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## Applying Erikson's Wisdom to Self-Management Practices of Older Adults: Findings from Two Field Studies

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### Abstract

According to Erik Erikson's theory on the stages of human development, achieving wisdom later in life involves revisiting previous crises and renewing psychosocial accomplishments. However, few studies have used Erikson's theory as a framework for examining how older adults self-manage physical and mental health changes that commonly occur later in life. This paper presents findings from two qualitative studies that demonstrate how older adults apply wisdom in new domains. Specifically, it was found that older adults (1) reasserted autonomy by initiating creative problem solving; and 2) applied skills gained from productive activities earlier in life to new health-related problems that arise later in life. These findings highlight the importance of engaging older adults to repurpose their life skills, and thus reapply wisdom to new areas of their lives. Implications for practice are discussed.

### Keywords

Self-management; relocation; problem-solving skills; repurpose; housing transitions; chronic illness; disability

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In older adulthood, a stage where “the life cycle weaves back on itself” (Erikson, Erikson, & Kivnick, 1986, p. 55), challenges in both daily living and major life transitions can be optimized by integrating skills learned earlier in life. This integration, or repurposing of skills, allows older adults to reapply wisdom learned in other contexts and maintain autonomy in decision making rather than relinquish tasks to others. According to Erikson and colleagues (1986), the ultimate goal is to overcome the last stage of developmental crisis, integrity versus despair, to achieve wisdom. In this paper, we use Erikson’s concept of wisdom as a framework for understanding findings from two studies that examine how older adults engage in self-management practices in creative ways by drawing upon the skills and knowledge they gained from activities such as work, leisure, and caregiving, which lead to involvement for these people.

## Background

### Aging, Health Status, and the Life Cycle

Older adults often experience physical (Brenda et al., 2009) and cognitive decline (Unverzagt et al., 2001), which may lead to limits in mobility (Brenda et al., 2009; Kluger et al., 1997). While many community-dwelling older adults experience minor declines in physical health and cognition, 52.8% of adults ages 65 and older report having a disability, and more than a third have a severe disability (Brault, 2005). However, older adults with all levels of decline (both naturally occurring and clinical) need to manage aspects of their health and health-related services to maintain or improve their overall wellbeing.

### Self-Management of Health

According to Clark et al. (1991), self-management refers to the “day to day tasks that individuals must undertake to control or reduce the impact of disease on physical health status” (p.5). In addition, relocation of residence is a major life transition that may be considered a self-management activity for older adults who believe that a change in their environment will improve their living situations (Koenig, Hee Lee, Macmillan, Fields, & Spano, 2013). Self-management is a dynamic learning process that relies upon a number of skills, including: problem solving, implementing solutions, and evaluating outcomes; decision making; researching; forming partnerships with health care providers; and taking action, which involves devising a plan and carrying it out (Lorig & Holman, 2003).

The concept of self-management is particularly relevant to older adults because they are likely to experience multiple chronic conditions (Clark et al., 1991), have geriatric maladies as urinary incontinence and injuries due to falls (Lee, Cigolle, & Blaum, 2009), and experience additional vulnerabilities when living alone (Haslbeck, McCorkle, & Schaeffer). These trends, combined with older adults’ life context for disease management, create unique challenges for this population and point to the importance of age-specific approaches to increase self-management activities (Clark et al., 1991; Lee et al., 2009). Adams and Corrigan (2003) of the Institute of Medicine (IOM) identified self-management as one of the priority areas for improving the quality of health care in the U.S. due to high prevalence of chronic conditions, their associated healthcare costs, and the benefits of effective self-management. As a result, a number of self-management interventions have emerged that

include care planning, motivational interviewing, peer-led groups, health coaching, and brief primary-care interventions (Barlow, Wright, Sheasby, Turner, & Hainsworth, 2002; Lawn & Schoo, 2010). Such programs have been associated with improved clinical outcomes for chronic conditions such as diabetes and hypertension among older adults, although this may not be the case for some other conditions (see review Deakin, Welschen, Nijpels, & Singh, 2006).

### Theoretical Framework

Erikson's theory on the stages of human development provides a framework for understanding older adults' interest and capability for engaging in self-management. According to Erikson and Erikson (1997), individuals encounter eight stages of psychosocial crises: basic trust versus basic mistrust; autonomy versus shame and doubt; initiative versus guilt; industry versus inferiority; identity versus identity confusion; generativity versus stagnation; and integrity versus despair and disgust. Successfully overcoming each stage results in respective psychological strengths: hope, will, purpose, competence, fidelity, love, care, and wisdom. His work also centers around a lifelong principle of epigenesis where the unfolding of an individual happens throughout the life course and there is a sequential nature in development, where progress in early phases in development influence later phases (Peedicayil, 2012; Erikson & Erikson, 1997).

Although integrity versus despair and disgust are most often associated with later life, Erikson believed that the previous stages of development are renewed in late adulthood and mature forms of these psychological achievements are integrated "into a comprehensive sense of wisdom" (Erikson et al., 1986, pp. 55-6). Erikson et al. (1986) provided several examples of this process of renewing earlier psychosocial achievements. For instance, adults develop a mature sense of competence when they must adapt their sense of industriousness from previous work experiences to their post-employment environment during retirement, where existing knowledge and skills may be transferred to newfound hobbies, volunteer work, and/or caring for disabled family members. However, Erikson acknowledged that physical and cognitive changes occurring later in life create limitations on competence (Erikson et al., 1986), which may constrain older adults' ability to self-manage health and disability. These restrictions may also offer opportunity for older adults to replay earlier developmental tensions. For example, to address the earlier Eriksonian stage of initiative versus guilt, older adults may renew their sense of purpose by "initiating" participation in new activities to counteract a sense of guilt that may come with imposed inactivity. As an activity, self-management may provide occasion for mastery and renewed purpose.

