Constructions of Continuity after Stroke

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Prior research suggests that illness disrupts biographical self because of the resulting difficulty in continuing to draw on the same material and symbolic resources used in self-construction. Recent literature suggests that constructing continuity is possible because of the multifaceted nature of self-construction. One hundred and twenty-two veterans who had been hospitalized after an acute stroke and discharged home were enrolled in the study. In-depth interviews were collected from the veterans at one month post-stroke. Results indicate that some of these individuals construct continuity through their use of personally accessible discursive resources such as expectations for aging and religious beliefs.
Keywords: narrative, illness, continuity, self, disruption, stroke

The influence of an illness on one's identity continues to be of interest to social scientists and health care professionals alike. Several authors theorize about the role of illness in the construction of self (Bury 1982, 1991; Charmaz 1983, 1991; G. Williams 2000). According to Charmaz (1995), illness disrupts individuals'

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***Symbolic Interaction*, Vol. 31, Issue 2, pp. 205–224, ISSN 0195-6086, electronic ISSN 1533-8665.** **© 2008 by the Society for the Study of Symbolic Interaction. All rights reserved. Please direct all requests for permission to photocopy or reproduce article content through the University of California Press's Rights and Permissions website, at http://www.ucpressjournals.com/reprintinfo.asp.** **DOI: 10.1525/si.2008.31.2.205.**

abilities to continue constructing identities as they did prior to their illness. For Bury (1982), this occurs because the material and symbolic resources used in pre-illness self-construction are no longer relevant for the post-illness situation. He suggests that illness calls into question previously used commonsense ways of thinking about the world and one's self within it, partly because of the lack of new explanatory frameworks.

In this article, we challenge the view that illness disrupts explanatory frameworks, which then results in a disruption of self. Based on our study of narratives of stroke survivors, we suggest that people can construct continuity of self by drawing on personally accessible discursive resources not affected by the onset of illness (Pound, Gompertz, and Ebrahim 1998; Strauss 1995; S. Williams 2000). We argue that two discursive resources, expectations for aging and religious beliefs, are actively employed in stroke survivors' narrated constructions of continuity. Rather than being adaptive resources that minimize the disruptive impact of illness, they represent preexisting explanatory frameworks that make continuity of self discursively possible.

THE MULTIFACETED SELF

Constructing continuity following illness is possible because self is a multifaceted object defined by the various symbolic meanings that we, and others, attach to it (Markus and Wurf 1987; Mead 1934). Thus many selves are possible because self-constructions draw on different resources at different times and in different contexts (Giddens 1991). The process of self-construction is tied to the access people have to various symbolic and material resources because "in life and myth, we cannot transcend our resources" (McAdams 1993:110). One potent resource useful in self-construction is found in the stories people tell about who they are or who they would like others to believe they are (Goffman 1973; McAdams 1993). When telling their stories, people make judgments about how to best present self-relevant facts (Ellis and Bochner 2000; Schlenker 1980). In this way, storytelling is the process of self-construction (Kelly and Dickinson 1997). It represents the active discursive manipulation of symbols, part of how individuals construct personally relevant and meaningful tales of the self (Maines 1993; Ricoeur 1984; Riessman 1993; Strauss 1995).

Over time, as different resources become available or as familiar ones become scarce, self-definitions change (Charmaz 1991). Generally speaking, self-change occurs slowly, giving individuals time to incorporate the new narrative resources (McAdams 1993). Sometimes, however, changes happen too rapidly for individuals to incorporate them efficiently, as in the case of illness or disability. One result can be a disruption of self (Bury 1982, 1991; Charmaz 2002).

Chronic and sudden-onset illnesses disrupt an individual's taken-for-granted knowledge of the body. The body is an important material and symbolic resource for self-construction (Bourdieu 1985; Bury 1982, 1991; Goffman 1967; Gubrium and Holstein 2003; Mead 1934; Shilling 2003; S. Williams 2000). As a material resource,

the body shapes how the social environment can be experienced (Merleau-Ponty [1962] 2002). As a symbolic resource, various social meanings are associated with it, such as sex or gender (Connell 1987). Illness generally forces a reinterpretation of the body, and because bodily changes represent changes in the material and symbolic resources available for self-construction, it follows that the taken-for-granted self is also reconstructed (Becker 1997; Charmaz 1983). Much of the research on illness and self has borne out the truth of the body-self connection (S. Williams 2000).

However, the variability of self, coupled with individuals' interpretations of personal experiences, provides different frames of reference for thinking about the meaning of illness. People interpret illness differently, and individuals may employ unique strategies to help explain the meaning of illness in their own lives (Dowswell et al. 2000; Kaufman 1988; S. Williams 2000). Thinking about one's illness in comparison with those who are more physically impaired can leave chronic illness sufferers with the feeling that things are not so bad (Gubrium et al. 2003). The same person might reference illness against his or her (pre-illness) identity as worker, as family member, or as television watcher and come to different conclusions about how disruptive the illness is, depending on the comparison point (Charmaz 1991). This suggests that the symbolic value of illness is also subject to active manipulation by those constructing selves. Thus the interpretive work that takes place in constructing the multifaceted self means that illness, for some, may not necessarily be disruptive.

