Linking Aging Theory and Disability Models: Increasing the Potential to Explore Aging With Physical Impairment

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Purpose: Social theories of aging are discussed in relation to their preparedness to address the aging-with-physical impairment phenomenon. Design and Methods: An overview of the social theories of aging is presented. Individual theories of aging are reviewed to examine (a) how they currently depict and/or include disability in their frameworks and (b) how they could be used to explore the experience of aging with physical impairment. Results: Most social theories of aging do not directly address aging with physical impairment or the cumulative experience of disability over the life course. Implications: Potential exists for social theories of aging to be applied to the experience of aging with physical impairment. To do so, physical impairment and disability must be clearly operationalized. The author suggests using social models of disability as frameworks in this process and provides examples of how this might be done with current social theories of aging.

Key Words: Disability, Aging, Theory, Social

We are currently witnessing a new demographic phenomenon in the United States. For the first time in our nation’s history, individuals with severe physical impairments are living long enough to enter the ranks of old age (Campbell, 1996). Through advancements in emergency medicine, rehabilitation technology, public health and consumer education, life expectancy is increasing for persons with polio, spinal cord injury, cerebral palsy, and other diagnostic conditions characterized by severe physical impairment (Campbell, 1997). This is creating a new category of older adults, persons aging with physical impairment. This group is identified as individuals who acquire physical impairment at younger ages (birth to middle age) and live with physical impairment throughout their lives (Campbell, 1996; Treischmann, 1987). This is distinct from persons who acquire physical impairment for the first time in old age and live with physical impairment in old age only.

The aging-with-physical-impairment population is not large, but it is anticipated to have an impact on the aging landscape in two primary ways. First, as significant numbers of people with long-term physical impairments grow old, the range of diagnostic conditions related to physical impairment found among the older adult population will broaden. What was once unusual will become more commonplace. Second, many people aging with physical impairment will become consumers of old-age services after having been consumers of disability-related services. This is important because the service models of disability and aging programs are typically distinct. Disability service programs are more likely to incorporate consumer direction, modeled on the philosophies of self-determination and independent living that come out of the disability rights movement. Aging service programs generally follow the medical model more closely, using a care-management approach to service delivery. These models are ideologically at odds, and policy experts predict that disability rights issues will surface within an aging policy context as larger numbers of people aging with physical impairment begin to use old age programs and services (Scala & Nerney, 2000; Simon-Rusinowitz, Bochnia, Mahoney, Marks, & Hecht, 2000; Torres-Gil & Putnam, 1999, in press).

What does this mean for gerontologists? It suggests that aging with physical impairment is likely a permanent trend and one that needs attention. Gerontology as a field of study has long been concerned with the issue of disability. People aging with physical impairment are a group of individuals who will likely have had different life experiences with disability than
those older adults who have not lived long term with physical impairment or who did not have physical impairments earlier in life. Gerontologists are often interested in the impact or effect of physical impairment on the physical and psychological status of the older adult. In addition, they are concerned with lessening the burden of disability on older adults medically, financially, and socially. Research in the area of aging with physical impairment is just beginning. However, evidence has indicated that younger and middle-aged people with physical impairment experience a wide range of disabilities that affect their physical, mental, social, and economic well-being (Bassett, 2001; Ferguson, 2001; Gill, 2001; Kemp & Krause, 1999; Pescosolido, 2001; Schriner, 2001).

The cumulative effects of having a permanent physical impairment have not been well studied as they relate to aging over the life course. As research on these areas commences, the question arises as to whether current aging theories provide a theoretical basis to predict and explain the experience of aging with physical impairment. If not, a second question regards what is needed to make these theories more robust and inclusive of the life experiences of people aging with physical impairments.

To answer these questions, I first review how the major theories of aging, both past and present, address the experience of living long term with physical impairment and the experience of disability. This includes examining how disability is (or is not) defined, conceptualized, and generally integrated into the theory. Second, I discuss how theories of aging can address the experience of aging with physical impairment. I have started this process by dividing aging theories into categorical sets as a way to simplify the discussion. The four sets of theories considered here are theories of the aging individual, theories of the aging individual within the social system, theories of power differentials, and theories of individual competence and the environment. Each set is discussed below.