Erikson and Erikson (1997) also explained that overcoming the crisis of integrity versus despair is not an easy task for older adults, making it very easy for them to become frustrated with the daily demands that contribute to maintaining integrity. For example, Erikson and Erikson (1997) described the significant challenge and continuous effort that a person in his nineties may experience in the simple task of trying to locate his glasses (p. 112). Despite such challenges, Eriksonian theory suggests that when older adults experience declines in their physical health and/or cognitive abilities, their renewed sense of purpose may result in engaging in self-management to remain autonomous, rather than passively

allowing family, friends or professionals to manage their services and care for them. Similarly, the renewal of competence indicates that older adults' previous experiences may be transferred to the task of self-management.

### Context of Current Studies

Despite the growing body of research on health and disability self-management among older adults, little is known about how older adults revisit the previous psychosocial stages, as Erikson's framework suggests, to self-management of physical and mental health. This paper aims at expanding current understanding of self-management among older adults by using Erikson's developmental theory as a framework for understanding findings from two natural studies in which older adults demonstrated self-management beliefs and behaviors.

### Methods

This paper draws upon the findings from two separate field studies that examined health and disability self-management of older adults. The studies are complementary in that Study A examined self-management from a day-to-day perspective of older adults with chronic health conditions, while Study B examined older adults' experiences of self-management of a major life transition, housing relocation, that they were making in an effort to accommodate physical and mental health changes they experienced later in life. Study A was conducted by [Blinded] and Study B was conducted by [Blinded]. All research methods were approved by the internal review boards of the respective authors' institutions. Greater detail on each study is provided below.

#### Study A: Day-to-Day Management of Health and Disability

**Sample**—This study involved in-depth interviews with 37 older adults in Central and South Florida. Eligibility to participate included: being age 60 years old or older; speaking English; having at least one chronic health condition or disability that requires support or ongoing medical care; and not experiencing moderate to severe cognitive impairment (as determined by the Mental Status Questionnaire [MSQ]) (Kahn, Goldfarb, Pollack, & Peck, 1960). The sample of older adults varied; 24 (66.7%) were women and participants' ages ranged from 60 to 97 (mean=76.4 years). Twenty-six (72%) had a high-school education or less, and 13 (36.1%) were Medicaid eligible or self-identified as Medicaid non-eligible, but low-income. In terms of race, 30 (83.3%) were white, six (16.6%) were African-American or Afro-Caribbean, and three (8.3%) identified as Hispanic. Subjects' disability status varied as well, with chronic conditions including cardiovascular (hypertension, heart disease), diabetes, cancer, developmental disorders (cerebral palsy, down syndrome), neurological (pain disorders, spinal injuries/paralysis), and blindness. Most participants (83.3%) had co-occurring conditions.

**Data collection**—We conducted in-depth interviews with all research participants within their homes or another community-based setting, each lasting between 45 and 90 minutes. Prior to each interview, participants were required to sign a consent form. Interviews were conducted using a semi-structured schedule and included questions that covered a variety of topics related to health and disability self-management, including their health-related

behaviors, experience with health providers, support service providers, and family members. Participants were compensated with a \$20 gift card for a local supermarket chain.

**Data Analysis**—Interviews were transcribed and checked for accuracy. Analysis involved a systematic process using Atlas.ti that began with open coding, in which codes were unrestrictedly assigned to data segments that reflect the concepts those data segments represent (Strauss, 1987). Then, we assessed the data using constant comparison, in which individual codes were compared with previous data to assess for conceptual similarities and differences (Corbin & Strauss, 2008). Later in analysis, thematic codes that were conceptually similar were linked together in larger integrated categories (Corbin & Strauss, 2008). The second and third author coded the data separately, which resulted in minor discrepancies in data analysis. These were resolved by discussing the rationale for coding until an agreement was reached between coders.

### Study B: Management of a Major Life Transition

**Sample**—This ethnographic study of relocation in older adulthood included 43 single older adults and 19 couples where both partners were relocating, for a total sample of 81 older adults. Participants' ages range from 57–91 and they all resided in the Midwestern United States, in and around a small college town. To be eligible for the study, older adults needed to be planning to relocate, or had to have relocated recently. The researcher followed the participants, where possible, through three stages of moving: pre-move planning, moving, post-move adjusting. Seventy-seven of the participants were Caucasian (95.1%). Three African Americans (3.7%) and one Asian (1.2%) also participated in the project. There were fifty-nine females and twenty-two males. They were moving from homes, apartments, or other types of senior housing into independent living residences of Continuing Care Retirement Communities (CCRCs), subsidized senior housing, or housing requiring less maintenance and eased navigation of space, such as condos or single story layouts.

**Data Collection**—Data collection involved semi-structured interviews, participant observation, and document review to capture the “holistic view” of moving for older adults. Topics of the interviews included the timing and motivations of their move, the contributions of their family and professionals, and the meanings of moving. Because of the anthropological orientation of the project we conducted both formal and informal interviews. To understand the moving process, the researchers observed participants while helping during activities such as packing objects and planning furniture layouts in the new residences. Many of the observations were digitally audio recorded so conversations about moving could be captured (e.g., during the sorting of items and packing of boxes). The researcher composed field notes to document the observations.

**Data Analysis**—In the anthropological tradition, data analysis involved reviewing of field notes (from participant observations of packing/unpacking, garage sales and moving day experiences), analyzing digitally recorded interviews selectively transcribed, and reviewing documents (marketing materials, collected sketches and lists related to moving made by older adults in the study). As we iteratively examined the data, the themes emerged. We did not place “constraints on outputs,” (Patton, 2002, p. 39) given the epistemological emphasis

in anthropology on being open to emergent themes. To increase the trustworthiness of the data analysis, the researcher presented findings to study participants in large group presentations and in follow-up conversations (Rubin & Babbie, 2011).

