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How do research participants with age-related vision loss talk about their experiences? A secondary discourse analysis of published qualitative extracts

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1 **Abstract**

2 Age-related macular degeneration (AMD) is a common, chronic, progressive
3 eye condition that can affect individuals in later life and lead to loss of central
4 visual function. In this analysis, we aimed to explore the discursive landscape
5 of talk about AMD, drawing on extracts published in peer-reviewed qualitative
6 studies on AMD.

7 Drawing on procedures of qualitative meta-synthesis, we compiled a corpus of
8 raw data extracts from 25 qualitative studies on AMD published in English,
9 largely carried out in high-income countries. Extracts were analysed to identify
10 dominant discourses and key interpretative repertoires (such as recurring
11 metaphors, tropes, and figures of speech). We adopted a Foucauldian
12 discourse analytic approach, to consider the implications of dominant
13 discourses, and their associated subject positions, for the subjective
14 experience of living with AMD.

15 Our analysis identified five distinct ways in which AMD was constructed in
16 research participants' talk about their experience of AMD. They included: AMD
17 as a mysterious affliction, linked to biological ageing; AMD as compromising
18 independence; AMD as grievous loss; AMD as a condition to be stoically
19 accepted; and – to a more limited extent - AMD as an opportunity for
20 discovery.

21 Drawing on theory from critical disability studies and gerontology, we suggest
22 that the constructions identified are underpinned by broader discourses which
23 construct ageing and disability in largely negative, medicalised and
24 individualistic terms. Taking up subject positions within such discourses may
25 compound feelings of isolation, hopelessness and powerlessness. We suggest
26 there may be value in exploring talk about experiences of living with AMD
27 within a broader range of everyday social, relational and environmental
28 contexts.

29

30 **Keywords**

31 Age-related macular degeneration; **visual impairment**; qualitative
32 methodology; discourse analysis; secondary analysis

33 Introduction

34

35 *Age-related Macular Degeneration and qualitative research*

36 Age-related macular degeneration (AMD) is a chronic eye disease that is a major
37 cause of central vision loss worldwide (Lim *et al.* 2012). Risk of AMD increases with
38 chronological age, and global estimates suggest that 196 million people were living with
39 AMD in 2020 (Wong *et al.* 2014). AMD is often categorised as either 'wet' (neovascular) or
40 'dry' (non-neovascular); both forms can lead to **visual impairment**, although the wet form
41 can develop very suddenly, while the dry form progresses more gradually. Treatment for
42 wet AMD involves eye injections, which can slow and stabilise the vision loss; however, no
43 treatment is available for the dry form of AMD (Ammar *et al.* 2020).

44 While there is now a substantial qualitative literature on the lived experience of
45 AMD (i.e. what it is like to live with AMD) (Thier and Holmberg 2020), to our knowledge no
46 studies have set out to explore AMD *discourse* (i.e. the language used to construct meaning
47 around AMD). Therefore, the research presented in this paper aimed to identify the
48 discourses that are mobilised by people with AMD to construct their experiences within the
49 context of research interviews or focus groups. This secondary analysis of participant
50 quotations in published qualitative studies on AMD aimed to focus on how people talk
51 about their AMD experiences, in light of broader, dominant discourses about ageing, illness
52 and **visual impairment**. This research involved a discourse analysis approach underpinned by
53 social constructionist epistemology, entailing a critical approach towards taken-for-granted
54 knowledge (Burr 2015).

55

56 *Defining our approach to discourse analysis*

57 Discourse analysis concerns itself with close attention to how “language is organized
58 into discourses which are culturally specific and whose availability depends upon social,
59 historical and cultural contexts” (Willig 2014, 342). The language and terminology that is
60 used to construct age-related vision loss illustrates how discourse - “a set of meanings,
61 metaphors, representations, images, stories, statements and so on” - can “produce a
62 particular version of events” (Burr 2015, 75), or in more Foucauldian terms a “regime of
63 truth” (Foucault 1980), historically and socially contingent norms and ideas that, though
64 human constructions, become seen as the natural order of things.

65 Discourse analysis can be considered a broad family of approaches, rather than a
66 distinct method (Burr 2015). In this paper, we adopted a Foucauldian Discourse Analysis
67 (FDA) approach, which allows for reflection on how socially and culturally available
68 discourses around AMD, visual impairment (or ‘blindness’), ageing and disability may
69 circumscribe or shape possibilities for individuals’ practice and subjective experiences.

70 Some discourses may be more dominant than others, and FDA considers how power
71 structures and ideologies may amplify, co-opt or repress certain discourses. A ‘dominant
72 discourse’ can be seen to reflect the prevailing ideology of a particular status quo (Hare
73 Mustin 1994), thus becoming more readily “available and accepted” (Becker *et al.* 1995:
74 145) than alternative, more marginal discourses. While dominant discourses can become
75 neutralised - taken for granted as the seemingly non-ideological ‘common sense’ position on
76 an issue (Fairclough 1985) - they may also be resisted through alternative discourses which
77 can advance as social practices evolve (Burr 2015).

78

79 *Critical disability studies as a framework underpinning the discourse analysis*

80 Discourse analysis involves a “top-down approach to interpretation”, whereby
81 discourse analysts “come to their data with a set of conceptual tools derived from theory”
82 (Willig 2017, 279). In this paper, our analysis was informed conceptually by critical
83 perspectives on visual impairment, disability and later life. Such perspectives draw attention
84 to alternatives to common-sense understandings of chronic illness and disability, alert to
85 how the medical model of disability has typically dominated in research on age-related
86 vision loss (McGrath *et al.* 2017). This model has tended to dominate common-sense
87 understandings of disability (Barnes 2012), locating the “problem” or “personal tragedy”
88 (Oliver 1986) of disability in the individual’s “body-gone-wrong” (Michalko 2002).

89 In contrast, a social model of disability (SMD) distinguishes between impairment –
90 the specific issue affecting a person’s body – and disability, which are losses and restrictions
91 stemming from physical barriers, economic discrimination, prejudicial attitudes or
92 behaviours, and social oppression (Barnes 2012; Oliver 1986). From this SMD perspective, a
93 person with visual impairment from AMD is disabled when confronted with inaccessible
94 features of the environment, such as small print on documents, or obstacles on pavements
95 which hinder mobility and navigation (Bolt 2005). The SMD is therefore a transformative
96 tool for political action and social change, shifting the focus away from perceived individual-
97 level ‘deficits’ or ‘problems’, and towards collective action to confront barriers and
98 discrimination at the social or environmental level (Oliver 2004). Building on and nuancing
99 the SMD, critical disability theorists have also highlighted the direct, bodily consequences of
100 impairment that can often involve pain, suffering and fatigue (Crow 1996; Morris 1992),

101 particularly when disability arises from chronic illness (Wendell 2001).¹ Carol Thomas' social-
102 relational model of disability (Thomas 1999, 2004) recognises the impact of "impairment
103 effects" (the direct and unavoidable restrictions on embodied functioning attributable to
104 impairment) alongside "disablism" (the avoidable restrictions imposed upon disabled
105 people at interpersonal, institutional and/or societal levels). For example, challenges with
106 face recognition experienced by a person with AMD could be considered as a direct
107 "impairment effect" stemming from AMD itself, which would persist even if disablism or
108 disabling barriers in the environment were to be addressed (McGrath *et al.* 2017). In the
109 present analysis, these disability frameworks helped to critically interpret participants' talk,
110 and to interrogate and deconstruct the dominant discourses around AMD.

