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# 13 Getting Beyond ‘*Mustn’t Grumble*’ and ‘*What Can I Expect At My Age*’: A Narrative Approach to Older Women’s Health Stories

PAT CHAMBERS

When asked by researchers to rate their health, many older women reply: “Mustn’t grumble”. Other older women, who objectively may manifest similar or fewer health problems but may have internalised ageist and sexist assumptions, will reply: “What can I expect at my age”. Indeed, the discrepancy between so-called “objective” measures of health in later life and lay perspectives is well reported in the literature on old age. However, little attention has been paid to the way in which these diverse responses arise from older women’s attempts to make sense of changing health circumstances in the context of their individual, and collective life course, and growing old in an ageist society.

This chapter, therefore, seeks to raise such a discussion by drawing on data derived from recent empirical research on older women and biography (Chambers, 2002a) to explore the interaction of personal/collective biography, ageism and current self reported health in the types of ‘health stories’ older women tell.

## **Introduction**

The gendered nature of later life is well documented (Arber and Ginn, 1991, 1995; Bernard and Meade, 1993; Bernard et al., 2000; Gibson, 1996; Stevens, 1995, 2001) with some commentators suggesting that old age is a female experience (Gee and Kimball, 1987). Indeed, after the age of 80 years women outnumber men in the ratio of approximately 4:1 (ONS, 2000). However, despite this greater longevity, statistical evidence (ONS, 2000) suggests that in terms of ‘health and illness’ older women do not seem to fare too well. For example, their health is likely to suffer as a result of caring for an ailing spouse, widowhood and financial and material disadvantage (Arber and Ginn, 1991, 1995). Furthermore, they are likely to develop chronic conditions which may result in limited mobility, and if they do need assistance with daily living,

they are likely to receive differential support from formal caring services when compared with the support available to older men (Sidell, 1995). Indeed, it could be argued that in an attempt to highlight the gendered nature of health and material resources in later life there has been a tendency, even in some of the gerontological literature, to 'problematise' older women (see Gibson, 1996 for a useful discussion of the 'problematism' of older women).

On the other hand, qualitative evidence is available which suggests that, despite changing health circumstances and material disadvantage, older women are able to adapt (perhaps as a result of the flexibility that is developed in the course of their lives, in which they manage multiple 'careers') and talk positively about their changing health circumstances. According to Stevens (1995) for example, throughout adulthood women are subject to repeated role loss and the necessity for readjustment, and thus undergo a socialisation process that facilitates adaptation in later life. There is also evidence to suggest that women are able to develop and sustain nurturing relationships from which they gain both material and emotional support (Gibson, 1996), and which enable them to successfully manage what may objectively appear to be quite stressful circumstances.

Lay perspectives of health and illness offer a further dimension to our understanding of older women's health by demonstrating the way in which older women's responses to questions about health are socially constructed within an ageist and sexist society (Sidell, 1995). However, recent biographical research on later life widowhood (Chambers, 2000, 2002a, 2002b) whilst acknowledging the social construction of age and gender inherent in older women's responses to specific questions, has suggested that in order to get beyond such socially constructed responses and better understand what influences the 'world view' of older women, we need to engage with their individual and collective life stories and the multiple narratives which arise from those stories.

This chapter therefore draws on that work and seeks to understand older women's attempts to make sense of changing health circumstances in the context of their individual and collective life course, and growing old in an ageist society.

Firstly, I briefly explore what the literature tells us about lay perspectives on health and what might influence those perspectives. I highlight the discrepancy between what older women say and so-called "objective" measures and cite evidence to demonstrate the way in which age, cohort, gender and class impact on these perspectives. I then go on to provide examples from my own recent research to examine the way in which older widows talk about their health and the context in which that 'talk' occurs. The interaction of personal/ collective biography and structured ageing on the 'health stories' these women tell is also explored.

### Older Women's Perspectives on Their Health

What influences lay perspectives on health generally? According to Cornwell, (1984 cited in Sidell, 1995) they are influenced by factors such as age, gender, class and culture, rather than 'objective' measures of illness and wellness. This is borne out for example by research which suggests that, despite the statistical evidence pointing to high levels of chronic illness, older women in the United Kingdom generally rate their health as 'fairly good' (Bernard, 2000).