Review of Social Theories of Aging

Theories of the Aging Individual

Three major theories of the aging individual are disengagement theory, activity theory, and continuity theory. Each focuses on the individual person and the psyche in adapting and adjusting to changes associated with growing old. Disengagement theory, as formally delineated by Cumming and Henry (1961), proposes a natural withdrawal or disengagement from life roles as the way to greater life satisfaction for older adults. Activity theory, offered as a counterinterpretation by Lemon, Bengtson, and Peterson (1972), posits that the maintenance of activity is critical to high levels of life satisfaction in old age. Continuity theory, developed by Atchley (1989), holds that individuals preserve and maintain both internal psychological structure and external structure in the social and physical environment by making adaptive choices that allow them to feel a sense of continuity between past and current events. In this way, people maintain a stable, yet evolving sense of self as they age.

Over the years, each of these theories has undergone critical review, yet collectively their imprint on the study of aging is immeasurable, as they have significantly influenced the course of gerontological research. Perhaps without intent, disengagement theory, activity theory, and continuity theory narrowly set the parameters of theory regarding the aging individual. By design, each theory excludes from its framework individuals aging with substantial physical impairment (i.e., physical impairment related to polio, spinal cord injury, cerebral palsy, etc.). Both activity theory and disengagement theory were based on the Kansas City Study of Adult Life, which excluded chronically ill elders from its sample by design (Cumming & Henry, 1961; Lemon et al., 1972). The intent was to study “normal” aging. Somewhat similarly, Atchley (1989) originally formulated continuity theory to apply to the normal aging process as well, offering a caveat in his discussion of the theory that the principle of continuity may not necessarily be applicable to individuals aging with substantial physical impairments. However, Atchley did describe how continuity theory applies to individuals who acquire physical impairment in old age in his 1999 treatise on the theory but did not specifically address persons aging with severe impairment (Atchley, 1999).

As described by their authors, each of these theories was premised on the concept of normal aging. Whether experiencing life-long physical impairment or any cumulative effect of disability is included in the normal aging process is not articulated, but these theories do attempt to separate normal experience from pathological experience. The rationale for doing so is most likely related to the desire of early gerontologists to combat aging stereotypes. By separating healthy and unhealthy adults (physiologically, psychologically or socially), researchers could show that illness and frailty were not concomitant with the aging process and could demonstrate a healthy side of aging.

Theories of the Aging Individual Within the Social System

Theories included in this grouping attempt to explain the relationship between the aging individual and society; however, they do so in different fashions. Social exchange theory, as proposed by Dowd (1975), examines the cost–benefit relationship between the individual and society. The central premise of this theory is that there is a reciprocal relationship between the individual and society, where the cost of interacting with an individual at society’s optimal point is in proportion to the benefit derived from that individual. When applied to aging, the assumption is that the cost–benefit ratio falls out of balance as the exchangeable physical, intellectual, and social resources of the individual decrease (Dowd, 1975). Therefore, the costs associated with interacting with the older adult often outweigh the benefits. The older individual can restore the cost–benefit balance by increasing her or his
resources. If this is not possible, she or he may decide to assume a position of compliance, taking on a designated role or set of behaviors deemed socially appropriate for an individual in that position in exchange for goods and services (Dowd, 1975). For example, an older worker agrees to retire in exchange for a pension and medical insurance, providing his or her employer with the opportunity to hire a younger, more cost-efficient worker.