111

112 *Discourses of age-related vision loss*

113 As noted above, to our knowledge, discourse analysis has not been used to analyse
114 the talk used by research participants with AMD specifically. However, discursive
115 constructions of AMD draw on broader discourses that surround the phenomena of ageing,

¹ There are rich, complex debates within the broad area of critical disability studies, for example regarding the SMD's distinction between impairment (stemming directly from the body) and disability (exclusions or restrictions that are environmentally or socially constituted). The various approaches developing, challenging or nuancing the SMD cannot be covered in their full complexity due to considerations of space, but some suggest that there may be more of a continuum or intersections between impairment and disability than implied by the 'strong' version of the SMD (Beaudry 2016; Shakespeare & Watson 2001) - as indeed, Mike Oliver, one of the key proponents of the SMD acknowledged (Oliver 1996, quoted in Shakespeare & Watson 2001). These debates have opened up a space for other models or frameworks, which accept many of the fundamental premises of the SMD, but also make more space for subjective, embodied experiences of disability. These include Carol Thomas' social-relational model discussed above which "recognises the *social dimensions of the biological* and the irreducibly *biological dimensions of the social*" (Thomas 2014, 14); and the work of Donna Reeve, whose work on psycho-emotional disablism recognises that "the structural and psycho-emotional dimensions of disability can be intertwined and/or mutually reinforcing" (Reeve 2004, 97). As Reynolds (2022) points out, it is also important to remember that all models or theories of disability, such as 'the medical model' or 'social model' of disability, are oversimplifications, belying the multiple different conceptualisations within these models.

116 disability, chronic illness and visual impairment. For example, a critical ethnography by
117 McGrath et al (2016) considered how aspects of the environment shape disability for older
118 adults living with age-related vision loss, all of whom were living with AMD (as well as, in the
119 case of some participants, other chronic eye conditions such as glaucoma). Specifically, the
120 authors explored how positive ageing discourses (associated with terms such as ‘active
121 ageing’ or ‘successful ageing’) shape the experience of age-related vision loss. They trace
122 how positive ageing discourses, initially a reaction against society’s and the academic
123 gerontological literature’s disproportionate focus on the losses and limitations of ageing
124 (Boudiny & Mortelmans, 2011), can exclude frail and/or disabled older adults, including
125 those living with visual impairment.² Such discourses risk an excessive emphasis on
126 individual agency and personal responsibility for staying well, overlooking the societal and
127 structural factors that exclude older adults with disabilities and present barriers to their
128 participation in society. In particular, McGrath and colleagues (2016) illustrate how
129 discourses of positive ageing (in combination with biomedical discourses around disability)
130 construct independence as the valorised, idealised goal for older adults living with vision
131 loss. By constructing independence narrowly in physical, functional terms as an

² It is important to note that an increasing body of scholarship aims to address the relatively limited theorising about growing older with a disability, or into (acquired impairment and) disability, despite critical gerontology and disability studies’ shared concerns with understanding how social and environmental contexts shape embodied experiences (Lamb 2022; Leahy 2021). As Aubrecht, Kelly and Rice comment, introducing their text on the ‘ageing-disability nexus’, “*There is also a tendency in popular culture and mainstream media to conflate disability and aging and to subsume one under the other without giving adequate attention to the tensions that shape how disability and ageing are known, experienced, and responded to*” (Aubrecht, Kelly, and Rice 2020, 6). Oldman (2002) suggests the difficulty of bringing together theory on ageing and disability may stem from debates (discussed in part above) around where pain and chronic illness fit within the social model of disability, and concerns that linking ageing with disability “might further problematise later life” (Oldman 2002, 804). A challenge of reconciling ageing and disability thinking is the way that living with impairment and disability in older age has become “institutionalised” within “the standard view of the lifecourse” (Grenier, Griffin and McGrath 2016). This can mean that impairment becomes seen as an apparently ‘natural’ part of ageing, such that “older people with impairments are not seen, and do not see themselves, as ‘disabled’ in quite the same way as disabled children or younger adults” (Priestley and Rabiee 2002, 609).

132 achievement of the individual, such discourses in turn risk perpetuating stigma around
133 depending on others (Fuchigami et al., 2022; McGrath et al., 2017).

134 Turning to literature in social science and the humanities on discourses of visual
135 impairment, scholars have sought to examine and deconstruct the use of terms such as
136 'blindness' both historically and in contemporary society and culture. For example, Georgina
137 Kleege reflects that "the word [blind] connotes a lack of understanding or discernment, a
138 wilful disregard or obliviousness, a thing meant to conceal or deceive" (1999, 21). David Bolt
139 similarly discusses the many connotations linked to discourses of 'blindness' in English,
140 including imagery of darkness, confusion, ignorance and concealment (Bolt 2005). Bolt
141 highlights that using the term 'visual impairment' (rather than 'blindness') is more
142 "pertinent to the discourse of the Social Model of Disability" (2005, 547), and sees the
143 notion of visual impairment as a continuum as a contrast to the "dominant, ableist
144 discourse" (2005:550) of "*the sighted and the blind*", configured as binaries. Indeed,
145 constructions and imaginaries of blindness as "irreversible, unremitting darkness" (Paterson
146 2013) and a "complete absence of any visual experience" (Kleege 1999) obscure the reality
147 that only a small proportion of those certified as severely sight impaired have total visual
148 impairment (without light perception). In the context of visual impairment rehabilitation,
149 Botha and Watermeyer (2022) conducted discourse analysis on a sample of material drawn
150 from websites of organisations that provide visual impairment rehabilitation services in
151 South Africa. Their analysis found that such organisations tend to construct visual
152 rehabilitation as a linear, predictable journey, with "beneficiaries" transformed from being
153 hopeless and dependent to independent, productive members of society. The authors note
154 that these polarised constructions "perpetuate blindness fantasies between which real
155 visually impaired people must navigate their lives", for example by dichotomising concepts

156 such as in/dependence, or overlooking complex lived experiences, such as the fact that
157 feelings of loss and struggle may persist even after visually impaired people have seemingly
158 reached a point of “acceptance and success” (Botha and Watermeyer 2022, 13).

159

160 *Research objectives*

161 The examples above aim to illustrate that talk about visual impairment in older age is
162 informed by broader discourses around ageing, disability and sight/vision, deeply rooted in
163 specific social and cultural contexts. They illustrate how discourses may circumscribe or
164 shape possibilities for individuals’ practice and subjective experiences, by opening up certain
165 ways of talking about a phenomenon and closing down others. This analysis aims to explore
166 whether and how these broader discourses are drawn upon in previous qualitative
167 literature to construct the phenomenon of life with AMD. FDA is a particularly apt
168 methodology for the purpose of exploring how AMD is socially constructed in discourse; as
169 FDA allows us not only to map the discourses circulating within qualitative research on
170 AMD, but also to consider speculatively how these discursive resources may have
171 implications for how the condition is subjectively experienced. This contrasts with other
172 critical psychology methodologies rooted in social constructionist epistemology such as
173 discursive psychology, which is more fundamentally concerned with the micro-level features
174 of language within social interaction and largely focuses on naturally occurring talk or text
175 (rather than interview-based data, especially as decontextualised in the present analysis).
176 FDA by contrast allowed for tentative consideration of how dominant discursive
177 constructions of AMD within existing qualitative research may enable or limit possibilities
178 for subjectivity and practice (Seymour-Smith 2015).