CONSTRUCTING CONTINUITY FOLLOWING ILLNESS

While certainly not a common finding, illness in some contexts can actually reinforce identity (Carricaburu and Pierret 1995; Corbin and Strauss 1987; Idler 1995). Research on hemophiliac and gay HIV-positive men found that an HIV-positive status reinforced rather than disrupted their identities. This was somewhat more evident for hemophiliac men than for gay men. Hemophiliac men had a lifelong engagement with the medical community and tended to construct themselves as persons with a medical condition before the appearance of HIV. Being diagnosed as HIV-positive did not alter familiar narrative resources for constructing this salient medical-patient identity. For gay men, however, being diagnosed as HIV-positive tended to disrupt pre-illness self-constructions built around their taken-for-granted healthy bodies. But again, comparison points were important. Researchers found that being HIV-positive tended to reinforce pre-illness self-constructions built around gay activism. Both groups of men were able to avoid disruption. That is, the men contextualized illness in ways that enabled them to construct self-continuity. This was possible because the discursive frameworks for continuing to construct an established identity, that of medical patient for hemophiliac men or gay community activist for gay men, did not change (Carricaburu and Pierret 1995).

The multifaceted nature of self also means that when illness does threaten to disrupt a favored identity, focusing on identities that remain unaffected provides a

means to construct continuity, as happened for the gay men in Carricaburu and Pierret's study. In other research, female stroke survivors situated the self as mother, grandmother, or housewife in their stories of illness (Kvigne, Kirkevold, and Gjengedal 2004). This is not to say that the women did not struggle emotionally with the stroke; they were depressed, bitter, and angry at various points during their physical recovery. While some identities, such as being an employee, were disrupted because of forced changes in routines, the women turned to other valued self-constructions. By relying on identities situated in gendered social roles they were already familiar with, continuity of self was possible. Rather than adaptation, these women continued to construct a familiar pre-illness self because some of the resources for constructing the multifaceted self remained the same.

Bury and Holme (1991) pointed out that a disruption in one's self-construction because of illness has much to do with the timing and context in which illness occurred, and age is an important piece of understanding the meanings people developed. Chronic illness and advancing age are linked in Western notions of the aging process, with a common belief that as people age, their bodies will deteriorate (Cornwell 1984; Gooberman-Hill, Ayis, and Ebrahim 2003; Pound et al. 1998; Sanders, Donovan, and Dieppe 2002). Pound et al. (1998) suggested this belief might be more prevalent among the working class, given their likelihood to engage in physical labor. For the women and men Pound and her colleagues interviewed, illness was a biographically anticipated event (S. Williams 2000), just a part of the normal process of aging in a life course filled with hardship. Researchers viewed the vocabulary of "age" as a coping mechanism that can ameliorate the disruptive effects of illness (Bury and Holme 1991; Kaufman 1981). We accept age as an important adaptive strategy, but also suggest that the vocabulary of age and the aging process is a powerful discursive resource useful for constructing continuity. While age is not typically a salient feature of identity, expectations for the aging process represent already present explanations for physical decline that enable people to view illness-related physical deterioration as an expected part of the life trajectory (Sanders et al. 2002).

Religious beliefs can also serve as an important discursive resource for constructing continuity after illness (Atkin and Ahmad 2000; Idler 1995; Mansfield, Mitchell, and King 2002). Framing illness in terms of divine intervention provides the ill with a sense that sickness was meant to occur. Religious beliefs (in God and God's will) provide a readily accessible vocabulary. They represent a resource that was likely used prior to illness to frame other life events. Unlike perceptions of age, which provide a vocabulary for the physical experiences of the body, religious beliefs provide vocabularies for framing most everything that exists or occurs within the social world and, more important here, for ways to construct the self. Like age, illness may not limit access to this unique discursive resource. And as has been shown, illness may strengthen an individual's belief in his or her faith (Idler 1995), encouraging continuity of self-construction.

In sum, there has been a call for medical sociologists to pay "greater attention to the timing, context, and circumstances within which illnesses are 'normalised' or

'problematised,' and the meaning in which identities are threatened or affirmed" (S. Williams 2000:62). We follow Williams's call and focus on two of the mechanisms of self-construction that make constructing continuity after a stroke possible. We suggest that illness may not necessarily result in portrayals of disruption and look at how two discursive resources, expectations for aging and religious beliefs, can be employed to enable individuals to claim continuity of self.

METHODS

Data

These data are part of a larger study on the recovery experiences of stroke survivors after discharge from the hospital. The study began in 2001 and includes qualitative and quantitative data collected over twenty-four months. The data presented here are drawn from in-depth, semistructured, face-to-face interviews with 122 male veterans obtained one month postdischarge. Participants were selected from five geographically and ethnically diverse Department of Veterans Affairs Medical Centers (VAMCs) in Florida and Puerto Rico. Study participants were stroke survivors discharged directly home following hospital care for their stroke (ICD-9 codes 430–438, except 435). Those with severe communicative difficulties were excluded from the sample.