**Development of Themes**—When both lead researchers discovered that similar themes were found in each study, they continued data analysis by pooling interview transcriptions and field notes from both studies that related to participants' health self-management knowledge and activities. Through deductive reasoning, the researchers then used Erikson's theory to constantly compare the codes, patterns, and smaller themes found in early analyses until major themes were identified and named (Corbin & Strauss, 2008). The researchers assessed the major themes separately and held regular meetings to assess inter-rater agreement. Discrepancies were addressed by discussing rational for analysis decisions until agreement was reached. Member checking was used in both studies to strengthen the trustworthiness of data themes.

## Findings

Older adults across the two studies varied considerably in their experiences with chronic health conditions and disabilities. However, all of the older adults acknowledged that they experienced changes in their physical health and (for some) mental health status as they aged. In most cases, participants viewed these changes as a part of the natural life cycle, reporting that most people in their age group are similarly "slowing down," "becoming forgetful," or experiencing chronic pain and loss of mobility. Completing mundane tasks became more difficult and required support at times.

For example, from study B, Ms. Sand<sup>1</sup>, a Caucasian female who was age 79 at the time of her move, was excited about the change. She explained that her washer and dryer were located in her basement. An avid swimmer, she had to launder wet (thus heavy) bathing suits several times per week. She would put her suits and other laundry into a laundry bag and throw it down the basement stairs. After finishing the laundry, she would drag the bag on the floor to the top of the stairs or wait until her handyman's weekly visit, when he would bring it up to her living space two floors above. By selecting a new residence with her washer and dryer, and all living space, one on floor, she felt relieved and more assured that she would be able to deal with her laundry more easily. This is an example of self-management in the decision making process of a major life transition. Mrs. Sand reflected:

I mean it was the same thing over there when I go to pack up I said, "Why is it getting so hard?" Then I realized I'm a year older. My balance is worse; it's harder for me to get on the ladders to put my stuff up in my vent storage. Uh you know, it's, it's harder for me to do things around the flat...And uh fixing things that I would have fixed in the past. I can't do it anymore you know.

In both studies, participants described attitudes and behaviors related to their self-management of age-related changes in their health. Some participants reported negative feelings about their declines in physical and/or mental health functions, but did not report a

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<sup>1</sup>Please note that pseudonyms are used throughout.



clinical diagnosis of depression. These changes in their health might also be viewed as threats to independence. Many older adults, especially those with more serious health declines, acknowledged that the changes in their health status and mobility threatened the autonomy and independence they experienced throughout adulthood. Explaining the intensity of the threat, Eve, a 66-year-old African-American woman from study A, reported that she continuously refused the recommendations from her physician and family to use a motorized wheelchair, in fear that it would impede on her independence. She explained:

They been trying to give me a motor wheelchair, with a motor wheelchair that was, that's combine, confining me and I wanted to get away from depending on. I want to get Eve back. You understand what I'm saying?...It takes everything away.

In Eve's case, she fought recommendations to using an assistive device because it might decrease her independence, rather than focusing on the opportunities it might offer. She asserted her independence by refusing to use a wheelchair, which also illustrates different ways of looking at independence and autonomy.

These struggles for independence and autonomy can also be examined from the lens of self-management within the context of Erikson's theory of human development. Three major themes emerged from the data that indicated older adults' repurposing of prior psychological achievements for self-management: *I've been through this before*, *self-management becomes productivity*, and *reapplying competence*. These themes are presented in greater detail in the following sections.

### **I've Been Through This Before**

Older adults describe their new struggle for independence as one of many lifetime experiences in which their independence and autonomy were challenged. For instance, many participants reported that they have survived prior challenges to independence, including divorce, single-parenthood, racism, early onset of disability, and even the Holocaust. When faced with challenges posed by physical declines in later life, they drew upon these previous experiences, reminding them of their resiliency and reapplying the same coping skills they used to survive then. One example from study A included Armen, an 85-year-old Caucasian woman, who explained that her struggles with her mother over Armen's blindness earlier in life prepared her to stand up to individuals who challenge her own independence now:

She was very protective. She was very negative. Anything I wanted to do, "No you can't do it." But I must have been a strong personality. I did it anyway. I wanted to learn how to roller skate in the street like the other kids. As I said, I lived in the city. So she says, "No." And she wouldn't buy me any skates. So I cashed in her milk bottles and I bought skates. And my girlfriend had a baby brother in a stroller and I'd hang on to the stroller and I'd learn how to skate. So, one day when [my mother] was coming home from grandmother's, she saw me coming down the hill that goes right into the boulevard if I don't turn. (Laughs) And she nearly had a heart attack - she saw me skating.

Earlier experiences with self-determination enabled study participants to demand independence as seniors. In a similar way, previous life experiences may affect health

decision making for older adults. When asked why she thinks that some older adults defer their health-related decision making to other people such as doctors and family members, Betty, a Caucasian 73-year-old woman and stroke survivor replied:

Well I think a lot of women – and they aren't a few decades [older than me], like I'm 73 maybe they are in their 80's – basically they relied on their husbands. They didn't make decisions, so their decision-making capacity is diminished....When you hear sometimes what comes out of women's mouths, I think, "Oh my God!"... Don't forget I was a single parent way back. I come under the old New York...for a couple of years. [Laughs] And so I'm used to making a decision. Sometimes they don't work out, end of story. Sometime they're better than you know you expect because there's also different circumstances that you don't have control over.

Betty's response highlights how learning which took place decades earlier as a single parent influenced her approaches to problem solving later. These influences were also demonstrated by participants in study B. Mrs. Jackson, a Caucasian 70 year old at the time of her move, had been in a wheelchair since she was a teenager. She had lived through the challenge of raising five children and operating a home daycare, despite being disabled. She and her husband had modified their home to accommodate her needs. When they decided to move to prepare for her husband's health challenges, they already knew what modifications to request because they'd been through thinking about their spatial modifications before. They requested that their upper cabinets in their kitchen be lowered three inches so she could reach the top cabinets easily. They also requested six feet of additional concrete on their driveway to provide a paved surface to let her wheelchair descend electronically from the wheelchair lift onto concrete rather than grass, especially important in winter months (fieldnotes). She was also able to enter other residents' homes easily because the entire Continuing Care Retirement Community was barrier free.