179 We therefore aimed to identify discourses used to talk about AMD (with reference to
180 social scientific scholarship on disability and ageing), and the implications of these
181 discourses and repertoires for subjective 'ways-of-being' with AMD. The overall, broad
182 research question is: How do research participants with age-related vision loss talk about
183 their experiences? In particular, we aim to consider the dominant, 'common sense'
184 discourses and positions represented in the qualitative research on AMD experiences – as
185 well as those that are relegated to the margins – and consider how these discourses may in
186 turn shape the practices and subjectivities of people with AMD.

187

188

189 **Method**

190 *Secondary analysis of published qualitative data*

191 Our approach to secondary analysis follows Wästerfors' typology of qualitative data
192 reanalysis, one variation of which is to use "other researchers' data in the form of published
193 excerpts" (Wästerfors et al 2014, 468) as the source data. The authors highlight the
194 decontextualised nature of such data and the secondary analyst's lack of knowledge of the
195 original circumstances of data collection as potential issues in this kind of (re)analytic
196 exercise. They recommend "cultivating a cautious and reflexive attitude" (2014, 475), as in
197 any qualitative analysis. However, they also note that drawing on decontextualised data can
198 "motivate a fresh perspective in relation to contexts previously taken for granted" (2014,
199 475); this perspective arguably lends itself particularly well to some of the underpinning

200 tenets of discourse analysis, which involves interrogating and deconstructing taken-for-
201 granted knowledge (Burr, 2015).

202

203 *Compiling the dataset using initial steps of qualitative meta-synthesis*

204 To compile the dataset, this study drew on the techniques of qualitative meta-
205 synthesis. Over the last decade, several meta-syntheses on AMD experiences have been
206 conducted (Bennion, Shaw and Gibson 2012; McGrath and Corrado 2019; Thier and
207 Holmberg 2020). Qualitative meta-synthesis is an area of increasing methodological interest,
208 as a method of integrating findings from an ever-growing number and range of qualitative
209 studies (Beck 2019; Finfgeld-Connett 2018). A vital objective of meta-synthesis is to go
210 beyond organising and collating existing findings, taking a critical, reflexive approach which
211 is “interpretive, rather than merely aggregative” (Thorne 2015: 1348). This is where our
212 analysis departed from meta-synthesis, since our aim was less about integrating thematic
213 findings across studies, and more focused on using studies as data sources, from which we
214 could assemble a comprehensive corpus of qualitative extracts about living with AMD. In the
215 early stages of the study, we followed stages similar to those undertaken in other qualitative
216 meta-syntheses. However, we ultimately conducted a form of secondary analysis, using
217 existing data (in the form of published qualitative data extracts) to answer a new research
218 question that differed from the research questions posed in the source research articles
219 (Hinds, Vogel and Clarke-Steffen 1997).

220 To assemble the corpus of extracts, structured searches were carried out using the
221 databases Academic Search Complete, CINAHL, MEDLINE, PsycINFO and PsycARTICLES, and
222 citation tracking for further articles was conducted using Google Scholar. We combined two

223 families of search terms: firstly, terms relating to qualitative research (qualitative OR
224 interview OR “focus group” OR “qualitative survey” OR phenomenol* OR “thematic
225 analysis” OR “grounded theory” OR “lived experience”) and secondly terms relating to AMD
226 (AMD OR ARMD OR nAMD OR “age-related macular degeneration” OR “macular
227 degeneration”). Inclusion criteria were studies **published in any year**, that were: reported in
228 English; where sufficient data extracts, with full sentences, were available for secondary
229 analysis; and where all participants had a diagnosis of AMD. Studies specifically about
230 experiences of people with neovascular (‘wet’) AMD undergoing treatment were excluded,
231 as these often explore highly specific aspects of the treatment procedure or service delivery,
232 in contrast to our interest in more everyday talk about AMD.

233 The electronic database search – run on 9th December 2020 – yielded 856 records.
234 Through screening (Figure 1), we narrowed down to 25 articles, from which participant
235 quotations were extracted for discourse analysis.

236 <Insert Figure 1 about here>

237

238 *Analytic procedure: Foucauldian Discourse Analysis and interpretative repertoires*

239 Our analysis used Foucauldian Discourse Analysis (FDA), **underpinned by a social**
240 **constructionist epistemology**, to explore discourses in published qualitative data extracts
241 about the experience of living with AMD. Willig’s six-stage approach to FDA was used as a
242 starting point (Willig 2013), while omitting the third stage regarding ‘action orientation’,
243 since this would require an understanding of where the relevant extract fits within the
244 discursive context of the participant’s entire account. After compilation and extraction of

245 data extracts, and familiarisation with the extracts, the six stages were undertaken as
246 displayed in Table 1.

247 <Insert Table 1 about here>

248 Within the analysis of broader discursive constructions and positions, we also
249 considered 'interpretative repertoires' about AMD, defined by Wetherell and Potter as

250 "building blocks speakers use for constructing versions of actions, cognitive
251 processes and other phenomena... Commonly these terms are derived from one or
252 more key metaphors and the presence of a repertoire will often be signalled by
253 certain tropes or figures of speech" (Wetherell and Potter 1988, 172).

254 There are rich debates regarding the precise definition and distinctions between a discourse
255 and interpretative repertoire (Parker 1990; Potter *et al.* 1990). Here, we considered
256 interpretative repertoires as operating at a more granular, micro level, as commonsensical
257 everyday discursive resources (Golden and Pomerantz 2015), in contrast to discourses as
258 more macro-level "structures that impose a certain kind of subjectivity" (Burr 2015: 188). As
259 such, a focus on interpretative repertoires allows the researcher to examine the more
260 precise and localised ways in which discourses construct their objects and subjects.

261 Following the stages of FDA (in a recursive, non-linear fashion), we identified five
262 distinct ways in which AMD was constructed in the data. Each construction drew on
263 discourses and interpretative repertoires which recurred across the published extracts
264 included in our dataset. Here, we present the discourses and repertoires that we found to
265 be most dominant. Making a judgement of 'dominance' in part depended on how
266 commonly we found discourses to recur across studies, illustrating that certain discourses to

267 construct the experience of AMD prevail across different study contexts. However,
268 recurrence alone was not the only criterion; we also focussed on constructions that
269 appeared to draw upon naturalised, dominant ‘common sense’ discourses around disability,
270 visual impairment, chronic illness and ageing. Furthermore, we were particularly interested
271 in instances where there was a high degree of thematic or linguistic consistency in how a
272 particular phenomenon was constructed across studies, that appeared to indicate the
273 dominance of a given discursive construction. For example, in constructions of “losing
274 independence” due to AMD (see Section 3.2 below), extracts from different studies show
275 striking similarities in terms of vocabulary and syntax used to construct this phenomenon.

276 **Figure 2 summarises the approaches and frameworks employed in the analysis.**

277 <Insert Figure 2 about here>

278

279 **Findings: Key discourses identified**

280 <Insert Table 2 about here>

281 Details of the 25 studies selected are displayed in Table 2. Our analysis identified five
282 distinct ways in which AMD was constructed in research participants’ talk about their
283 experience of AMD. They included **constructions of**: AMD as a mysterious affliction, linked
284 to biological ageing; AMD as **a total loss of** independence; AMD as grievous loss; AMD as a
285 condition to be stoically accepted; and – to a more limited extent – AMD as an opportunity
286 for discovery. In what follows, we present each construction individually, and examine its

287 implications for how AMD may be experienced. Full quotations are displayed in Tables
288 under the respective construction; the relevant quotation is numbered e.g. as Q1 for
289 Quotation 1. In the Discussion at the end of the paper, we reflect on the relationships
290 between the constructions as well as their wider implications for research on AMD.