Participants had a wide range of functional capabilities, from severe functional impairment to little or no impairment. All of the men are middle aged and older, with the youngest aged forty-nine, the oldest ninety-one, and an average age of sixty-seven years. The sample is primarily made up of lower- and middle-socioeconomic-status veterans. Of the participants, 36 percent are non-Hispanic white, 39.4 percent are Puerto Rican, and 24.4 percent are African American. Of the individuals included in our sample, 67 percent are currently married, with 69.6 percent of whites, 73.1 percent of Puerto Ricans, and 54.5 percent of African Americans married.

All interviews were tape-recorded, and observations were made following written informed consent of both the survivors and their caregivers. Native-language speakers conducted interviews in either Spanish or English, which were then transcribed into English, with transcriptions checked against the tape-recorded interviews for accuracy. Data were entered into N6, a computer software program that assists with coding and data retrieval. Interviews focused specifically on individuals' daily lives, pre- and post-stroke experiences, personal management techniques in public settings, stroke and body construction, self-perception, the meaning of life, ethnocultural understandings, and their sense of the future.

Analytic Strategy

The theoretical approach to data analysis was motivated by understanding the interview data as part of the process of self-construction as it occurred in the

ongoing biographical work individuals do to construct a coherent and meaningful story about the self (Holstein and Gubrium 2000). The interpretive frameworks presented by individuals in their stories of stroke survival anchored various aspects of the self within a life trajectory (Holstein and Gubrium 2000; McAdams, Josselson, and Lieblich 2001). The data presented here represented one story of the self among many possible stories and were partially dependent on the context in which these stories were constructed (e.g., being asked about stroke recovery by a VA representative as opposed to talking with a friend about this experience).

Our analysis of participants' interview transcripts followed LaRossa's (2005:855) grounded theory method (GTM), which is based in Glaser and Strauss's 1967 work, but provides a "methodologically condensed but still comprehensive interpretation of GTM." We looked for themes and patterns in participants' personal accounts while remembering that what "emerged" from the data were our own theoretically based assumptions about the meaning of participants' stories (Strauss and Corbin 1990, 1998).

In this article, we discuss self-construction (a conceptual category) and mechanisms for maintaining the appearance of self-continuity after a stroke, where self-continuity and self-disruption are subcategories of self-construction. These conceptual categories are then defined in terms of their properties, or the general or specific attributes of the category, and dimensions, or how specific properties of the categories are related. For example, we discuss the role that discursive resources, one of the subcategories of self-construction, play in the self-construction process. Discussions of aging are a property of the subcategory "discursive resources," and discussions of whether one is "young" or "old" are understood as dimensions of age.

The next phase of coding was axial coding, in which we related categories and subcategories at the level of their properties and dimensions and looked for similarities and differences between them. Patterns emerged when some of the properties of categories aligned themselves along their various dimensions. For instance, coding someone as continuous or disrupted depended on his use of discursive resources, like expectations for aging and whether stroke is explained as a function of being young or old.

Open and axial coding occurred simultaneously as we worked back and forth between the categories and subcategories to delimit our themes. Memos, written records of our theoretical assumptions based in various conceptualizations we had of the raw data, were composed throughout the analytic process and helped guide coding decisions. To ensure accurate categorization, we analyzed the transcript as a complete document for overarching themes of continuity and disruption. Those personal accounts categorized as disrupted showed evident signs that people perceived changes in their sense of self. Those categorized as continuous told interviewers there was no change in their overall sense of self. Those for whom continuity or disruption were not evident were excluded from the analysis.

At their core, changes in self-concept are subjective interpretations. It follows that acute onset and chronic illnesses can be disruptive life events when perceived to be, no matter how severe or mild the physical disability. The interviews explored participants' self-perceptions, their understanding of the meaning of life, and their

sense of the future. Continuity is defined here as a persistent sense that despite the stroke, one remains essentially unchanged in these areas. This was not to say that participants coded as constructing continuity did not express some despair over their physical limitations. That said, despair was not disruption; it is possible to lament the loss of function while maintaining that on the whole, in the realms of self-perception, the meaning of the life, and future outlook, one continues to be the same person. Individuals who discursively constructed continuity did so by asserting that their self post-stroke is the same known quantity as their pre-stroke self. Thus the subjective nature of the illness experience coupled with a dynamic multifaceted self made it possible to not only code participants' stories as "continuous" but accept their claim that despite the stroke, they remained the same.

Our definition of disruption is roughly consistent with Bury's (1982) definition of biographical disruption (i.e., changes in self-concept and inability to marshal material resources). Participants categorized as constructing disruption told us that they were "not the same" or "different," words and phrases that flavor their stories of post-stroke selves and suggested they were experiencing changed perceptions of self. They also told us stories that made it clear their sense of the meaning of life had also changed, characterized by words such as "worthless," "meaningless," "useless," and "helpless," words that were uttered in relation to their hopes for the future. Overall, the majority of respondents at the one-month interview (n = 83) were coded as constructing disruption, with roughly one-third (n = 39) coded as constructing continuity.