Modernization theory, devised by Burgess in 1960, follows a similar logic but places it on a historical scale. Burgess proposed that with the emergence of new technology, beginning with the period of industrialization and continuing through modern day, older adults lost their place of prestige and power within the social system because they were unable to effectively compete in the new marketplace (Burgess, 1960). Advancements in mechanized production and the brawn of youth outmatched the physical strength of older adults. The recent schooling in modern technology made young graduates more relevant than mature workers with out-of-date specialized knowledge (Burgess, 1960). With reduced value to production, the status of older adults fell, and they became a marginalized population within society as of the mid-20th century. The solution to this current situation as recommended by Burgess was the rehabilitation of older workers to improve their competitive work ability.

Age stratification theory, brought to prominence in 1972 by Riley, Johnson, and Foner (1972), takes a different view of social structures, examining the movement of individuals and cohorts through social roles over the life course. Its basic premise is that age affects the roles individuals play in the social system and that there is an age structure to roles and certain normative age criteria for particular activities (Riley et al., 1972). In this way, individuals within the same age group, or cohort, can be expected to perform similar roles and activities at similar times on the basis of their age characteristics. As one cohort ages, that cohort transitions to a different set of roles as a younger generation takes its place. This process is described as cohort flow (Riley et al., 1972). The goal of age stratification theory is to explore society from the perspective of its age strata and to disentangle patterns of aging from patterns of cohort succession (Riley et al., 1972).

All three of these theories focus on the structure of society and the roles available to older adults. Each acknowledges that a change in resources, including a decline in physical health, can upset the relationship between the individual and society. For exchange theory and modernization theory, this is manifest in the reduction of an individual's marketplace value. For age stratification theory, it means a variation in patterns of aging within and between cohorts on the basis of health status as well as gender, ethnicity, and class. In these ways, change in physical status can mark a point of departure from previous status or roles. None of these theories directly addresses the concept of disability or how the experience of living long term with physical impairment alters the individual's position in, or interaction with, the social system.

Theories of Power Differentials

Based in critical theory, both the political economy of aging and the feminist perspective on aging theories use the variables of age, race, class and gender to examine power differentials within society. As delineated by Estes (1991), one of the first critical theorists within gerontology, the political economy of aging theory explores the social construction of age and how socially produced definitions of old age have an impact on both public policy and the structure of public and private organizations. A basic premise of the theoretical framework is that public policy on aging contains the recognizable imprint of the dominant class of the time period. The way a “problem” among the elderly population is defined and the type of “solution” that is provided to address it reflects how those in power view older adults (Estes, Linkins, & Binney, 1996). The images held by many in the dominant class are fueled in part by their position of advantage and are frequently seeded with unrealistic views about class, race, gender and age relations. In this manner, ideas about aging and older adults conceived from the position of cultural advantage become part of the structure of aging policy and directly influence the treatment of older adults in society by shaping the types of assistance provided to aged people as well as the perceptions of these assistance programs in the general population (Estes et al., 1996). Therefore, it is critical to understand how power differentials translate into structural influences, such as public policy, and affect the experience of aging.

The feminist perspective on aging theory is similar to the political economy model in its attempt to understand the way social structures influence the aging process, although its main focus is on gender differences. The concern among feminists is that the male experience of aging is accepted as the norm and is perpetually used as a basis of comparison for women. As proposed by Arbor and Ginn (1991), the feminist perspective on aging calls for the legitimacy of the female aging experience in its own right, meaning that the experience of older women should not always be viewed from a comparative position. This does not imply that there should necessarily be gendered theories of aging, but it does support the expansion of current theoretical models and the development of new models to allow for a broader range of human experiences.

Despite the critical lens they apply to the aging experience, political economy and feminist models of aging do not specifically address within their frameworks either aging with physical impairment or physical impairment in old age. However, recent works have called for the inclusion of disability as an independent variable (Kennedy & Minkler, 1999). In addition, there is a feminist perspective on disability that could be incorporated into the feminist perspective on aging (Morris, 1993).