### **Self-Management Becomes Productivity**

In many cases, older adults reported that they engaged in a number of self-management activities in response to changes in their health or disabilities. These activities range from mundane, daily tasks, such as medication management to more complex procedures, such as relocating to new residences that were better suited to their new physical and mental health limitations. Self-management activities among elders often involved considerable effort or time commitments and therefore were perceived as productive. This was significant for participants, many of whom lamented about how their decreased physical and mental health statuses posed limitations on their ability to engage in productive activities that they previously enjoyed or valued, such as work, hobbies, and housekeeping. Hence, self-management replaced their prior productive activities.

For instance, many older adults described their pill management and other mundane daily activities as "something to do" or "something to keep me busy," such as Anna, a 94-year older Caucasian woman from study A, who stated:

I feel I'm on too many [prescriptions], but I take them to my primary doctor and he says, 'Well you should have this and you should use this'...I take [pills] for the blood medicine, [pills] for the cholesterol, you know. So, you get older and that's



what you do. Some might take them in the evenings, I keep them on my night table. Those that I take during the day I keep in the kitchen. It's a whole ritual, but you know something? It gives us something to do [laughs].

Another participant in study A, Estella, a 90-year old Caucasian woman, felt that the computer games that she did for cognitive exercises was a productive activity:

I use the computer for solitaire. To keep my mind sharp. I use it for everything. But my eyes close quickly. I'm not an interneter [sic] or anything. I have games on it. So, that's what I do with my time. If I'm not doing something here, I'll go sit down and play my games. So, I keep busy. I know how to keep busy.

Similarly, Lois, a 73-year-old African-American woman from study A, reported being extremely upset when her family began to make arrangements for her home and belongings without including her:

I had my own house then. My relatives...after talking with them [about my diagnosis] it was like, I would be dying in a short period of time. When I went to Atlanta, my sisters and my nieces, they dismantled my house that I was living in. When I say dismantle, they start taking things and giving them away, putting them here, putting them there...It was upsetting. Very upsetting. Because I felt like, just wait until I die and then you can go and then do all of these things.

Older adults in study B often discussed the amount of work it took to voluntarily relocate. Relocation as a major life transition becomes a productive process that needs to be self-managed daily. Mrs. Sand, a retired university professor with membership in many nonprofit organizations, commented on the challenges she faced in organizing the correspondences she received in preparation for her move:

I know what I have to do that day and I fill it in with everything else you know, I mean I have to be on the computer, but is mostly been going through papers. I mean some mornings instead of going swimming----I only went swimming once because I think I can get at 5 o'clock and take another load of papers, get in bed with a pot of tea.

Another way this cohort engages in self-managed productivity is in supervising the design of their new residence. Some spent much time and effort to ensure their new residence had the specifications that integrated preferences and functionality, taking time to understand the plans for a new retirement community and proposing solutions to retirement community staff. For instance, Ms. Grant of study B, a Caucasian woman who was mid-seventies at the time of her move, explained:

The second thing is I feel extremely strongly about the configuration of the doors in the master bedroom, visa vie the door into the bathroom and the door into the bedroom... are, I believe in, in dangerous and if you swing the door the other way, which is what they said they're going to do, then you have diminished the functionality of that bedroom just a little bit. At least according to my lifestyle. You diminish it... So I'm saying, I don't like that idea. It diminishes the functionality of that room, so there are, there is, in my world, there is a very simple solution. It's a pocket door.

She later said:

I've asked them I asked them if, why don't you just give me a blueprint? If you just give me one, I wouldn't, I wouldn't bug you.

Older adults, managing both in daily tasks and major life transitions, engaged in productive activities to plan for their futures. These activities may have replaced other activities they were involved in earlier in life or were acquired earlier in life. The next section presents examples of specific ways older adults reapplied competence.

### Reapplying Competence

Many in our study reported that health self-management was not a new concept as they aged and provided examples of health issues and health-related decisions they dealt with earlier in life. However, in most cases their declining physical and mental health statuses required new approaches to self-management of new conditions they were experiencing. For many participants, they reported that, when learning how to self-manage and make adjustments for their changes in health status, they draw upon skills and knowledge from the productive activities they engaged in earlier in life and reapply them. More specifically, older adults drew upon knowledge and skills from their prior employment, caregiving, and recreational activities and adapted them as seniors.

The interviewer in Study A observed an example of this during an interview with Abe, a 94-year-old Caucasian man who is blind from macular degeneration. Earlier in life, he was a manager for warehouses and retail stores, requiring skills to organize inventories. These organizational skills became evident when he explained his prescription management system. Since Abe cannot see very well, he organized his pill bottles by the time of day he takes them, with three groups of pill bottles in different parts of the kitchen (morning, noon, and evening pills), similar to organizing merchandise at a store. Then, he showed the interviewer a shelf in his bedroom closet where he has each bottle lined up. He explained that the bottles in the closet each contained a two-week supply. So, whenever one bottle empties in the kitchen, he knows that he has two weeks of pills left and needs to reorder. This process was very similar to how inventory would be kept in a store. He explained that his system, "Keeps everything up to date."

In Study B, Mr. and Mrs. Johnson, both Caucasian older adults, ages 75 and 74 respectively at the time of their move, provided another example of reapplying competence. The couple moved primarily because Mrs. Johnson has multiple sclerosis. They planned to be travelers and participate in international mission work in retirement, but, because of her diagnosis, they have now chosen new roles as communication liaisons to support overseas work. Mr. Johnson was formerly employed as a landscape architect and he requested modifications based on his knowledge of layout and design. For example, he requested an alternate entrance to a storage closet (through the bedroom rather than the garage). This request ended up promoting better air flow through the living space. He also requested a secondary door to the outside rather than always needing to open the garage door to exit the garage. His professional expertise and his care of his original home (which also had the same secondary door from the garage) contributed to his requests in transitioning to a retirement community.