291

292 *Constructing AMD as a mysterious affliction, linked to biological ageing*

293 <Insert Table 3 about here>

294 In talk about the aetiology of AMD (quotations displayed in Table 3), participants
295 across studies used language to invoke a sense of surprise, mystery and unknowability to
296 discuss how they first either became aware of AMD themselves, or were made aware by a
297 professional. AMD was constructed as a profound surprise or “shock”, drawing on a
298 repertoire we termed ‘I never would have expected this’ (Q1-3 e.g. “I never, never dreamed
299 that... I was going to have this”).

300 Across studies, participants constructed AMD as ‘the unknown eye condition’ when
301 compared to other diseases (Q4-6 e.g. “nobody knows a lot about it”). AMD was
302 constructed as obscure and unknown relative to conditions such as glaucoma, and as poorly
303 understood in relation to its high prevalence. As many of the study authors themselves
304 conclude (e.g. Burton et al 2013), from a practice point of view, such talk highlights
305 implications for demystifying and improving awareness of the risk factors and symptoms of
306 AMD.

307 In tension with AMD as a source of shock and encounter with the unknown, the
308 condition was also constructed as a seemingly predictable consequence of age (termed the
309 interpretative repertoire ‘It’s just age’). This repertoire constructed AMD as an unsurprising
310 by-product of bodily decline (Q7-10) due to “old age” or “getting older”, seemingly an
311 “existential [inherent] limitation” of ageing (Baars and Phillipson 2013). This may be
312 unsurprising for a condition such as age-related macular degeneration, a name that
313 explicitly associates the condition with later life. However, such constructions may foreclose
314 a focus on what Baars and Phillipson (2013) term “contingent limitations” of ageing, which
315 are more structural in nature (such as unsuitable housing, inaccessible transport, or ageism)
316 and could be modified or addressed. For example, one participant in Bian *et al.* (2019)
317 stated:

318 “I think this is a natural process. I’m getting older. My children have already grown
319 up and do not need to be taken care of anymore. I’ll stay at home, being blind”.

320 Here, the participant constructs “stay[ing] at home, being blind” as the seemingly inevitable
321 end-stage consequence of AMD, a construction which appears to preclude possibilities of
322 interventions to prevent the speaker from becoming isolated at home. Furthermore, such a
323 construction, which simplifies the links between older age and AMD, risks erasing the
324 potential contribution of health behaviours such as smoking cessation in reducing AMD risk
325 (Lawrenson and Evans 2013). Thus it is possible that an overemphasis on the organismic,
326 biological process of ageing – represented as “a natural course of functional decline”
327 (Kelley-Moore 2010) – can overshadow the social and structural life-course processes that
328 could contribute to AMD risk.

329 Therefore, in participants' constructions of the origins of AMD, there is a seeming
330 tension between AMD constructed as entirely unexpected and unknown, and AMD
331 constructed as a fundamentally 'natural', unsurprising consequence of growing older. To
332 explore this tension in all its complexity would require access to participants' action
333 orientation, understanding how participants may deploy these different constructions at
334 different points in their account in the service of specific discursive functions. In this analysis
335 of de-contextualised extracts, it is not possible to explore how constructions might be
336 differentially mobilised depending on discursive context. However, the tension alerts us to
337 the potential for the co-existence of seemingly contradictory sets of constructions. One
338 possible common thread uniting these sets of constructions are the "dividing practices" of
339 normal versus abnormal (Foucault 1983) bound up within both. In the case of constructions
340 of AMD as unexpected and unknown, participants construct AMD as a fundamentally
341 abnormal event, disrupting their hitherto normal, healthy state; in contrast, constructions of
342 AMD as natural – located within a biomedical discourse of ageing as decline (Phelan 2018) –
343 equate it with being a normal, expected part of chronological ageing. Both constructions
344 thus arguably converge in affording a subjectivity of normalcy, in a world where impairment
345 or illness is often stigmatised and othered.

346 Furthermore, both constructions arguably position the subject with AMD as the
347 unsuspecting, passive recipient of a condition beyond their control, potentially helping avoid
348 feelings of guilt or self-blame. This subjectivity could be understood against the backdrop of
349 moralistic discourses around chronic illnesses with multifactorial (i.e. interacting genetic and
350 environmental) determinants, that often place heavy responsibility on the individual for
351 lifestyle modifications (e.g. Peel 2014, on discourses of the aetiology of dementia).

352 Interestingly, such discourse around individual responsibility for prevention was absent in
353 the included extracts on AMD. Therefore – with the caveat that lifestyle factors (such as
354 smoking exposure and access to a healthy diet) are socioeconomically and structurally
355 determined rather than purely individual choices (Everest et al 2022) - it could be noted that
356 the constructions here overlook the fact that risk of AMD may be determined by more than
357 purely ageing and, implicitly, genetics. (While AMD is largely genetically determined,
358 changes to smoking and diet in particular may reduce AMD risk for those with an elevated
359 genetic risk (Colijn et al 2021).)

360

361 *Constructing AMD as a total loss of independence*

362 <Insert Table 4 about here>

363 A recurrent interpretative repertoire across studies was the idea of ‘losing
364 independence’ due to AMD, with independence constructed as an all-or-nothing, binary
365 phenomenon, linked above all to continuation with functional activities (see Table 4 for
366 quotations – Q11-13). For example, a participant in McCloud *et al.* (2014) stated:

367 “I was independent all my life, I’ve done everything by myself, and now I have to
368 depend on someone... it’s [vision loss] taken away my ability to perform a normal
369 functional life, because I now have to rely on other people to help in many, many
370 ways.”

371 The construction of independence as a binary in included studies was reinforced through
372 the use of extreme case formulations (Pomerantz 1986), intensifying words which take
373 participants' claims to extremes; for example, in the extract above, "I was independent *all*
374 *my life*", "I've done *everything* by myself" [*italics added for emphasis*]. Specifically,
375 independence was largely constructed as inseparable from the notion of "doing things"
376 (Q13), physically acting on the world. In particular, driving was constructed as an essential
377 element of independence, and giving up driving due to AMD was constructed as a loss of
378 freedom and self-reliance (Q14-15), aligning with other studies where older adults construct
379 cessation of driving as a critical turning point towards dependence (Laliberte Rudman *et al.*
380 2006; Sanford *et al.* 2019). Arguably, this reflects a cultural preoccupation in Western,
381 industrialised societies with the car; as Kleege writes, "The inability to drive sets them apart,
382 reinforcing their status as abnormal. Because in America today, and increasingly in the rest
383 of the industrialised world as well, *normal* means not only to see, hear, walk, talk and
384 possess an average IQ and income, but also to drive" (p30). Indeed, while using a car
385 represents its own form of dependence on an object, car use becomes overwhelmingly
386 constructed as a means of independence due to the driver's sense of apparent total control
387 over where and when they travel (Hagman 2003).