As noted, much of the qualitative sociological inquiry into the illness experience highlights how illness results in a disruption of self (Becker 1997; Bury 1982, 1991; Charmaz 1983, 1991; G. Williams 2000). This certainly appeared to be the case for the majority of participants in this study. Others, however, were able to maintain constructions of continuity. Given the multifaceted nature of self, it is not surprising that illness does not disrupt all aspects of self (Pound et al. 1998; Strauss 1995; S. Williams 2000) and in some contexts can reinforce self-construction (Carricaburu and Pierret 1995; Corbin and Strauss 1987; Idler 1995). Individuals employ different explanatory frameworks for illness and do so in ways that are relevant to their lived experiences (Dowswell et al. 2000; Kaufman 1988; S. Williams 2000). For some of the men in this study, constructing continuity is possible because they drew on personally accessible narrative resources, such as expectations for aging and religious beliefs, to explain the effects of stroke on the body. It is to their narratives that we now turn.

RESULTS

Constructing Continuity

Those categorized as constructing continuity did not portray obvious signs of disruption in their discussions of their sense of self, even when their bodies and physical functioning had changed. Like Pound et al. (1998), we doubted at first our findings because we expected that stroke would be discussed as being immensely disruptive

to those stricken with it. However, for some, the overall theme of their interview one month after being discharged from the hospital was one of constructing continuity. This was evidenced in phrases like "I'm the same" or "nothing much has changed," common expressions that were used to express participants' self-perceptions, their sense of the meaning of life, and their future outlook. Of course, such phrases may not tell us anything more than they were aware of culturally appropriate responses to questions of well-being. We were cognizant that personal narratives are "embedded in temporal, geographical, political, cultural, and social fields—all which lend shape and form to the narration" (Karner 1998:198). The responses to interview questions about health and well-being were, to some extent, culturally prescribed and might simply be rote reactions to normative expectations for such questions. Or, their responses may tell us about one's desired state of being, a future possible state of being that individuals wish to attain, what might be referred to as a desired and future "possible self" (Markus and Nurius 1986; Markus and Wurf 1987). Then again, these responses may accurately reflect how participants perceived their situation. Regardless of the culturally embedded nature of participant responses, the fact some people choose to respond to questions about their perceptions of self, general view on the meaning of life, and future life outlook with variations of "I am the same person" suggested they hold a different self-understanding than those who characterized their post-stroke experiences with words like "worthless," "meaningless," "useless," and "helpless." If, as we assert, storytelling is an important part of the self-construction process (Gutman 1988; Loseke 2001), then saying "I'm the same" is an active attempt to present and construct continuity.

Given the nature of stroke as an illness that affects physical functioning, and the fact that the body is one of many resources used in self-construction (Bourdieu 1985; Freund 1990; Goffman 1967; Hochschild 1983; Mead 1934), we might expect that those with physical impairment would experience disruption. This was not always the case in our sample. Terrance, seventy-six years old, had a stroke that resulted in numbness in his left eye and left leg, a general sense of imbalance, and noticeably slurred speech. Although his physical functioning had been altered, Terrance focused on his everyday routines when asked about his general outlook.

> Let me tell you, [life] hasn't changed at all, the things I did, that I do now is the same things I did before the stroke too, the stroke hasn't abstained me of, of anything. . . . The same routine, I do and the routine I have now.

Thus referencing a similar routine pre- to post-stroke is an important resource for constructing continuity, as we might expect.

Another important resource for constructing continuity is unaltered pre-stroke identities. Frank, age sixty-eight, says, "I mean everything I did before I do now too, you know. I mean I ain't give up or anything like that, you know. . . . life hasn't changed a whole lot. I still do a whole lot." Part of his constructed sense of continuity comes from identities rooted in the family.

> I'm just old Grandpa, you know. . . . I guess I'm a little softer. I don't fuss at [my wife] as much. . . . Well one reason I got to be with her 24 hours a day, ya know.

> (Laughs) . . . [My family] watch[es] me pretty close. . . . Especially the oldest [daughter], she's over here all the time to see if she can give her mom a break.

Frank's family rallied around him to provide him with care. Doing so can highlight the fact that one is a valued member of the family. Like the women in Kvigne et al.'s (2004) research on female stroke survivors, Frank's experience with after-stroke care reinforced a personally important identity that relied on interaction with family members. Thus, by drawing on pre-stroke identities, Frank is able to claim continuity, much the same process that occurred in men in Carricaburu and Pierret's (1995) study on HIV. Given that these data are drawn from the one-month interviews, it remains to be seen whether Frank's family identities continue to serve as sources for continuity. Evidence certainly suggests that family members' goodwill can run out, leaving the illness sufferer socially isolated and experiencing disruption (Charmaz 1991). With this caveat in mind, we point out that no matter what the future may hold for Frank, he is, for the time being, demonstrating that it is possible to construct continuity following a major illness.

Constructing continuity is possible through the use of various resources, such as pre-illness routines or identities. Our focus in this article, however, is on the use of age, particularly expectations for aging, and religious beliefs as key narrative resources for constructing continuity, which we discuss below.

Discursive Resources for Constructing Continuity

Age

Aging is both a biological process and an interpretive one (Faircloth 2003), and the meanings associated with bodily experience vary by culture, time, and context (Nettleton and Watson 1998). One way bodily changes may be accounted for, because of stroke, is through the use of age (Faircloth et al. 2004; Pound et al. 1998). Because advancing age is associated with increased physical deterioration (Sanders et al. 2002), when stroke affects the body's functioning, physical changes can be explained as a normal part of the aging process (Kaufman 1981). Manuel, eighty-three years of age, blamed his physical difficulties on advanced age. "I wait at my age, that one day goes to the other, that's all. I think it's natural, natural." He then added, "I expect to be here today, and I may be gone tomorrow," as if to emphasize how important age is in thinking about the self. Ted, aged seventy, shared this perception: "I would say age related. Uh with me I can't move as fast as I used to when I was younger."