Theories of Individual Competence and the Environment

Within gerontology over the past three decades, there has been a concerted effort by researchers who
study community-related issues like housing and transportation to develop an understanding of the environmental factors that can act as barriers or facilitators to older adults with physical impairments. In particular, they have looked at how individuals react to physical demands of environments and what resources are available to moderate a person–environment mismatch. Theoretical work on the source of incongruence between a person’s capabilities and the demands of the environment has led to several theoretical models and multiple hypotheses attempting to explain the nature of the problem and the potential for resolution. For consideration here, two works were chosen based on their appropriateness for this article.

Lawton and Nahemow’s (1973) ecological model of aging has been extremely important in this subfield of gerontology. This model posits that there is a balance point between environmental demands and individual capabilities where optimal functioning occurs and an individual is able to satisfy either a behavioral need or an internal aspect of psychological well-being. A change in this relationship on either side due to increased environmental pressure or reduced individual competency would result in the need to rebalance the equation by modifying either the person or the environment to deal with the new scenario. For example, an individual with severe arthritis may not be able to climb the stairs in her home to the second floor where her bedroom is located. To moderate the impact of this impairment, she may seek physical therapy that enables a greater range of motion and increased strength, thereby increasing her own physical capacity. If that is not a possibility or a preference, she may choose to relocate her bedroom to the first floor where there would be no need to climb stairs. Later revisions of the ecological model of aging included the corollary that an individual’s appraisal of a particular environment has a causal effect on behavior that may be independent of the physical attributes of the environment. That is, how individuals perceive an environment may influence whether or not they believe a disability exists or what action they will take to moderate a disability. On the basis of this hypothesis, the concept of “environmental proactivity” was proposed to clarify the opportunity for the environment to provide resources for overcoming disability as well as creating demands (Lawton, 1998).

A second influential model of the person–environment relationship builds on the ecological model of aging. Kahana’s (1982) model of person–environment congruence elaborates on the ability of the person–environment fit to lead to psychological well-being. Her main hypothesis states that the more congruent, or well matched, the person’s physical capabilities are with the demands of the physical environment, the more favorable the outcome of the person–environment transaction will be (Kahana, 1982). The strength of these ecological models comes from their grounding in environmental psychology and the insight they provide on how disability occurs and how the person–environment relationship can be put into a balance, thereby eliminating disability.

Summary

The results of this brief overview suggest our theories of aging were not necessarily designed with the aging-with-physical-impairment experience in mind. Most aging theories do not consider the cumulative experience of disability. However, it seems that what we have in gerontology is a good set of theories to explain the general phenomenon of aging. They have the potential to apply to people aging with physical impairment as well, if they are expanded in scope. As a first step, we need to be clearer about how we define and discuss the concept of disability. Disability is a complex construct, and living with long-term physical impairment or experiencing disability continually over the life course likely has a substantial influence on the aging experience.

Conceptualizing Disability

There are multiple theories that attempt to define what disability is. These models and theories appear in many fields as disability is viewed through different lenses including economic, political, historical, feminist, and public health perspectives. Within the last quarter century, social models of disability have become prominent in the social sciences. Social models of disability attempt to explain both what disability is and how an individual experiences disability. Many versions of the social model of disability exist (Brandt & Pope, 1997; Hahn, 1994; Lawton & Nahemow, 1973; Nagi, 1965; Pope & Tarlov, 1991; Verbrugge & Jette, 1994; World Health Organization, 2001). Some are more refined than others. A short review of social paradigm of disability is provided below, illustrated by a select set of social models of disability.

Social Models of Disability

In general, social models of disability are premised on the notion that disability is not inherently a part of the person, but rather a function of the interaction between the person and the environment (Brandt & Pope, 1997; Hahn, 1994; Lawton & Nahemow, 1973; Nagi, 1965; Pope & Tarlov, 1991; Verbrugge & Jette, 1994; World Health Organization, 2001). That is, disability is a dependent variable and results from a gap between the capabilities of the individual and the demands of the environment, both independent variables. As such, the individual may have a physical impairment, but this on its own does not constitute disability.