388 In more biomedical research on age-related eye disease, 'functional independence'
389 (the notion of performing – mostly physical – daily activities) tends to be valorised as a
390 taken-for-granted positive goal of treatment and rehabilitation. However, more critical
391 perspectives suggest that discourses of positive, successful ageing can obfuscate the very
392 real potential for ill health and disabilities to "make independence an untenable goal"
393 (Trentham 2019). Conceivably, the pedestalisation of independence may create distress or

394 self-blame for people with AMD, if independence becomes internalised as a key marker for
395 success which is challenging to achieve in reality (McGrath *et al.* 2017). Perspectives from
396 disability studies may encourage us to take a more expansive view of independence,
397 whereby independence is “not linked to the physical or intellectual capacity to care for
398 oneself without assistance; independence is created by having assistance when and how
399 one requires it” (Brisenden 1989 cited in Morris 2004). Accordingly, independence is not
400 necessarily about self-sufficiency, in terms of managing on one’s own or doing everything
401 for oneself, but more about being in a position to make one’s own decisions and access
402 appropriate support (Beresford 2012). From this perspective, social or material support can
403 strengthen wellbeing and empowerment, rather than being a marker of dependence
404 (McLaughlin 2020).

405 Such a discourse of *interdependence*, recognising that people with AMD may rely on
406 but also be relied upon by others in a complex web of relational ties, is certainly
407 underrepresented when compared to discourses centred around a binary of dependence
408 versus independence. This is not to deny the lived experience of many people with AMD,
409 who may see maintenance of independence as a crucial prerequisite for living well; but to
410 highlight that alternative ways to configure in(ter)dependence do not find their way into
411 discourse about AMD within these qualitative studies. Indeed, where a dependence on
412 others is discussed, it tended to be presented in at best a neutral sense (for example, “She
413 [*participant’s wife*] now reads to me, she knows that it gets so arduous for me” (Participant:
414 Moore and Miller 2003)) or at worst as a source of great loss or disappointment (Q16-17,
415 e.g.: “All the plans that I had for our family have all gone and it’s now all reliant solely on
416 [*my wife*]... I hide in the background”). Here, agency is constructed as being transferred

417 from the participant to a family member, reminiscent of the ‘all or nothing’ independence-
418 dependence binary discussed earlier. There is little sense of collaboration or shared
419 decision-making, but rather the speaker deferring entirely to their relative, with the
420 participant consequently becoming “hid[den] in the background”.

421 It is noteworthy that strong dichotomies of dependence versus independence are a
422 common feature in research and policy spheres considering ageing more generally. Many
423 dominant models of ‘successful ageing’ are concerned with “independence, avoidance of
424 disability, and individual responsibility” (Martinson and Berridge 2015), while fears of
425 becoming ‘dependent’ may underpin hegemonic ideologies which see ageing and disability
426 as states to be feared (Stone 2003). However, a more critical perspective helpfully directs
427 attention to the complex social, structural, relational and environmental factors which
428 shape possibilities for independence (Priestley and Rabiee 2002). Indeed, it is instructive
429 that in a study exploring how a couple experience living with AMD together (Burton et al
430 2015), the participants co-constructed a more nuanced, dialectical and dynamic view of
431 in/dependence:

432 “[Sally]: And I do try to write things, but when we’ve written things down we
433 can’t see what we’ve wrote! I write the shopping list, but he has to take the
434 magnifying glass, that means when he goes around the supermarket he’s got the
435 supermarket trolley, the shopping trolley, the shopping list and the magnifying
436 glass...

437 [Jack]: And a thing to tick them off (Sally: laughs) I’m like an octopus (laughs).”

438 The participants – both living with AMD - construct a division of labour within the dyad,
439 where each partner uniquely contributes within their collective unit. This construction of a
440 harmonious, humorous interdependence arises in a specific interview context, involving two
441 partners living together with AMD. This contrasts with the other studies, where the
442 constructions generally reinforce a rigid demarcation between the now-‘dependent’ person
443 with AMD, and either their ‘independent’ pre-AMD self, or the rest of their family or social
444 group.

445 Closely bound up with discursive constructions of (in)dependence is the metaphor of
446 ‘burden’, either constructed as an imaginary state to be feared or as one currently
447 experienced (Q18-19). AMD was often constructed as precipitating a shift from being an
448 independent, fully-functioning person to an implicitly dehumanised “burden” position,
449 bound up with feelings of guilt, passivity and worthlessness. In their critical ethnography of
450 older adults living with vision loss in Canada, McGrath and colleagues note the
451 preponderance of participants describing themselves with terms such as “burden” and
452 “nuisance”, out-of-place in a world teeming with seemingly efficient, independent agents
453 (McGrath *et al.* 2016). More broadly, McLaughlin’s exploration of “burden fixation” in the
454 context of families affected by disability demonstrates how this pervasive framing can
455 obscure the full and valued role of disabled people within their families and communities
456 (McLaughlin 2012). Furthermore, the burden metaphor has political and socioeconomic
457 implications, with disability scholars linking the discourse of burden with the privatisation of
458 care in many societies. For if care for people with chronic conditions and disabilities
459 becomes discursively configured as an individual or familial ‘burden’, it may become a
460 private, hidden activity that absolves public services of their responsibilities. Equally, if

461 community or public services do not provide appropriate supports, individuals then become
462 more likely to require more material help and care within the private domain, that may
463 itself reinforce a sense of inconveniencing others (Soldatic and Meekosha 2012).

464

465 *Constructing AMD as grievous loss*

466 <Insert Table 5 about here>

467 Consistently across studies, participants constructed the experience of AMD as one
468 of deep loss and grief, either being experienced in the participant’s present or a fear for
469 their future (see Table 5 for quotations). From a critical perspective in disability studies,
470 many of the extracts can be considered examples of what Oliver refers to as ‘disability as
471 personal tragedy’ (Oliver 1986). For example, participants in a UK-based diary study
472 (Stanford et al 2009) wrote entries such as “I live in a sad world of my own” or “I’m in a state
473 where there is no way out.” These comments vividly construct a sense of despair, loneliness,
474 and claustrophobia. An associated interpretative repertoire is ‘AMD as a prison’ (Table 5 –
475 Q20-22), with participants constructing themselves as “imprisoned” or “cut off”; such
476 metaphors of entrapment, of a world closing in around the participant, have a concrete,
477 physical quality.

478 One feature common to these accounts is a sense of dread, drawing on the
479 interpretative repertoire of life with AMD as a site of ‘no future’ (Q23-24), a common
480 representation in many dominant culturally entrenched representations of disability (Kafer
481 2013; Rice et al 2017). Indeed, with AMD being a progressive disease, the construction of

482 decline over time was a common discursive feature across accounts, for example with one
483 participant in Moore and Miller (2003) stating: “And do what you want to do now because
484 it’s not going to get better, it’s going to get worse.” This constructs a sense of ‘living on
485 borrowed time’ and a diminished future awaits where the participants’ opportunities will
486 become restricted.

487 Underpinning these constructions is a sense of what Alison Kafer (2013) identifies as:
488 “the “before disability” self and the “after disability” self (as if the distinction were
489 always so clear, always so binary). Compulsory nostalgia is at work here, with a cultural
490 expectation that the relation between these two selves is always one of loss, and of loss
491 that moves in only one direction” (Kafer 2013: 42).