Manuel, Ted, Terrance, and Frank are all older than the mean age of participants in the study (sixty-seven years), and it makes sense they may explain physical changes as part of the natural aging process, stroke or no stroke. However, using age to understand or rationalize stroke-induced physical changes is a technique used by many of the younger-than-average men in this study as well. Karl, sixty-three years old, discussed his physical health by framing it within the context of advancing age. Throughout the interview he mentioned "feeling a little bit older" and states that he

felt he had been "getting tired out faster" after the stroke. Even though his perception of his post-stroke physical abilities had changed, he stated, "That's about the only difference." Later, Karl was asked to elaborate on why he felt he was "getting tired out faster." "I'm slow. I'm old! What do you expect? Other than that, I feel okay. You get older you get, I guess you get a little bit more sense you got to slow down a little bit." The changes in the physical body related to lack of energy could be viewed as natural when using age as a discursive resource to frame those changes. Routines remain similar but take longer. In essence, age is used to normalize physical change by framing it with general understandings of the aging process.

Decreases in strength and sexual activity can also be explained by drawing on expectations for aging. Walt, sixty, noted that his body is "slowing" down and that he is less sexually active, but he attributed these physical changes to "Old-timers' disease." Louis, who is fifty-eight, discussed some of the physical changes he had seen in his body since the stroke. The stroke left him relying on assistive devices, such as canes and wheelchairs; however, he saw his physical problems as "related more with age and the, and the disuse of my body for so many years and bad eating habits, nutritional and of eating and drinking." He went on to say, "When you are fifty-eight years old it is natural that you get . . . not to be able to do the things that you used to do." At age forty-nine, Daniel was one of the youngest participants in the study. "Well I'm getting older and I just don't have strength and energy that I used to have." To emphasize his physical limitations are age related, he stated, "It's less because of the stroke."

Understanding the stroke's physical effects as a function of age enabled some participants to see the stroke as a normal event, one of many possible natural events that take place as one ages (Sanders et al. 2002). To the extent that bodily changes are seen as normal, the stroke may mark the point at which advanced age-related bodily changes occur. It is the cultural expectation of bodily change during aging that these survivors use as their resource to describe the current physical changes of the loss of stamina and increased fatigue.

Simply put, the vocabulary of aging, as a discursive resource, can be used to construct continuity because it explains the physical effects on the body from a stroke. "I look at my body as age wise," says Ed, whom we heard from earlier. "Everything about it is age-wise. Like [my friend] says, 'You're eighty-one years old. What the hell do you expect?" Using age moves beyond adaptive strategies for dealing with the effects of illness. Age gives the men the ability to normalize their physical situation by aligning their physical experiences with what they expect to be true of the body during the aging process. In a way, expectations for aging are employed as a bridge to pre-stroke selves; the stroke does not appear to have changed their notions of what it means to age. In fact, the stroke seems to have reinforced some of their aging expectations, leaving them free to construct continuity.

The ability to use age as a resource to construct continuity may be especially important for men who are younger, both chronologically and by cultural standards. Because age is a subjective experience (Gooberman-Hill et al. 2003; Sanders et al.

2002), the chronological age of the participants is somewhat irrelevant to whether they use expectations for aging as a discursive resource, no matter if they are forty-nine or fifty-eight or eighty-one. What does matter is how individuals of varied chronological age describe their health, bodies, and selves in the aftermath of the stroke. Forty-nine-year-old men are in their middle years and are expected to experience relatively good health. Some do not, as Daniel's story demonstrates. By cultural standards, Daniel should not be able to use age to portray the stroke's physical effects on his body as an expected outcome of aging. The question remains as to whether others will accept Daniel's identity claim, given that he is chronologically young. For the time being, however, the subjective nature of the aging experience coupled with the subjective nature of illness enables Daniel to employ the vocabulary of aging as a discursive resource for constructing continuity.

We offer again the caveat that responding to questions of health and well-being by stating that one is "fine" or that one is simply "getting older" is, as mentioned above, a conversational convention in which the men feel some pressure to put the best spin on their situation. In addition, such responses might be constrained by cultural expectations for masculinity, in which, as male veterans, they feel compelled to stoically claim to be unaffected by the stroke, thus enabling them to demonstrate their mental toughness at being able to emotionally handle profound physical disruption. If true, then age takes on a new dimension; it becomes the discursive resource that enables these men to continue constructing valued masculine identities. The result, however, is the same; the ability to construct continuity. And as before, we recognize that one-month post-stroke is far too early to say with any certainty that these men can maintain their constructions of continuity over time. That said, the fact that they are claiming continuity and using age as a resource for doing so suggests something about the resilience of the individual to continue constructing a familiar self in potentially devastating circumstances.