On the day of her move, Mrs. Johnson discussed whether this was the best year for the move citing two reasons. She would never walk quickly again, and her husband had been plagued by back problems this year. Mr. Johnson handled much of the physical labor of the move, which was the first time the couple had ever experienced the selling of a home. He had been working hard on fixing up their house, lining kitchen cabinets with new shelf paper and a detailed list of projects to be completed before the move. Mr. Johnson kept a notebook specifically for his move, complete with sketches, lists, and telephone contacts. These lists were inventories of measurements of furniture in his office (see Figure One), weekly tasks to prepare for his move (see Figure Two) and tasks to be completed, organized by room, to prepare for the sale of the house (see Figure Three). Some of these skills were recalled from his decades of organizing space as a professional, rather than experiences with moving, as this was he and his wife's first home sale. Making the change this year assured that he had the organizational skills and logistical strength to handle the task. Thus, he could organize and supervise the move, while his children could do most of the heavy lifting. His ability to reapply competence was seen as time dependent as his health status may continue to change, which is why self-management for the future depended on a major life transition at a time chosen by the couple.

Additional examples included Armen [Caucasian, age 85, Study A], who explained that the nutrition courses she took in high school were helpful in making dietary adjustments when she developed Type II diabetes, and a number of participants from both studies who previously worked within the health care industry or had administrative positions that gave them specific skills that were useful in managing their health and health-related services. For instance, Sarah, a 64-year-old woman from study A, discussed how her prior career as a massage therapist provided her with helpful knowledge on how to address her chronic conditions:

I was a trained massage therapist. I know what fruits and vegetables to take or to avoid [swollenness from] arthritis. And I try not to eat those vegetables and I [inaudible] vegetables that cause inflammation. And I try to eat things like pineapple - the acid in the pineapple destroys the inflammation.

The examples above show that educational and professional backgrounds helped older adults reapply competence to their challenges. However, there were other ways that participants demonstrated how they reapplied competence. From study A, Rosie is a Caucasian, 61-year-old woman whose physical health has declined to the point where she now requires a wheelchair for mobility and considerable support in homemaking and personal care. When asked what she does differently now that she's in a wheelchair, she replies, "I've learned how to do certain things from my chair that I used to do standing up. I [can] cook. I can't cook gourmet meals like I used to, but I can slice an apple real well and do whatever from the chair." As she prepares her meals, she demonstrates her ability to adapt in her application of competence. She cooks, but not in elaborate ways. She also acknowledges that there are limits to what she can do for herself in other domains and the impact that these limitations have on her emotions. She explains that, "I can't get my own shoes on. When it comes to that, when you can't do things like that - put on your own shoes - that to me is very demeaning to me. No one's doing it to me, but I find it demeaning."

Rosie offers a case example that indicates the ambivalent nature of reapplying competence in two ways: She can cook, but in modified ways and she has other domains where she is unable to apply past experience to present contexts.

A final example from study B can be found in the life of Mr. Ross, a Caucasian male who was age 80 at time of move. Living in a retirement community, Mr. Ross notes that on occasion emergency vehicles will visit homes in response to residents' needs. When he inquired about the wellbeing of his neighbors, the retirement community staff members told Mr. Ross that, because of confidentiality mandates under the Health Insurance Portability and Accountability Act (HIPAA), they were unable to disclose information about other residents. Mr. Ross explained, "I questioned that, and of course you know having worked under HIPAA instructions professionally I said, 'This really does not apply here because there is nothing medical going on here.'" In this instance, Mr. Ross is drawing upon his knowledge from his former profession to inform important aspects of his current life, such as being aware of the health and wellbeing of his neighbors, and their ability to know about any issues he might face.

After researching HIPAA guidelines, Mr. Ross discussed his findings with the retirement community staff, however, they did not change their policy. In navigating the dystonic elements of shame and doubt versus autonomy, Mr. Ross was confronted with a situation where his knowledge and expertise were unable to bring about the change he desired. When asked about his response to the retirement community's decision, he informed the researcher that, "We took a more creative, uh, direction. So my suggestion was, for the residents, that how about we form a care response team and then it's the team's business to look into the business of the residents regarding health and other matters that affect their lives and affect community." Still having faith in his competencies, Mr. Ross successfully navigates the two stages by displaying confidence in his autonomy in the face of resistance, and industry by pursuing his objective through the creation of the care response team.

## Discussion

Findings from these studies add to our current understanding of self-management of health and disability later in life. Overall, it was found that when participants were faced with declines in their physical health and/or cognitive abilities later in life, they drew upon their experiences and skills acquired in earlier adulthood for the purpose of self-managing their new conditions. First, to cope with their negative health changes they reflected on their resilience to overcome significant challenges they faced in earlier adulthood. Second, participants reported that health self-management activities replaced some of the productive activities that they engaged in earlier in life, but gave up. Lastly, participants identified skills and knowledge that they gained through the productive activities they engaged in earlier in life and reapplied them to managing their health changes. However, it is important to remember that not all outcomes are positive in older adulthood, given the spectrum of personal and external resources of older adults.