There are multiple social models of disability. Three major conceptual categories are functional limitation models, disability process models, and political frameworks. Functional limitation models have their origin with Nagi’s (1965) functional limitation perspective. In his seminal work in this area, Nagi outlined a pathway describing how active pathologies become physical impairments, leading to functional limitations that result in disability. He defined active pathology as “(a) the onset of disease involving the interruption
of normal processes, and (b) the simultaneous efforts of the organism to restore itself to a normal state of existence” (p. 101). Impairments are classified as “anatomical and/or physiological abnormalities and losses” (p. 101). Functional limitations are identified as “impairments set on the individual’s ability to perform the tasks and obligations of his usual roles and normal daily activities” (p. 102) and disability as a “pattern of behavior that evolves in situations of long-term or continued impairments that are associated with functional limitations” (p. 103). In Nagi’s model, then, disability is a limitation in performance of socially defined roles and tasks within a sociocultural and physical environment that is related, but not equivalent, to pathology, impairment, and functional limitation (Nagi, 1991).

The Institute of Medicine built on this model to create the disabling process model using Nagi’s (1965) pathway and definition of disability but adding the concepts of risk factors and quality of life (Pope & Tarlov, 1991). Risk factors include biological, environmental (social and physical), and lifestyle or behavioral characteristics that influence the development of disability at each step in the disability pathway (pathology, impairment, functional limitation, disability). The World Health Organization model proposes interaction between risk factors and the disabling process as a point of potential intervention. Quality of life is recognized to affect and be affected by outcomes at each stage of the disabling process. Verbrugge and Jette (1994) articulated a similar model of the disablement process with a main pathway to disability following from Nagi’s (1965) model that operationalizes the social context surrounding the disability process. This model posits that the main pathway to disability is shaped by a set of risk factors that include demographic, social, lifestyle, behavioral, psychological, environmental, and biological factors as predisposing characteristics. It also articulates intrapersonal and extrapersonal interventions that have the potential to buffer the disablement process. Verbrugge and Jette outlined intrapersonal factors as lifestyle and behavioral changes, psychosocial attributes and coping activities, and activity accommodations. Extrapersonal factors are listed as medical care and rehabilitation, medications and other therapeutic regimens, external supports, and built physical and social environments (Verbrugge & Jette, 1994). Verbrugge and Jette provided examples of the disablement process:

A woman age 74 with osteoarthritis in both hands (pathology) has weak grip and restricted finger flexion (impairments). This causes difficulty in grasping and rotating fixed objects (functional limitations), and she has trouble opening jars or doors (disability). She purchases kitchen devices and special door handles (interventions) to overcome the difficulty. (p. 9)

The Institute of Medicine revised its 1991 model of disability, creating the enabling–disabling process (Brandt & Pope, 1997). In this revised version, the Institute of Medicine makes three significant changes (Brandt & Pope, 1997). First, the state of disability is not included within the model but identified as a potential outcome of the interaction of the individual and the environment. The enabling–disabling process outlines four stages: no disabling condition, pathology, impairment, and functional limitation. Second, transitional factors and quality of life are posited to interact with the enabling–disabling process. Third, the pathway to disability is shown not as unidirectional but as bidirectional, highlighting the potential for reversal in the disabling process.

The enabling–disabling process model describes the interaction between the person and the environment as the context for disability, using the visual image of an individual standing in the center of an “environmental mat.” The mat is depicted as a large, flexible, three-dimensional object representing the physical and the social environments an individual moves within (home, work, church, grocery store, etc.). The individual stands in the center of this mat. The amount of disability a person experiences is a function of the strength of the environmental mat. For example, if an individual has a physical impairment but his or her physical, social, and cultural environments are supportive (meaning they offer some sort of assistance in compensating for variation in physical ability), the mat is strong and the amount of disability the individual experiences is small. The image is of the individual standing on a firm mat, in a similar situation to an individual with no physical impairment. On the other hand, if environmental supports are weak, the mat is weak, and the amount of disability can be quite large. Thus, the individual sinks downward as the mat under his or her feet strains to support and/or accommodate him or her. In this model, disability is presented as a relational outcome, not as a stable attribute across situations. Determination of disability is dependent on the particular environment an individual is functioning within. Disability is not located within the individual but is created in a situation where the physical capabilities of the individual and the demands of the physical or social environment are not in optimal alignment (Brandt & Pope, 1997).