Despite a number of campaigns which seek to promote a healthy old age (see Bernard, 2000) and, indeed, a wealth of research in Gerontology (for example, Thompson et al., 1990; Bytheway, 1995; Sidell, 1995; Phillipson, 1998; Bernard et al., 2000), old age is popularly, and often professionally, constructed as a time of inevitable decline and ill-health. So powerful is the myth that it is sometimes difficult to disentangle age and illness in older people's health stories. According to William (1990) "the belief that age brought about illness was sufficiently entrenched to make it possible eventually to make illness the grounds for seeing oneself as 'really old'" (p.63). One of the effects of this myth is that older people in general have low expectations of health in later life and thus construct their concepts of 'health' according to the dominant public narrative of old age as pathology: hence *'Mustn't grumble'* or *'What can I expect at my age?'* More specifically for older women, this may be further compounded by the sexism which results in the 'problematism' of older women in social policy, health and social care practice (Hughes, 1995; Gibson, 1996; Bernard et al., 2000; Granville, 2001).

Although not widely reported in the literature, we must also take note of the impact of 'cohort', as well as age, on the way in which older people construct aspects of their lives (Giele and Elder, 1998; Chambers, 2002a, 2002b). It could be argued that the current generation of older women demonstrate a cohort 'passivity' in their construction of health, with many of them believing that they can do little to influence their own health and well being (Greer, 1990). Wenger's (1988) research in North Wales highlights a 'moral' aspect of older people's attitudes to health and illness which may also be 'cohort specific': "Good health is associated with the right attitude and moral fibre and complaining or talking about health is seen as self-indulgent" (pp.12-13). This confirms other work on the way in which older women talk to each other about 'health' in settings such as older people's clubs (Jerome, 1981, 1990).

The final dimension which is relevant to the current discussion is the way in which 'class' is juxtaposed with age, cohort and gender. Blaxter and Pearson's (1982 cited in Sidell, 1995) study of working class grandmothers and their daughters highlights the particularly low expectations of health held by older working class women, with 'health' being constructed simply as being

able to go about ones daily business. Such class differences in expectations of health are also confirmed by Calnan (1987) who suggests that working class older women are more likely to perceive health as 'not being ill' or 'getting through the day'. In contrast, for middle class older women, health is much more likely to be associated with fitness and exercise, or coping with the stresses and crises in life.

Having ascertained some of the structural issues which underpin older women's 'lay perspectives' of health, I now go on to argue that a narrative approach to older women's lives offers a valuable insight into the way in which older women construct health.

### **The 'Health Stories' Older Women Tell**

Although not the primary focus of my research (Chambers, 2002a), I nonetheless sought to discover the way in which the older women who participated in my biographical study of later life widowhood talked about their health and changing health circumstances in the context of individual and collective biography. What was particularly interesting was firstly the discrepancy between objective measures of ill-health and the self reporting of feelings about health/ill-health, and secondly the diverse narratives of health inherent in their life stories. I was also interested in the way in which such health narratives were situated within the 'major' narratives of widowhood which emerged from my study: 'widowhood as a time of loneliness and despair'; 'widowhood as a time for getting on with your life'; and 'widowhood as a transition'.

Noting the absence of any correlation between those older women with clearly identifiable chronic health conditions and health stories which focused on illness and also little evidence of the 'class-based' health stories identified by Blaxter and Pearson (1982), and Calnan (1987), it seemed that instead, the health stories which were told reflected the older woman's feelings about 'self' and relationships over the life course, the way in which her life had been historically structured (both individually and collectively with other women from her cohort), her current management of daily living **and**, importantly, her personal internalisation of constructions of age and gender. That is, they seemed to be rooted in the 'multiple' personal and collective narratives of later life which were derived from individual and collective biography (Chambers, 2002a, 2002b). The following diverse narratives of health were evident.

- Health as ill-health
- Health as a valuable, but nonetheless manageable, commodity
- Health as well being

With reference to the stories of some of my participants, I now discuss each of these in turn.

### *Health as Ill-Health*

Vera and Patricia are both in their late-60s with some physical ill-health. Neither has or has ever had an extensive network of family and friends and both women describe themselves as 'lacking in confidence'. 'Health' came up in conversation as a negative feature of old age and widowhood and was construed as 'poor' or 'ill' health which was prohibitive to getting on with life, and was one of several reasons for loneliness.

What can I say? I really don't go anywhere because of my health. I don't go out much. There are three reasons really. Because I can't get there quickly, everywhere I go I've got to go on a bus, and that gets on your nerves after a while. I can't afford to go out, I've no money to go out and I just think I can't do that anymore, and I've really nobody to go with. As I say there are those factors that keep me in.