## Wisdom in Health Self-management

Erikson's theory on the epigenetic stages of human development provides a framework for explaining these findings. According to Erikson and colleagues, older adults develop a "comprehensive sense of wisdom" by renewing earlier stages of development and developing mature forms of the psychological achievements they that they made throughout the life course (Erikson et al., 1986, pp. 55-6). Based on the findings from this study, older adults' engagement in health self-management is an example of this process. For instance, in facing declines in health status, older adults in this study faced threats to the independence, essentially revisiting the crisis of autonomy versus shame and doubt that they experienced as children. By reflecting back on prior life challenges to their independence, these individuals remembered their resilience, giving them a mature sense of will. A second example would be older adults' description of health self-management as a productive activity. Most older adults participating in these studies had severed their ties with the paid labor force and many reported that declines in their health status caused them to give up work, volunteer, and recreational activities later in life. In a number of these cases, participants reported that their daily self-management activities and/or preparations for housing relocation renewed a sense of productivity. For instance, medication management and addressing medical needs became "something to do" or "something that keeps me busy." Based on Erikson's theory, older adults who face physical health and cognitive decline revisit the crisis of initiative versus guilt, but may achieve a renewed sense of purpose by engaging in productive activities that maintain their health. While such positive outcomes may not be expected in all cases given the variability of individual and environmental characteristics, these examples highlight the mastery in the ninth stage of Erikson's framework.

In their work, *The Life Cycle Completed*, Erik and Joan Erikson proposed a ninth stage where an older adult revisits the previous eight stages. The authors acknowledge that increased longevity provides time for those in their 80s and 90s to "come to terms with the dystonic elements in their life experiences in the ninth stage, they may successfully make headway on the path leading to gerotranscendence (1997, p. 114). An important feature present in the writing on the ninth stage is the ordering of syntonic and dystonic characteristics. In the previous stages, the syntonic feature described as supporting "growth and expansion" precedes the dystonic feature (1997, p. 106). The purposely placed dystonic features more prominently and highlights the previous eight stages as experienced by older adults. For example, for basic mistrust vs. trust, they write of mistrust of capabilities. Additionally, in shame and doubt versus autonomy, they point out that others become more powerful such as grown children, which may lead to shame and doubt. Also, for inferiority versus industry, one's competence may be seen as inferior. Lastly, for stagnation versus generativity, care for others may be less evident in older adults as this stage "releases elders from the assignment of caretaking" (1997, p. 112).

The reverse in order of syntonic and dystonic characteristics later in life has implications for late-life depression. Among older adults, chronic conditions are often associated with mental health problems, including depression (Fiske, Wetherell, & Gatz, 2009). Using Eriksonian theory to interpret current findings, it may be said that older adults who have successfully overcome psychosocial crises earlier in life by achieving syntonic outcomes may expect

similar outcomes when facing similar psychosocial crises later in life. However, given physical and cognitive limitations that older adults may experience, they may surprisingly find that they experience dystonic outcomes later in life. Older adults who have difficulty in coping with this unexpected and undesired outcome may experience negative feelings, such as depression, frustration, and anger.

The finding that has the greatest implications for policy and practice is that older adults report reapplying prior knowledge and skills gained through productive activities early in life for the purpose of health self-management. Most of the participants in these studies reported that they enjoyed generally good health during their younger adulthood. As a result, they did not have prior knowledge about or expertise in caring for the negative health-related changes (diabetes, sensory loss, limited mobility, etc.) that they experienced later in life. However, they believed that other types of knowledge and skills that they possessed could be reapplied to health self-management for their health decline. Based on Erikson's epigenetic theory of mastery unfolding over a lifespan and the ninth stage as a platform for revisiting previous stages, it could be said that older adults facing challenges stemming from declining health revisit the crisis of industry versus inferiority, with those who successfully reapply prior skills for the purpose of health self-management re-master competence.

### **Implications for Practitioners**

One of the implications of this finding relates to how we approach health self-management education for older adults. Currently, health self-management education is conceptualized as teaching older adults a variety of new skills that they may use to meet their needs, such as medication management, communication, and decision making. While older adults may not have expertise in their conditions, these are all activities that they have engaged in throughout their lives and therefore older adults may require "retraining," rather than "training" in health self-management. Essentially, by identifying ways of personalizing health self-management so that it emphasizes the older adults' existing skill set and knowledge, it may be possible to increase the effectiveness of current health self-management programs and improve health outcomes for older adults. This may especially be true in the case of health conditions where health self-management education has not been as effective (see review by Deakin et al., 2006). This suggestion aligns well with prior assertions that health self-management should be individualized (Lawn & Schoo, 2010) and that primary care should emphasize person centered practices that take into account older adults' experiences with managing their health in addition to symptomatology (Author, 2013).

### **Implications for Future Research**

There are a number of strengths to the studies presented in this paper, including: triangulation of data sources; a sizable, combined sample; multiple raters in data analysis, and member checking. While the findings presented here add to the existing literature by providing greater detail on older adults' experiences with self-managing their health, the qualitative nature of both studies does not allow us to examine an association between older adults' reapplication of skills and knowledge to health self-management and health outcomes. Therefore, it is suggested that further research should explore how older adults'



reapplication of skills and knowledge contributes to their physical and cognitive functioning. Specifically, future research should aim at identifying the types of information and skills that older adults repurpose for health self-management and the extent to which such knowledge and skills relates to physical and mental health outcomes.

## Conclusion

We have demonstrated creative ways that older adults maintain their autonomy. The renewal of wisdom results when knowledge and skills are reapplied to respond to change. This article highlights Eriksonian perspectives on the ninth stage in three ways. First, our case studies show older adults who are actively working on the sytonic features of the developmental stages. For example, instead of mistrusting their capabilities, they are trusting and making visible their capabilities, by using them to organize their activities. Additionally, they are exhibiting autonomy, as they are not allowing others to become more powerful in self-management activities. As far as inferiority versus industry, their industry, and thus their competence, is highlighted rather than diminished. In terms of care, they exhibit features of generativity, retaining responsibility for their care rather than relinquishing it to family or formal care providers. While family and family care providers may be part of the care plan, it is evident from these data that the older adults are central to their plans as well. This research expands scholarly view of self-management practices in understanding the nuanced ways that older adults respond to challenges that they may face. Vitality in older adulthood is harnessed by addressing these challenges through self-management of daily practices and major transitions.