492 In line with Kafer’s notion of “compulsory nostalgia”, and the idea of the “before disability”
493 and “after disability” self, there were several examples of participants constructing
494 themselves as a fundamentally different person to who they were before the onset of AMD,
495 an interpretative repertoire we termed the ‘before AMD and after AMD self’. For example, a
496 participant in Mogk (2008) stated starkly: “This isn’t me—I mean, I’m a very visual person.”
497 As an element of this interpretative repertoire, participants frequently constructed a
498 dichotomy between pre-AMD success and post-AMD failure with reference to functional
499 activities. These constructions were frequently deployed in participants’ talk about their
500 inability to perform daily functional activities, concentrated around frequent use and
501 emphatic repetition of the term “can’t” (Q28-30, e.g. “I can’t read the paper. I can’t
502 [socialize]. What can I do out there?”). In the latter quote, the participant positions
503 themselves as isolated from the activity-rich world outside, and excluded from functional

504 activities. It is noteworthy that difficulties with functional daily activities are a predominant
505 theme in the qualitative literature on everyday life with AMD. From a social constructionist
506 perspective, a focus on ‘activities of daily living’ can be considered a discourse that codifies
507 ‘normal’ and ‘abnormal’ functioning within a body. This risks “reducing a life to functional
508 limitation in instrumental or daily care acts” (Richardson and Abrams 2020: 43), and
509 reproducing restrictive normative limits for what it means to function and age well with
510 AMD. Such discourse creates parameters for a “normal functional life” (Q12), which if
511 unattainable, may result in a subjective experience of failure.

512 Another common discursive construction within this theme is the repertoire of vision
513 loss due to AMD as a ‘fate worse than death’ (Q31-33), with one participant in Wong *et al.*
514 (2014) stating: “Suicide is far better than going through this”. Such constructions of AMD as
515 a fate worse than death are drawn upon by participants to emphasise how they could not
516 accept or imagine a future without sight. This trope of ‘better off dead than disabled’ is
517 widespread, as disability scholars have noted (e.g. Shakespeare 2013), reflecting the
518 negative valuation of impairment in many contemporary societies, and rooted in a discourse
519 of disability as personal tragedy (Oliver 1986). *As Kleege states, regarding the portrayal of*
520 *vision loss in the 1992 film *Scent of a Woman*, “darkness might as well be death; life without*
521 *sight is hardly living” (Kleege 1999: 47).* Profound fear of blindness, often constructed as the
522 ultimate negative destination of AMD, permeates this discourse that frames life with vision
523 loss as unliveable and unacceptable (e.g. “I just hope I don’t live too long if I go completely
524 blind” (Participant: McCloud *et al.* 2014)). Notable here is the construction of “blindness” as
525 an imagined, anticipated state rather than an experienced reality. This aligns with the
526 argument that hypothetical imaginaries of visual impairment as catastrophe can drown out

527 the perspectives of individuals actually living with visual impairment (Schillmeier 2006).
528 Furthermore, on a practical level, such discourses that position blindness as the catastrophic
529 endpoint of AMD underline potential for eye care professionals to raise awareness that
530 AMD rarely leads to total loss of vision (Crossland *et al.* 2007).

531

532 *Constructing AMD as a condition to be stoically accepted*

533 <Insert Table 6 about here>

534 In contrast to the constructions of AMD as a catastrophe or source of loss and grief
535 discussed above, the extracts also included examples of participants taking up a more stoical
536 subject position and an attitude of perseverance (see Table 6 for quotations). Often this
537 stoic position was made available by drawing on constructions of carrying on as before and
538 accepting AMD (Table 6 – Q34-40 e.g. “I’ll accept it, what happens will happen” (Participant:
539 Moore and Miller 2003)). Alternatively, participants drew on constructions of acceptance
540 that were more gradual and phased in their nature, involving initial shock and depicting
541 acceptance as an eventual restoration of equilibrium (e.g. Q36). Some participants adopted
542 a stronger position of stoicism (e.g. Q39 – “It doesn’t affect me at all”). However,
543 participants’ stoical constructions presented unconcern about AMD as an effortful, wilful
544 process (e.g. Q40 – “I don’t let it bother me. I’m not going to”), an outlook to be cultivated
545 rather than emerging naturally.

546 A common discursive strategy was the use of comparisons with imagined or real
547 others in more difficult situations, a repertoire termed ‘there’s always someone worse off’

548 (Q41-43), which has been noted in several studies of age-related vision loss (e.g. McGrath
549 and Corrado 2019). Such downward comparisons can set up a kind of “hierarchy of
550 impairment” (Deal 2003), a continuum of more or less desirable health states, that may
551 communicate a sense of gratitude and acceptance even as this creates a distance from
552 those positioned as ‘worse off’. An additional discursive strategy that emerged across
553 extracts to set up positions of persevering in spite of AMD was the construction of AMD as a
554 ‘critical juncture’ (Q44-46), a fork-in-the-road presenting a choice between becoming stuck
555 in self-pity versus adopting a resolute, forward-looking attitude (e.g. “You either get up and
556 go or you sit in your chair and die, and I think I’d rather get up and go” (Participant: Lane *et*
557 *al.* 2019)). These constructions set up the subject position of the agentic individual,
558 summoning their willpower, control and determination to choose to “get up and go”.

559 Indeed, in common with discourse in other chronic conditions, metaphors of
560 ‘fighting’ AMD were drawn upon, which configure the body as a battleground and put the
561 onus on individuals with a chronic condition not to give up the fight (Willig 2011). It is
562 notable that AMD was constructed as a kind of ‘encroaching enemy’ by one participant (e.g.
563 “I think of it as a living creature” (Mogk 2008)), which the individual has to fight to keep at
564 bay (Q47-48). This discourse of fighting AMD is employed to convey a desired resilience to
565 the effects of AMD: a sense that even if vision loss attributable to AMD becomes more
566 advanced, the participants will not allow the condition to erode their quality of life. As has
567 been highlighted elsewhere, such discourse affords positions that are typified by their
568 “relentless and unforgiving individualism” (Willig 2011: 902), in terms of the individual’s
569 responsibility to ‘stay strong’.

570 However, a participant’s extract from Moore *et al.* (2000) provided a counterpoint to
571 this individualistic position, discussing the value of an access bus for people with disabilities
572 and of audiobooks: “I’d fight to the death anybody that decides to take those books away
573 from me, or that bus”. Here the participant positions themselves in a fight to retain vital
574 resources such as accessible audiobooks or transport for themselves, but which could also
575 be congruent with the Social Model of Disability. In this way, we see an alternative
576 construction of a ‘fight’ to expand or protect rights and resources, an endeavour whose
577 effects could have implications beyond the individual.

578

579 *Constructing AMD as an opportunity for discovery*

580 <Insert Table 7 about here>

581 In a small number of extracts, participants went beyond a stoical acceptance of AMD
582 to draw on constructions of new discoveries and growth since diagnosis (Q49-50). In these
583 extracts, the participants construct their journey with AMD as a ‘quest’ with a focus on
584 “what can be reclaimed of life” (thus resonating with what Frank (1998: 204) refers to as the
585 “quest narrative”), for example in terms of meaningful changes to their way-of-being (Q49 –
586 “I’m a more balanced person”), or a sense of curiosity and playfulness, for example treating
587 a buffet as a “treasure hunt” (Q50).

588 Several participants when describing how they had adapted to AMD drew on
589 constructions of compensating by using other faculties and skills, setting up the subject
590 position of the person with AMD as an innovator who ‘lives and learns’ (Q51-52). These

591 constructions, of innovation, effort and learning, challenge the idea of “compensatory
592 powers” (Jernigan 1974; Makepeace 2021), a common trope in narratives of vision loss,
593 suggesting that visually impaired people have extraordinary abilities that ‘compensate’ for
594 low vision.³ Indeed, this trope discounts the time, practice and effort that people with visual
595 impairment may expend in order to adapt to vision loss, illustrated in one included extract
596 with its emphasis on “trial and error” (Q52).