Religious Beliefs

The role of religious beliefs in self-construction is well known in sociology, being cited as an important factor in social integration as well as psychosocial well-being (Durkheim 1915). In the form of personal prayer, religion is a resource that is readily available for making sense of the situations and consequences of illness (Koenig 1993). Religion can also be seen as an important mechanism for individuals to construct continuity of self, especially when they become sick or disabled (Mansfield et al. 2002); as Idler (1995:700) notes, "The inner, spiritual self can be beautiful and whole even when the material, physical body is broken or diseased."

Many of the participants spoke of the importance of religion in their lives, both the spiritual and communal-community aspects of their religiosity. More specifically, their narratives often turned to the spiritual as they attempted to make sense of the stroke, and many said that the stroke was part of God's plan. Many were unsure of God's purpose, but readily accepted his role in their stroke experiences. Sal, seventy-eight, told

us, "I feel like the Lord put something on me that he want me to have," a sentiment shared by eighty-five-year-old Tom, who told us, "I think this is what God gave me and I think that this is, I have to adjust to it." Neal, seventy years old, did not like the stroke's effects, but said "I'm accepting what God has for me. . . . I can't do some of the things I used to do before, and I have to accept it." Accepting changes in one's body does not necessarily result in disruption. Neal continued, "I see my physical aspect has changed, but inside I'm the same." Thus religious beliefs are powerful discursive resources for constructing continuity, in large part because they help some of the men frame the stroke as an experience that was inevitable, determined by the hand of God.

As a God-sent sign, several participants said that they were being punished for things they had done in their past. The stroke was portrayed as a wake-up call, a direct message from God conveying his displeasure. "Physical suffering may take on the religious meaning of identity with Christ; with the mortification of the flesh, the spirit is purified" (Idler 1995:685). John, age sixty-six, spoke to this belief.

> Before I had the stroke I used to drink, I smoked. But when I poisoned myself, from that Japanese pill (homeopathic vitamin), well, I told him, I made a promise to God, that if I came out of that well, that I would turn to the church and I didn't do it. I came out of that, continued to smoke and drink and then, since God said it, and that's when I had the stroke. And, I, the next day. . . . I blame the stroke to the disobedience and disrespect toward God. That I well, promised him and didn't follow through.

Stroke, when cast as a message from God, is powerful reinforcement of one's religious beliefs. "It brought me closer to God and Jesus Christ and that's all I can say," said Preston, sixty-five, who told us that he now regularly attends church service, something he did not do before his stroke.

Whether being punished or as part of God's plan, participants used their religious beliefs and belief in God as symbolic resources to understand the stroke's physical consequences. In this regard, religious beliefs serve the same function as expectations for aging. Thus religious beliefs provided a unique interpretive framework because they enabled the men to view the stroke as an event that reified important aspects of their spiritual selves. We suggest the stroke functioned for these men something like HIV-positive status did for the medical patient identities of hemophiliac men in Carricaburu and Pierret's (1995) study, used to portray a reinforced spiritual sense of self. Constructing continuity was possible because God was (presumably) already an important aspect of their pre-stroke selves. Stroke as a sign from God reinforced the men's sense of self as someone prone to the whims of God's will, enabling them to minimize changes in the physical body.

DISCUSSION

While we present narrative excerpts from stroke survivors who drew on the narrative resources of age and religion to construct continuity one-month post-discharge, the majority of respondents were coded as constructing disruption at the one-month

interview ($n = 83$). Participants categorized as constructing disruption told us that they were "not the same" or "different," words and phrases that flavored their stories and highlight a difference between pre- and post-stroke self. They constructed narratives that made it evident that the meaning of life may have also changed. This change is characterized by words such as "worthless," "meaningless," "useless," and "helpless," statements uttered, for many, in relation to their hopes for the future.

Ken, a sixty-four year old, told us, "It's just self-degrading. I really, the way I feel, feel about myself." For him, disruption appeared to be related to several areas of his life that he feels have changed. "I can't seem to coordinate my things, my activities, you know, and ah, I can't focus." With his ability to engage in daily activities altered, he told us, "I don't have the self-reliance that I once had in myself." He worried that "I might be a burden on someone," and for a man who told us that he had been self-sufficient for many years, this was difficult to accept. Stroke also affected his ability to continue normal sexual relations with his spouse. "Being a man, being able to communicate with his wife about, whatever. Things he's lost he can't do anymore. I just feel I can't measure up to that point I was, had before, and therefore, I feel sub-standard." When asked if his attitude toward the future had changed since having the stroke, his response was full of resignation and anger. He told us he deals with the stroke's effects "with an attitude to say well nothin' stays the same."

> I felt that I got a blow. A dirty blow. Why did it happen to me? I don't smoke, I don't drink, I, you know, try to go to church and I try to be active in the community. So why did I have a stroke? And here's a guy, never worked, never take care of his family, etc., etc. walk around and nothing happens.

Those coded as constructing disruption told us that stroke has changed their self-perceptions, the meaning of life, and their future outlook. Several of the men in the study, like Ken, said that having a stroke was "self-degrading," causing them to question their self-worth, leaving them feeling "substandard." We presented these few excerpts from Ken to remind readers that for him and the majority of our participants, stroke was an extremely disruptive event that, in Bury's (1982:170) words, caused a "fundamental rethinking of the person's biography and self-concept."