The International Classification of Functioning, Disability and Health (ICF), another prominent model used in the study of disability, originates from the ICIDH and the ICIDH-2 (World Health Organization, 2001). The ICF is positioned as a universal model of human functioning designed to classify and catalog personal and environmental factors that interact with health conditions to influence an individual’s body function and structures, activities, and participation in life domains. There is no formal definition of disability within this model. Instead, the ICF attempts to articulate environmental and personal factors, and their interactions, that facilitate the assessment of the impact of disability on the individual.

There are more politicized social models of disability, the most prominent being the minority group model of disability developed by Hahn (1994). In his model, Hahn placed social models of disability within a political context, finding social attitudes to be the
root cause of disability. The minority group model includes the following three postulates:

a) the source of the majority of problems confronting disabled people can be attributed primarily to social attitudes
b) that almost every facet of the environment has been shaped or molded by public policy and
c) that, at least in a democratic society, policies are a reflection of pervasive attitudes and values. (Hahn, 1994, p. 4)

Using this framework, Hahn found that the pathology that leads to disability is stigma and discrimination and that changing policies as well as characteristics of the social and physical environment would alleviate disability (Hahn, 1994).

The Importance of Social Models of Disability for Gerontology

As social models of disability have become more prominent, research on disability has widened in focus. Although there remains a strong focus on rehabilitation of the individual, empirical research on the role of the workplace, community, social networks, and cultural attitudes and beliefs is increasingly demonstrating the significant role that the environment plays in shaping life experiences of people with physical impairments (Fougeyrollas & Beauregard, 2001). Our challenge as gerontologists is to continue to explore these relationships as they exist among individuals in old age.

Social models of disability help us to do that. First, they make clear distinctions between physical impairment, functional limitation, and disability. Physical impairment is a personal characteristic. Functional limitation refers to individual performance of a given activity without reference to a situational context. Disability is a situational variable. In much of our work as gerontologists, we use activities of daily living to measure disability, a situation- and context-specific event. However, we often talk about disability as if it were a personal characteristic or a permanent attribute. The true issue here is much more than semantics. From the theoretical standpoint of social models of disability, a person does not have a disability, a person experiences disability. This distinction has the net effect of removing from the person the exclusive burden of accommodating him- or herself to the environment that contributes to disability by sharing the responsibility with the environment to create a more balanced situation. In social models of disability, both the person and the environment have adaptive capabilities. With the passage of the Americans With Disabilities Act, that responsibility has become legalized and institutionalized. Social models of disability are fundamental building blocks of the philosophies of consumer direction, self-determination, and independent living that are the core of many disability service models. By using social model of disability concepts and definitions, gerontologists are forced to tighten their theoretical constructs and be more specific in defining variables within their research.

Second, social models of disability provide frameworks to explore the experience of aging with physical impairment within the person–environment relationship from broader contextual standpoints, allowing for a rich assessment of age-related issues including work, family, social participation, asset accumulation, and access to health care.

Incorporating Social Models of Disability in Our Analysis

The concepts and constructs of social models of disability are not foreign to the field of gerontology. Arguably, Lawton and Nahemow’s (1973) ecological model of aging contains many of the same concepts as most recent social models of disability. However, their model addresses disability within the individual experience and is not designed to explore other facets of the aging individual, including personal development, interaction with social systems, and influence or impacts of power differentials on individuals or groups. If we can build on the strength of definitions found within social models of disability and incorporate them into our social models of aging, recognizing the significance of the person–environment relationship, I think we have the potential to explain the life experiences of people aging with physical impairment. The first step in doing this is to address disability as a variable within our theories and models; briefly, my perspective on what results from that follows.