597

598 **Discussion**

599 In sum, the dominant discourses around AMD, as drawn upon by participants quoted
600 in peer-reviewed qualitative studies, appear largely – though not exclusively – to be shaped
601 by biomedical logics that construct AMD as a tragedy and a threat to independence. **The**
602 **constructions of AMD identified are also inherently tied to biomedical discourses of ageing**
603 **which configure ageing as bodily decline and, echoing McGrath *et al*'s (2016) analysis of**
604 **positive ageing discourses drawn upon by people with age-related vision loss, frame the**
605 **functional and psychological response to AMD largely as a question of individual**
606 **responsibility. By contrast, constructions of the aetiology of AMD in the included studies**
607 **(Theme 1) tended to position the participant with AMD as an unsuspecting, passive**
608 **recipient of a condition constructed overwhelmingly as a consequence of physiological**
609 **ageing, potentially helping avoid subjective experiences of guilt and self-blame. The**
610 **emphasis on age as the fundamental cause runs counter to healthist discourses of individual**
611 **responsibility for managing disease risk that dominate in many other chronic conditions**

³ Georgina Kleege reflects on “the familiar myth of compensation” in *Sight Unseen*, as an “attempt to console the sighted with the promise that lost sight will be repaid in some way or another” (p220).

612 (Gibson et al 2015; Peel 2014). This suggests there may be value in a public health approach
613 to addressing some of the modifiable factors partially contributing to risk of AMD,
614 particularly smoking and diet; while accepting that ‘risk factors’ are socioeconomically and
615 environmentally patterned, and avoiding a potentially moralising discourse of individual risk
616 management.

617 Approaching the analysis with the Social Model of Disability in mind, extracts where
618 participants saw the challenges of living with AMD and visual impairment as a social,
619 collective, political or economic issue were notable in their scarcity. AMD was generally
620 constructed as an individualised experience of shock, a loss of function and independence,
621 and a source of deep distress (even as a “fate worse than death” – Theme 3), that
622 participants can only overcome through individual effort. Such constructions of AMD as
623 personal tragedy arguably function to legitimate the subjective experience of suffering
624 caused by vision loss, in a society set up for sighted people where individuals are “subjected
625 to a daily diet of the personal tragedy model of visual impairment” (French and Swain 2004:
626 35).

627 It is important to note that the majority of the included studies were conducted in
628 English, in high-income country contexts. However, two studies were conducted in China
629 (Bian *et al.* 2018 and 2019). These studies both explicitly attest to the importance of family
630 support, as well as concern about how AMD may impact not just the individual but the
631 wider family; not only emotionally, but also financially in a context where patients paid for
632 injection treatments for wet AMD, prior to 2019 when medical insurance was extended to
633 cover treatment for wet AMD in China (Lu *et al.* 2021). In this context, constructions of loss
634 of independence and the person with AMD as a burden – aligning with constructions found

635 in studies conducted in countries such as the UK where AMD injections are free at the point-
636 of-use or covered by medical insurance – may be informed not only by societal discourses
637 but also by more material, economic concerns. Additionally, outside English-speaking
638 country contexts, one included study was conducted in Sweden, but only included limited
639 published extracts; the quotations published verbatim were most relevant to Theme 5,
640 within the repertoire of “You live and learn”, but the paper also focused prominently on
641 problems and limitations linked to AMD. Therefore, on the basis of relatively limited data, it
642 is challenging to argue that any of these three studies conducted in non-English-speaking
643 contexts represents a radical departure from the constructions identified across the
644 included studies overall.

645 Our findings largely align with McGrath et al.’s (2017) call to incorporate critical
646 disability perspectives into research on age-related vision loss, in order to question or
647 nuance ideological notions of independence and normalcy. Indeed, it is striking in our
648 analysis how frequently, and similarly across countries, that the experience of AMD is
649 constructed as a total loss of independence (Theme 2), framed within an ‘all or nothing’
650 polarity. The analysis also identified a similar, though perhaps less strikingly uniform
651 polarity, in the construction of AMD across studies as a ‘critical juncture’ or ‘fork-in-the-
652 road’ (Theme 4), presenting a stark binary choice between exercising willpower to keep
653 living well or withdrawing into oblivion. Such a binary reproduces moralistic discourses
654 common in Western, industrialised societies that emphasise individual will and self-reliance
655 in achieving health and success (Kittay 2015); and concurrently downplays the ways in
656 which, for example, features of the physical, social, economic or political environment
657 around the person may influence how they respond to and live with AMD and vision loss. To

658 draw on Baars and Phillipson's (2013) typology of "existential" and "contingent" limitations
659 linked to ageing, the discourses and repertoires mobilised by participants generally tended
660 to configure AMD solely as a source of inherent, "existential" problems within the
661 individual, rather than of problems borne of societal, structural or environmental barriers
662 which are arguably "contingent" or modifiable. **Indeed, the polarities and extremities often**
663 **evidenced in the included extracts, such as the construction of losing all independence or**
664 **vision loss as a fate worse than death, arguably close down the potential for life with AMD**
665 **to be (for at least some individuals) "mundane, a mere matter of seeking practical solutions**
666 **to everyday inconveniences" (Kleege 1999: 228).**

667 The concept of "ideological dilemmas" (Billig *et al.* 1988) can help to make sense of
668 the disparity between critical thought about disability and ageing (which suggests that many
669 dominant, naturalised discourses are in fact socially and historically "contingent"), and
670 participants' talk, which constructs many of the effects of AMD as "existential" and
671 unavoidable.⁴ Critical thought from gerontology and disability studies could be considered
672 'intellectual ideology' (defined as "a system of political, religious or philosophical thinking"
673 (Billig *et al.* 1988: 27)), theoretical positions that valuably seek to reconfigure society's
674 understanding of ageing and impairment. In contrast, participants' discourse is generally
675 situated in the 'lived ideology' – "what passes for common sense within a society" (Billig *et*
676 *al.* 1988: 27) – of illness, impairment and ageing that is rooted within biomedical

⁴ The ideological dilemmas concept acknowledges that our common-sense thinking in everyday life is inherently 'dilemmatic', often drawing on contrasting, even contradictory discourses and repertoires. A good example is in the cultural currency of seemingly incompatible maxims and proverbs – the proverb 'many hands make light work' exists in tandem with, and yet contradicts, the proverb 'too many cooks spoil the broth'. Neither maxim predominates common-sense thinking, nor is one inherently more valid than the other; and the same individual may draw on each proverb but in different social and rhetorical contexts for different ends.

677 understandings of these phenomena, which shape mainstream, ‘common-sense’ ideas
678 around vision loss. From the ideological dilemmas perspective, there is a dialectic between
679 the ‘intellectual ideology’ and the ‘lived ideology’. How these ideologies are deployed in
680 discourse will change depending on social and argumentative context, rather than existing
681 at polar opposite ends of a binary. From this viewpoint, research on AMD tends to be a
682 context for focussing on understanding and addressing ‘problems’, especially as much of the
683 research is conducted within the clinical worlds of ophthalmology and optometry. (There
684 were a small number of exceptions to this more biomedical framing, where an expressly
685 critical or sociocultural approach was adopted e.g. McGrath et al 2016; Mogk 2008.) Indeed,
686 a recent scoping review considering the ‘loss focus’ in AMD research concluded that
687 “negative expectations and attitudes reflected in research questions and the outcomes
688 reported may contribute to negative outcomes” (Tanner et al 2020). Such a ‘loss focus’ may
689 explain why more dilemmatic, everyday aspects of living with AMD are less salient in the
690 included extracts. Arguably, qualitative research in AMD may call for less dualist and more
691 “both/and” thinking (Spinelli 2014: 14), which recognises that individuals in their everyday
692 life may move between, and find meaning in, both a more ‘intellectual ideology’ of
693 interdependence and a ‘lived ideology’ of independence, for instance. In line with McGrath
694 et al (2017), our findings also suggest the value of an approach drawing on critical disability
695 studies and critical gerontology, which can shift the emphasis towards a focus on how
696 societies and environments produce disability for people living with AMD.