In light of the well-documented ways that illness disrupts or alters self-construction, our interest was in how some individuals maintained self-continuity. We argued that it is the variable and contextual nature of self and the subjective nature of illness that creates conceptual space for understanding how self-continuity can be possible following serious illness. Because self is a complex and multifaceted construct, it is rooted in many different material and symbolic resources. At any given time, some factors are more important than others. Loss of function because of illness may influence self-construction more when a person is thinking about the sexual self than when thinking about the self-as-grandpa. The inability to continue the same routine may be frustrating when men are no longer able to engage in paid work, but inconsequential when precluded from doing housework. There is

evidence that this is different for women (Kvigne et al. 2004), which speaks to the intersection of gender and illness. Because of the variable and context-specific nature of self, no single factor is involved in a person's self-construction. Thus physical difficulties associated with illness are meaningful in some contexts and not others.

Our findings are consistent with the literature documenting age (Gooberman-Hill et al. 2003; Pound et al. 1998; Sanders et al. 2002) and religious beliefs as useful narrative resources for avoiding disruption (Faircloth et al. 2004; Idler 1995; Koenig 1993; Mansfield, Mitchell, and King 2002). We add that, rather than being mechanisms for adaptation, these resources enable claims of self-continuity. Expectations for the aging process and the role of religious beliefs in one's life provide readily available vocabularies for constructing continuity, allowing changes in the body because of illness to continue to fall under some of the same interpretive frameworks used prior to the illness. The result is that constructions of self-continuity are possible even when illness has changed the body.

Like the working class in Cornwell's (1984) study and the elderly interviewed by Sanders et al. (2002), dealing with hardship was a taken-for-granted part of everyday existence, and illness in older age was expected. When stroke occurred, it was understood as part of the normal process of aging, often framed by drawing on the vocabularies of aging.

> For many people the stroke did not involve a recognition of the worlds of pain, suffering and death (Bury 1982) since as a result of their age and possibly also their social class position, these people were already familiar with such worlds. (Pound et al. 1998:500)

There are limitations to exploring continuity using personal accounts of the stroke experience. Qualitative interviews, as autobiographical accounts of one's life (Thorne and Latzke 1996), are partly storytelling exercises that change with each retelling because of changing context (Byrne 2003). The personal accounts given during the interview are stories *and* active self-constructions, biographical work *and* context-specific self-presentation, an extension of one's self understandings *and* stories that convey some aspects of a person's desired sense of self. Qualitative interviews that focus on self-construction and biographical history represented experiences that are woven together into a personally meaningful tale of who one is and who one would like to be in the eyes of others (Maines 1993; Riessman 1993). Personal narratives don't necessarily get at the "true" self (Gubrium and Holstein 1997, 2000) because the self may be a largely performative construct (Goffman 1967) and constantly changing depending on the audience. The stories one tells about their experiences are "to some extent the *biography-at-hand*, a story assembled for the purposes of the moment" (Gubrium and Holstein 1997:156). People attempt to shape others' perceptions of them (Stets and Burke 1994), so they leave out parts of the story that are inconsistent with self-views. We live in a culture in which a dominant story line is that people are in control of the self. Responding to questions in an interview provides an opportunity to construct a personal narrative "in which the

protagonist self struggles to defeat the . . . problem" (Polkinghorne 1996:366). In telling us "I'm the same," participants may be reframing their stroke experiences in a way that constructs a masculine self—strong, determined, and unfaltering—that endures irrespective of the hardships encountered. It is, perhaps, a construction consistent with their sense of self, but breaks from the reality of their daily experiences.

We recognize the role of talk in self-construction, but want to be cautious not to "write" the body out of existence, a charge that has been leveled at some postmodern and disabilities studies researchers (S. Williams 2000). Only those who had the ability to verbally communicate their stroke experiences were able to take part in this study, and so our sample is biased toward those able-bodied enough to share their stories. We don't know if stroke survivors with more severe speech impairments use similar symbolic resources to construct continuity or, for that matter, if continuity construction is even possible.

There is a difference between the lived reality of experiences and how those experiences are communicated (Polkinghorne 1996). We understand that our participants' stories are one possible story among others they might construct in their day-to-day lives in interactions with other audiences (Gubrium and Holstein 1997). At some times the self may be portrayed as disrupted, for example, talking to one's spouse, while in other contexts or at other times individuals may be more likely to construct continuity, such as when talking to a stranger during an interview. We understand personal narratives are active constructions expressing truth claims, biographical work and self-presentation, an extension of one's self understandings, stories that convey some aspects of a person's sense of self within the contours of the time and space in which the story is told. Self-narratives represent experiences woven together into a personally meaningful tale of who one is and who one would like to be in the eyes of others (Maines 1993; Riessman 1993), and perhaps, who one would like to become (Markus and Nurius 1986). Autobiographical accounts of the self "are not just vehicles for collecting personal information; they are the very process of identity construction" (Mathieson and Stam 1995:288). That said, we amend our statement that there are limitations to exploring continuity using personal accounts of stroke experience *if one assumes a "true" or static self exists*. Our assumption about the multifaceted nature of self should make it clear that we do not.