(Patricia)

Vera, who describes herself as *isolated* and *lonely*, identifies poor health, particularly a *minor heart condition*, as prohibiting many opportunities for 'joining in'. She would have liked to join a sports club or a keep fit class but feels unable to do so. It is interesting to note the subjectivity of these stories. 'Poor health' features in other narratives of later life widowhood, explored later in this paper but, instead of being prohibitive as it is in this discourse, it is a restricting, sometimes irritating, factor, which needs either to be overcome or to be embraced alongside other more important features of later life. By contrast, the perception of 'health as ill-health' in the current narrative is that it is prohibitive to participation and thus is a major contributor to loneliness. Furthermore it is a manifestation of old age. This was particularly difficult for both Vera and Patricia, who had internalised dominant ageist and sexist ideologies and openly expressed both ageist and sexist views. Firstly Patricia, referring to other older women:

Oh no, I'm not that type. I don't know about those clubs, it's not for me, all those old people, I can just see them all, all these old ladies dancing together, but that's not for me, no, no, I'm not going to go to dancing. If I'm going to dance it's with a partner, a proper partner, a man. So that's where I'm different you see ... I would never dance with another woman, none of them can take a gent off properly, not at all. And I still won't go out even to the shops for a loaf without making sure my hair is alright, putting a bit of lipstick on ... not like some older women. That will never change. I don't care how old I get ... I'll never be a sweet old lady, I mean I don't think I'll ever let myself go in that respect, even though

there's no-one to see you. You see some women ... I mean my husband was keen on how you looked ...

(Patricia)

Vera echoes these sentiments:

I always got on a lot better with men than with women. That is probably because I've got three sons, my husband, and in the officers' mess it was mainly men. I was always in a man's environment, I was always talking to men and very few women. And I find that is a difficulty. I now have to re-do that as a widow. I have to rebuild my life, it cannot stay the same. But I find it difficult to talk to women about my interests, like sport. Yet I don't want to get married again ... Before my husband died, we went on holiday with a couple of friends. She was about eight years younger than me, but her husband was the same age as us. We were neighbours, we'd been going about together for years. We were at Blackpool one year ... as we were standing near the hotel, where we were staying, there were some coaches and a whole lot of women on their own got off that coach and Jenny stood there and said, 'Vera, do you think that in ten years time we'll be doing that?' And I'm now doing it. And every time (when I go away on holiday with Age Concern), I think of Jenny and what she said. All of those women on their own, not a man in sight. She was horrified that it might be us. I was in my late forties and I felt the same although I still feel like it now, and I think its your children's view ... I find it very sad.

(Vera)

For Vera and Patricia, therefore 'life is very difficult' (Chambers, 2002a): widowhood and old age and are both co-conspirators in their current loneliness and their narrative of 'health as illness' is a manifestation of this.

#### *Health as a Valuable but Manageable Commodity*

Phyllis, Jean and Pat are in their early 70s and Katherine, Evelyn and Elizabeth are in their mid-80s. Between them they have a range of disabling chronic conditions. They all have a network of friends and family and describe themselves as confident in some areas of their life but not others.

Phyllis has deteriorating eyesight and problems with her hip, which impact on her daily activities. These activities are such an important part of her daily living that she sometimes worries about what she will do if she is no longer able to do them:

I have my special glasses but my eyes ache. Jean's been very good, all my friends have but I can't knit now, I can't watch television much anymore. If I go shopping I can't see the prices. It annoys me. I'm too independent, I've always had to do things for myself, it's hard to ask for help. I can't do a lot of things and I do sometimes worry about the future.

(Phyllis)

Nonetheless, Phyllis does not allow herself to indulge these fears for too long: "it's taken me a long time to get over it, I'm really only just getting used to it but I know I'll cope, I always do."

In this narrative, 'health' is to be 'managed'. If you have good health, you should be grateful and if your health is poor, then you just have to deal with it. Those with good health are nonetheless very grateful that their health is good, especially compared to the health of friends. Katherine, for example says: "*I want to stay as I am, healthy as I am at my age and not being full of ailments as a lot of people are.*"

Katherine, like many of the women in the current narrative, makes links with 'age' in her story but notes that: "*you can't give in to it*". Old age, just like health and illness, is to be managed. Furthermore, there is a slightly critical tone in her use of the word "*ailments*", suggesting that some older people may indeed 'give in' to old age, reflecting both the 'moral aspects' of older people's health stories and also, gender and cohort. After all, 'putting up and shutting up' reflects the structured experience of many older women (Chambers, 2002a). Jean, who talks about an acquaintance at the Senior Citizen's club, explicitly illustrates this:

We had to give Connie a real talking to. After all, we all have something wrong with us, but we just have get on with it. She is always miserable, telling us this and that is the matter and really it doesn't do her any good to be like that ... she does try our patience!