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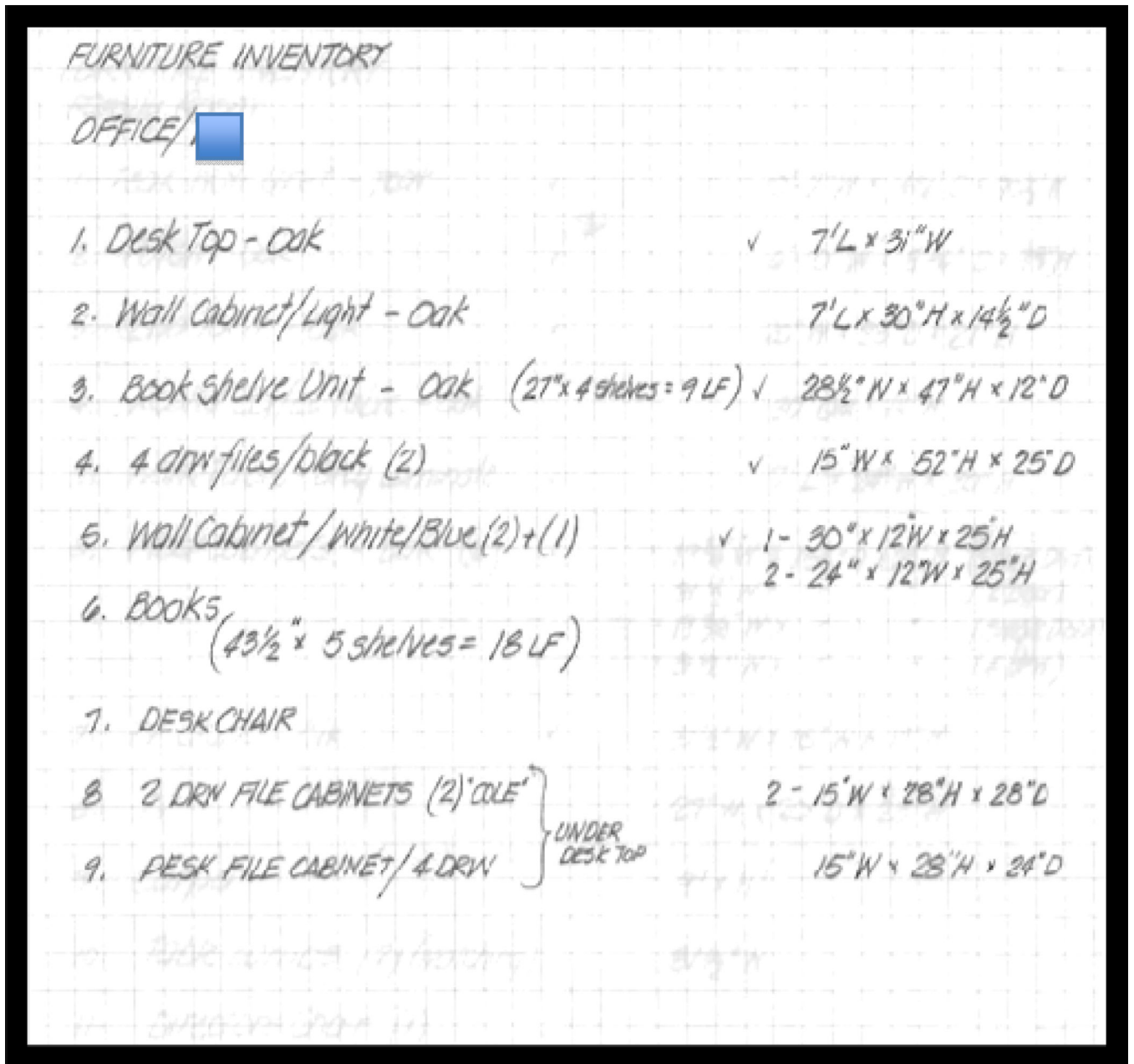


Figure One.