Finally, we note that all of the men in this study are veterans of the U.S. armed forces and all had operated in combat zones, either actively engaged in combat or providing combat support. Unlike participants in other studies, these men are in the unique position of having confronted death at a young age, their own and that of their friends, as part of their military service. Several men told us that dealing with a stroke was not too different from dealing with the stressful situations found in battle. "I've seen death" or "I've been around death" were common ways to explain why they did not view stroke as overly problematic. Such responses call to mind constructions of masculinity in which men's responses are efforts to present themselves as emotionally stoic, mentally tough individuals. If true, we suggest this is not

altogether problematic. To the extent that a masculine identity was important before the stroke, its effects provided a unique opportunity to demonstrate that one is still masculine, thereby giving the men some avenue for constructing continuity. On the other hand, and perhaps more likely given the nature of masculinity as a physically based social construct (Connell 1987), the benefits masculinity may offer for dealing with the effects of stroke are outweighed by the potential pitfalls. For men whose sense of masculinity was tied to physical ability, declining ability may create conditions for a more acute sense of disruption. We can only speculate on how masculinities might influence constructions of continuity following stroke, but we encourage other researchers to further explore this issue.

With regard to the intersection of gender and illness, another potentially fruitful line of investigation might look at the different ways in which men and women use narrative resources. For example, researchers might explore whether women are more likely than men to construct continuity by drawing on pre-illness family identities. Given that men have traditionally constructed family identities around the breadwinner role, when illness interrupts their ability to continue working, we envision it might also hamper their ability to construct continuity. This was not the case for Frank, who relied on his pre-stroke identity as "old Grandpa" to construct continuity. He may be unique in that he was retired at the time of the stroke, thus family and work identities were not as tightly intertwined, making it easier for him to continue relying on that important pre-illness identity. And what of men who are not retired? And for women whose identities are more reliant on domestic labor than paid labor, what happens when illness interrupts their ability to continue such work? We wonder whether continuity is possible in these scenarios.

Researchers might also ask whether men and women use the vocabularies of aging differently or whether the age of illness onset influences how men and women use these vocabularies. Our results suggest that age of illness onset does not necessarily influence men's use of age as a discursive resource to construct continuity, but future studies might comparatively assess men and women's use of aging vocabularies in self-continuity. The same questions can also be asked of men's and women's use of religious beliefs. By focusing on the strategies individuals use to construct continuity following illness, researchers can further expand our understanding of how illness affects the self. In doing so, they continue to highlight the dynamic flexibility of the socially constructed self.

CONCLUSION

The data presented here are excerpts that highlight the ways continuity can be maintained. They do not present changes in sense of self over time, nor do we make claims that continuity is maintained from interview to interview. We recognize that a person might struggle with self-image at one month post-stroke because of the relative newness of the stroke-related bodily changes. By six months, as they develop new routines, form new interaction patterns with others, and (re)acquaint

themselves with their bodies, they may again be in a position to construct self-continuity. We acknowledge that a longitudinal approach presents a fuller picture of how continuity is maintained, but feel that the first step in this analytic process is to highlight how individuals use various resources to construct continuity. Future work should further explore whether the discursive resources of age and religious beliefs are important in maintaining continuity over time, or whether continuity over time is possible.

Stroke is assumed to disrupt one's self-construction because it alters one's taken-for-granted experience of the body. We highlight constructions of continuity as an encouraging commentary on the multifaceted and dynamic processes of self-construction in the face of potentially devastating circumstances rather than a corrective to the extensive body of literature on the self-disruptive effects of illness. Partly because people interpret illness differently, and partly because discursive constructions of self tend to be self-relevant, individuals explain the meaning of illness within the context of their own lives (Dowswell et al. 2000; Kaufman 1988; S. Williams 2000). As mentioned above, illness is an interpretive process because bodily experiences vary by culture, time, and context (Nettleton and Watson 1998). In addition, the self may be defined in many ways (Markus and Wurf 1987), depending on the resources used and the contexts in which it is defined (Giddens 1991). Such theoretical understandings of illness and self make it possible to view discursive constructions of continuity following illness as one potential outcome of illness with regard to self-construction.

Our study provides evidence that stroke is managed through discursive resources that enable individuals to construct stories of self-continuity. Expectations for aging and religious beliefs are a means to construct continuity because they are important discursive resources that remain personally accessible following stroke. At worst, stories in which aging and religious beliefs are used to construct continuity are hopeful accounts that ameliorate the disruptive effects of illness. At best, these personal stories draw on the unique vocabularies of aging and religion as individuals strive to maintain a continuous construction of self.

Acknowledgments: This material is based on data from a study funded by the Department of Veteran Affairs, Health Services Research and Development, Department Services (grant award NRI 98-183-1 to Maude R. Rittman, Ph.D., RN, principal investigator and partially supported by the Rehabilitation Outcomes Research Center [RORC]; North Florida/South Georgia Veterans Administration Medical Center). A preliminary version of these ideas was presented at the American Sociological Association's annual meeting in Montreal, Quebec, in 2006, and we thank attendees whose comments were helpful. We gratefully acknowledge the helpful criticism and advice from three *Symbolic Interaction* reviewers. We are indebted to Jim Holstein for his comments on previous drafts and especially wish to thank Kimberly Findley and Jini Hanjian at the RORC for their administrative support.

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