Political economy theory and the feminist perspective raise questions about power differentials in relationships and the varied experiences people have based on social, biological, and physical characteristics. Adding physical impairment and disability status as variables to these theories would make them more congruent with Hahn’s (1994) minority model of disability. This model is used as a framework to explain the civil rights movement within the disability community and attempts to take into account issues relating to discrimination against people with disabilities at individual, community, and policy levels. By adding these variables, gerontologists could evaluate the experience of aging with physical impairment within the sociopolitical environment and explore the cumulative effect of physical impairment and disability over the life course in areas such as work, family, asset accumulation, and social participation, to name just a few. Researchers who include these dimensions could draw on the established literature in disability studies, psychology, occupational therapy, economics, and public policy in their analyses.

By including physical impairment and disability status as variables, theories of the aging individual in the social system seem poised to examine events that reduce the social value of individuals with physical impairments over the life course. Looking at the effects of physical impairment and age and of disability status and age, these theories could explore the impact that deviation from the norm of role acquisition or achievement because of physical impairment or disability has on opportunity structures. Cohort analysis within this context could be applied comparatively to
people who experience physical impairment or disability and those who do not. Alternatively, comparisons could be made between people with different diagnostic conditions, such as polio and spinal cord injury, to explore historical and social effects of having a particular condition in a given time period or developmental phase. In addition, these theories have the potential to examine personal and environmental modifications as intervening variables that moderate or even improve the social value of people aging with physical impairment. Both civil rights policies and advances in architectural design and assistive and medical technology can have significant influence on the social and cultural value given to people with physical impairments. This, in turn, may have positive or negative impacts on the experience of disability and the cumulative effects of disability over the life course.

This would permit the evaluation of how physical impairment or disability has altered the pattern of social roles of adults aging with physical impairment, such as work and family, and the examination of implications of these altered patterns on the ability to maintain a balanced position within the social system.

Theories of individual aging—activity theory, disengagement theory, and continuity theory—although premised on normal aging and not fashioned explicitly about individuals aging with long-term physical impairments, could be applied to this population by reconceptualizing physical impairment as a variation on a theme. It is unclear if the psychological and social processes of aging with physical impairment are significantly different experiences from either aging without physical impairment or acquiring physical impairment for the first time in old age. Research on younger and middle-aged individuals with physical impairments suggests that some people are more successful than others at coping with and adjusting to physical impairment. Indicators suggest differences in resiliency, particularly in the areas of locus of control, self-esteem, and depression. Empirical evidence supports the notion that adjustment and adaptation to physical impairment and disability is not a singular event but continues over the life course as physical impairment changes and pain and other symptoms fluctuate, as in the case of people with postpolio syndrome or spinal cord injury (Kemp & Krause, 1999).

As the experiences of the individual aging with physical impairment are explored, environments (social, cultural, physical) will provide important contexts to consider as variables that moderate the individual experience of disability. Although environment is often a variable under consideration when examining individual experiences, having a framework for modeling the environment as a contributor to disability and for understanding the tangible role it plays in shaping the disability experience is crucial. In conjunction, understanding disability identity or how people formulate individual and group political identity and use it as a mechanism for empowerment could be explored. Analysis from this perspective opens possibilities to see disability as a contextual feature, disentangling it from physical impairment and yielding the possibility to examine the positive feelings some people with physical impairments have about themselves while still holding negative views about experiencing disabilities.

Concluding Thoughts on Theoretically Preparing for a New Demographic Trend

After participating in this review, it seems to me that gerontology has a good theoretical toolkit to begin studying the experience of aging with physical impairment. However, to really appreciate and understand the experience, we need to do both (a) reassess how we define and conceptualize both physical impairment and disability and (b) begin contextualizing the aging process with experience of physical impairment and disability. If we can do these two things, I believe we will be better theoretically prepared to tease apart disability and physical impairment as we seek to understand the experience of aging with physical impairment. The more we understand the experience, the more adept we will be at addressing service needs for this population and creating public policy that reflects their interests.

References


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