Taking precautionary measures wherever possible is integral to managing health and neither age, nor gender, prohibits such measures. Pat, for example, acknowledges the importance of good health and tries to keep herself well. She has already anticipated the probability of a hip replacement, so attends a slimming club and a keep fit class to keep her weight down. In addition, Pat says: "*I walk a lot, I think it's good for you, no healthwise I'm quite fit ... I'm in BUPA so if I want anything, if I need anything, I've been paying that for years.*"

Those with poor health find it restricting, but not inhibiting, and thus adapt accordingly. For example, although Evelyn's sight is failing, and she has both osteoporosis and a heart condition, her discussion of her health is in terms of what she is able to do rather than what she is not able to do. She stresses the continuities between her life now, and in the past, and identifies the strategies she has employed to maintain these continuities and lead her life the way she wishes to lead it:

I spend most of my time here now, I don't move about as well. I enjoy knitting and reading. I knit for myself not for anyone else in case I make mistakes. And I do now! I've always enjoyed knitting, I've done it all my life. My mother taught me, the first thing I knitted was Granddad's garters. My eyes are beating me a bit

at the moment, that's problem with reading too. I'm not keen on the television but I like the wireless. I listen to Radio 2; I like the music and the interviews. I've been listening tonight to Roy Hattersley, he's an interesting man. And I listen to tapes; my niece's husband recorded all my old records for me. I like listening to Perry Como and I love listening to music played on the cello. I used to go to the Theatre Royal in Nottingham to listen to music. My mother used to take me. And in Blackpool, we used to go to the theatre. I don't go to the theatre now but I listen to the music. Sometimes I listen to Radio 4 and I enjoy the plays. (Evelyn)

Elizabeth too observes that she has good days and 'not so good' days:

I can't see as well now and I can't do as many things. I've got polymyalgic rheumatism and I'm on steroids. About once a month it seems to flare up again, and it always seems to be the same weekend ... it was this weekend ... I've got a stiff hand today and my legs ache. So with my eyes not being so good it means I can't knit. But it doesn't stop me getting out, I went to the library yesterday, I get big-print books. My knitting will have to wait for a good day. I don't let it get me down, I get on with what I can ...

Continuities abound in the lives of these women and they have always 'got on' with their lives (Chambers, 2002a, 2002b). Later life widowhood has been a continuation of those lives and even if old age has been accompanied by some ill health, this has to be 'managed' alongside other minor irritants. It is important to 'get on' with life and this is reflected in their narrative of 'health as a valuable but nonetheless manageable commodity'.

### *Health as Well Being*

Doris is in her early 80s and she has several chronic health conditions and very limited mobility. She has a small circle of friends (mainly staff at the residential home where she lives) and has a close (albeit long distance) relationship with her three sons. She describes herself as *liberated* by widowhood. Eunice is in her late 70s, with a minor heart condition, and describes her health as: *good for my age*. She has extremely good friendship networks and a close relationship with her daughter. She is a committed Christian and describes herself as confident.

In this narrative of health as 'well-being', physical and mental limitations are both acknowledged and accepted but not 'judged'. Neither age, nor gender, is construed negatively, but, rather, they are to be embraced wholeheartedly. This encompasses very strong feelings about inner self and spirituality.

Doris for example acknowledges that she has recently begun to weigh up more carefully what could reasonably be managed:

I don't go out at all now ... I'm aching and my arthritis is spreading ... (if I go out) I like to know where I am going and I like to know that I can cope, know

where the loo is, that sort of thing. That's why I wouldn't go on that committee for Age Concern. But I do things here you see, I'm on the residents' committee here and I'm very involved, that sort of thing. I suppose I feel safe here, I know what's what.

Doris's narrative of health as 'well being' comes from being able to make choices about her life now in a way that was not possible during her married life. She is very aware of her increasing disability and her need for care but this is more than compensated for by the autonomy she now has:

I thought, well I'm not staying here (in the marital home) I'm going to move. It could have been done before but he wouldn't. He was very stubborn. If he didn't want to do something, he wouldn't. So as soon as he died I felt I could please myself. It was the first time in my life that I could please myself. After he died I had the freedom to put the house on the market ... I knew I wouldn't stay there. I longed to get out of it because he wouldn't spend the money on it ... I thought I'll go where I can pay to be looked after and not depend on people and I'm very independent here. Since he died, and since I've become more disabled, it mattered to try to be more independent, to make choices, to make my own judgements. Because whatever I said, you know such as holidays, he'd say 'Oh no, you wouldn't like it there, we'll go somewhere else' ... and do you know I'd give in for peace, I hate arguments. I'm handling all my own money now, which is nice. It costs a lot to live here for the rest of my life. The boys know there won't be much left if I live for a long time (laughs). I have a financial adviser from the bank to help me make the money last as long as I can ... I quite enjoyed that side of things making my own decisions and selling the bungalow ... I had sixty years of married life and I felt I'd had enough. It's so good to be 'me'! For the first time in my life I'm doing what I want and it's so nice. And that is liberating ... and at my age as well. (Doris)

Eunice, who unlike Doris was both happily married and had a lot of autonomy in that marriage, nonetheless also speaks of well-being and contentment which she ascribes to her spirituality and the increased self awareness she has developed since the death of her husband:

Material things are not so important now. Whereas you might have been upset because a vase was broken, you really put things into perspective. People matter and I know when the car was damaged, I can remember being very shocked after the break in, my car was broken into. And I was very shocked ... but you do get it into perspective because you realise that you are not hurt and it is a material thing. I think you get things in perspective, you sort out what's important and you realise that life is never the same, it can never be the same but you are strengthened. I think I am able to understand how people feel and I feel I can comfort people who've lost anyone, not to be afraid of letting them talk to me. (Eunice)

Doris and Eunice have embraced later life widowhood as an opportunity to develop and a time to be valued. It has been a time of 'transition' (Chambers, 2002a, 2002b) in which they are enjoying being 'old' and 'female', and this is reflected in their narrative of 'health as well-being'.

## **Conclusion**

In this chapter I have presented a discussion which acknowledges the discrepancies between lay perspectives on health and the empirical evidence relating to older women's greater propensity to chronic ill-health: "mustn't grumble". I have also acknowledged the impact of ageism and sexism on the way in which older women talk about their health: "what can I expect at my age?" However, I have suggested that we need to go beyond the 'here and now' and incorporate instead a life course perspective, which draws on individual and collective biography **and** engages in meaningful discussions with participants. As Malcolm Johnson (1978) reminded us, nearly twenty five years ago now, our present life is sculpted from our past and so in order to better understand how older people experience their lives 'now', we must pay attention to the way in which they have constructed their lives 'then' and 'now'. More recently Gerontologists working within a life course perspective have argued for a greater understanding of the subjective experience of ageing, a subjectivity which is rooted in both individual and socially structured life history (Bornat, 1993; Birren, 1996; Birren et al., 1996; Ruth and Oberg, 1996; Ruth et al., 1996; Chambers, 1994).

With reference to my own empirical work with older widows (Chambers, 2002a), I have argued that the way in which older women makes sense of changing health circumstances in later life, and the ageism and sexism which accompanies those changes, is better understood with reference to individual and collective biography and the multiple narratives of self and relationships derived from those biographies. Indeed, I have argued that we need to engage with an older woman's view of her world in order to really appreciate the way in which she constructs her health narrative. To not do so, means that instead of really listening to the story which is being told, we are in danger of conspiring with stereotypes of 'ageing women' which abound in both the dominant (medical) narratives associated with women's greater morbidity and longevity, and those lay perspectives grounded in ageist and sexist ideologies, and thus responding with platitudes rather than understanding. To offer Patricia the advice, as her daughter and sister often do, that her health would be much better if she went out and met other women like herself, takes no account of either her lifelong low self-esteem or her internalisation of ageist and sexist ideologies. For Patricia 'life is difficult' and this is reflected in her narrative of: *health as ill-health*. To suggest to Jean and Phyllis that perhaps they might be

more sympathetic towards Connie's negative feelings, ignores their individual and collective histories of 'putting up and shutting up', a philosophy which has stood them in good stead for many years. As older women they believe in getting on with life and this is reflected in their narrative of: *health as a valuable but nonetheless manageable commodity*. And finally, if we only take note of Doris's objective measures of ill-health, we are in danger of not connecting with her excitement of life now, and the major transition she has experienced since becoming a widow, a transition which is reflected in her narrative of: *health as well-being*.

It is so important that as researchers we should seek to get beyond dominant public narratives and try to understand the way in which older women make sense of their changing health circumstances. I have argued that a biographical approach which engages with older women's multiple narratives is one way of accomplishing this quest. In summary, our narratives of health, as ageing women, are rooted in our own life stories and can only really be understood within the context of the whole life course.

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