what might have emerged? I'm kind of disappointed to now wonder what she had to oppress and at what cost? And how heavy was the pressure on her to be 'amazing' instead of 'just an old woman'? What would have been *her* version of amazing?

*****

"You can't expect to run as strongly anymore, and you'll decline from here." It felt like a face-slap, a gut-punch. So unexpected, dismissive. This physician, with an abundance of confidence in the imposition of her own voice, and a paucity of interest in mine, declared her diagnosis: Peri-menopause. This untreatable 'truth' from which I alone would have to fumble a way forward. Subduing my emotions and questions in order to support her ego, I ventured an "I guess so?" I doubted myself, I've never been pre-menopausal before, so maybe? But, "Perhaps I could get some bloodwork checked, just in case." "No," she said irritably, "That really isn't necessary." "Oh…okay."

My thoughts shifted to the work of coping with the end of my athletic life–I grieved a little. I guess I'll never run the Boston marathon or qualify for that CrossFit competition.

Not long after, I reflected that, of course I knew this diagnosis did not make sense; I mean, I had been doing athletics with ease up until a couple of months ago.

3 weeks later I was in emergency with heart palpitations, chest pain, and restless legs too severe for me to sleep. They found severe anemia. “Yay!” I was validated. I can and should trust myself.

I questioned what was wrong with me! I knew better! How was I, a nurse, an NP, and an athlete (who can’t keep up on with women running partners in their 70’s), so easily disoriented from my self-awareness and knowledge? I am ashamed of my ready vulnerability to fear-mongering messages about ‘old ladies’ and life-limiting menopause, not to mention insecurity in the face of medical privilege. I wondered about the consequences of long-standing, subconscious hesitation to lift heavier weight or feel my heart pound ‘too’ hard—How much do these hold me back?

*****

I sat around the lunch table with my friends. A comment from a neighbouring table jumps out at us: “Are there just going to be a bunch of geriatrics at the party?”

This prompts a sharing of stories of our mothers’ experiences which deterred them from pursuing healthier life choices. Alli’s mom had been finding her recommended Pilates too easy and wanted to progress to a harder class but, despite her good health, her doctor refused to sign the requested medical form. Kay’s mom had been slow to get her debit card out to pay because of arthritic hands and finds people swoop in without her consent to ‘help’ her. She dares not assert her capability for fear of being then treated as ‘a nasty old woman’. I’m reminded of my mom who had a fragility fracture attributed to being female, of a certain age, white, small build….was treated as biologically inevitable. I noticed that no one spoke of the potential contributions of her ‘lady-like’ lifestyle, significantly less physical than my dad’s over the decades of their marriage. Surely that’s worth considering I thought. Then, of course, there were

my mom's night sweats in her 70's dismissed as menopause…and not investigated and diagnosed as cancer until much too late.

My friends don't see themselves following a similar pathway, but I see these patterns in them already. "I have an old injury so I can't….", "I can't go back to school, I'm already forgetful after menopause", and "I'd never get hired…"