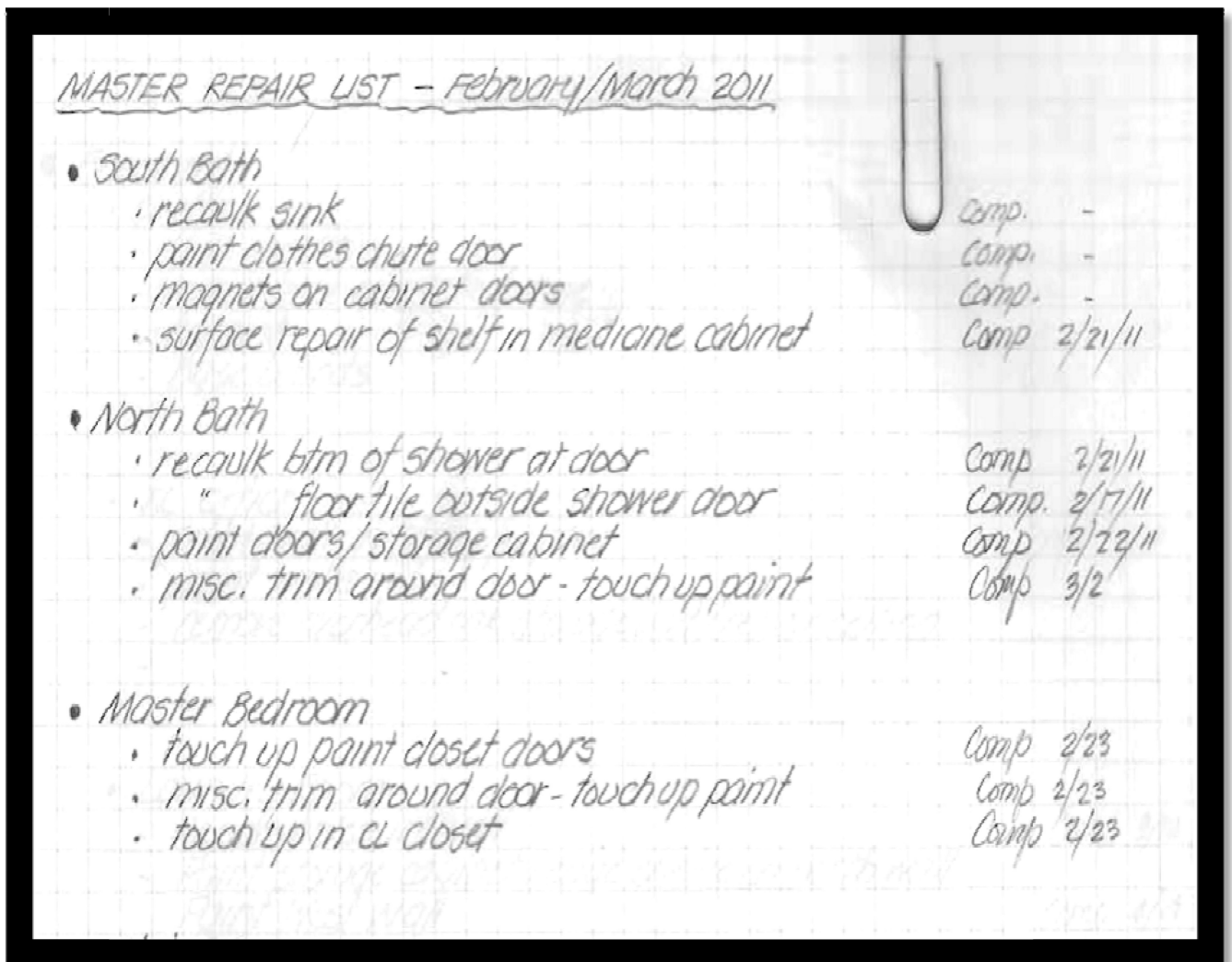


Figure Two.

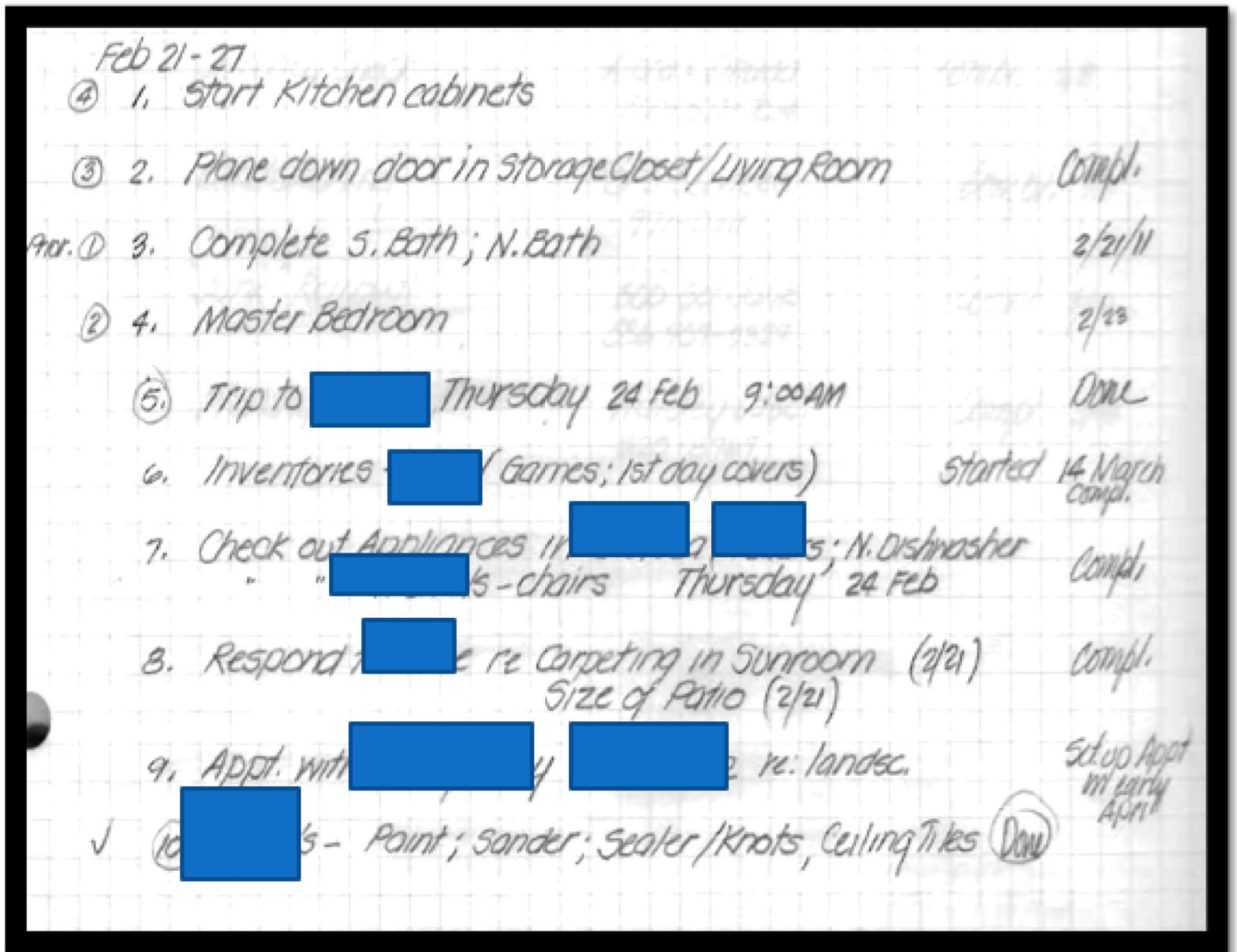


Figure Three.