697

698 *Limitations*

699 Our secondary analysis sought to attend to the discursive features of participant
700 accounts of AMD within previously published qualitative studies. A particular limitation
701 inherent in this approach was the decontextualisation of the included extracts, removed
702 from their accompanying context, commentary or qualifiers. **This lack of context can be a**
703 **problem arising in secondary analyses of qualitative data generally (Wästerfors *et al* 2014),**
704 **but particularly when using discourse analysis.** Using our approach, there was no way to
705 explore the different positions adopted by the same participant, and consider the
706 consistency or variability in how they draw upon discursive resources and repertoires within
707 interactional context. In our analysis of decontextualised extracts, we could not trace how
708 the same participant takes up different positions within the interview conversation, and
709 how they may have been positioned in specific ways in interactions immediately before the
710 talk that is quoted in the extract. **Furthermore, in the case of studies conducted in non-**
711 **English-speaking countries (Bian *et al* 2018 and 2019; Dahlin-Ivanoff *et al* 1996), it may be**
712 **assumed that the interviews and focus groups were conducted in Chinese and Swedish**
713 **respectively. This creates a potential issue in terms of equivalence of meaning between the**
714 **original and translated text, especially considering the notion of the translator's subjectivity**
715 **(Munday, 2014) which introduces an additional level of interpretation, and thus additional**
716 **distance between the participants' original words and our analysis.**

717 This secondary analysis focuses on decontextualized, published text rather than raw
718 data from individuals' accounts; however, this does not preclude ethical issues arising from
719 the analysis (Thorne 1998), a second key area of limitations. A potential ethical issue with
720 this analysis is that participants never provided consent for their talk to be analysed in this
721 way **from this particular epistemological standpoint; the included research studies generally**

722 **assume a realist epistemology, rather than the social constructionist epistemology**
723 **underpinning discourse analysis.** While we do not anticipate risks to participant
724 confidentiality, there is arguably an ethical issue of sensitivity and fidelity to participants'
725 perspectives. Drawing on the hermeneutics of faith and suspicion, as theorised by Ricoeur,
726 we can consider that the vast majority of the (largely) realist research articles included
727 operate using a hermeneutic of faith. Namely, many of the articles included in this study
728 implicitly or explicitly adopt an empathic attitude towards participants of "care or concern...
729 That concern, as we know, presents itself as a "neutral" wish to describe and not to reduce"
730 (Ricoeur 1970: 28). Discourse analysis does not imply a lack of "care or concern" or empathy
731 for participants; however it does to some extent involve using a hermeneutic of suspicion, a
732 "tearing off of masks" (Ricoeur 1970: 30). This hermeneutic of suspicion entails a kind of
733 questioning or deconstruction that looks beyond the face value of talk, described as an
734 interest in "the sense beneath the sense" (Tomkins and Eatough 2018: 194). Subsequently,
735 as attempted in our analysis, it is possible to reengage with a hermeneutic of faith when
736 tentatively considering the implications of discourse for subjective experience. In the
737 present analysis, practising a hermeneutic of suspicion often involved working with theory
738 from critical fields such as disability studies and gerontology. Much of this could be
739 considered opaque and abstracted from participants' experience, an "intellectual ideology"
740 seemingly divorced from (and potentially even seen as invalidating of) their "lived
741 ideology".⁵ Participants in the original studies could, for example, validly critique our
742 critique of biomedical discourse, given that advances in positivist, biomedical science hold

⁵ In their discussion of discourse analysis in mental health research, Challenor *et al* (2021: 130) similarly note that "participants themselves may not recognise the claims that are being made on their behalf", meaning that researchers must "remain acutely reflexive and alive to the potential for the abuse of power that lies with their own role".

743 out hopes of slowing their vision loss. Indeed, for reasons that may lie in participants'
744 identities, politics, life histories or self-concepts, many people with AMD may not identify
745 with the more social dimension of disability discussed in this analysis (Grue 2017; Kafer
746 2013: 14; McGrath *et al.* 2017; Mogk 2008). Therefore, there is a fundamental tension that
747 this secondary analysis proposes interpretations which could be problematic to the original
748 research participants. This underscores a need for awareness that we as analysts are shaped
749 and bounded by our own interests (for example here, critical gerontology and disability
750 studies perspectives); and that a multiplicity of other valid complementary or divergent
751 interpretations could be made on the basis of the same texts.

752

753 *Conclusion*

754 To conclude, we suggest that the constructions identified (through our analytic lens
755 informed by critical gerontology and disability studies) are underpinned by broader
756 discourses which construct ageing and disability in largely negative, medicalised and
757 individualistic terms. While only tentative claims may be made regarding the implications of
758 such discourses for subjective experience (especially when analysing decontextualised
759 extracts), taking up subject positions within such discourses could potentially compound
760 feelings of isolation, hopelessness and powerlessness, and close down alternative avenues
761 of experience. For example, talk of losing all independence in extreme terms across studies
762 underscores the absence of an alternative valid (but arguably less culturally available)
763 discourse of interdependence, which if more available could potentially reduce feelings of
764 guilt, failure or being a 'burden' when someone with AMD might require support with

765 **certain activities.** From a policy and practice view, our analysis suggests a value in framings
766 of AMD which may allow space for feelings of grief and loss but avoid alarmist or totalising
767 narratives of tragedy or an end to independence (since from our FDA-informed perspective,
768 such discursive constructions may end up shaping the expectations and assumptions of
769 what people believe to be possible). For example, moving away from an all-or-nothing
770 construction of AMD as the end of independence frees up space within research and policy
771 to focus on supporting the broader inclusion and welfare of people with AMD even if their
772 independence, in the narrow physical/functional sense, has been affected by vision loss.
773 This therefore entails a shift in focus, away from focusing only on a person's impairment as
774 the root of their challenges; towards a more holistic consideration of how the social,
775 structural and environmental context around the person can shape their wellbeing with
776 vision loss.

777 Relatedly, the analysis points to tensions between dominant discourses drawn upon
778 by people with AMD in published studies, and the more counter-hegemonic frames offered
779 by theory in disability studies and critical gerontology. This more meta-level finding suggests
780 there could be a value in adopting a pluralist, multi-perspectival approach to research on
781 experiences of living with AMD, which attends to both the embodied, corporeal,
782 phenomenological realities of AMD, and the discourses, norms and practices that shape the
783 social and environmental context in which AMD is experienced. For example, in line with
784 Thomas' 'social relational' theory of disability (Thomas 1999), this could involve attending to
785 both *impairment effects* – the embodied, sensory experience of living with AMD and vision
786 loss – and *disablism* – avoidable oppression caused by institutions, physical and social
787 structures, and discriminatory attitudes. As McGrath *et al.* (2017) suggest, research on age-

788 related vision loss could benefit from a “a greater focus on the influence of the sociopolitical
789 environment in the creation and sustainment of disability” (McGrath *et al.* 2017: 1996).
790 Such research could explore the dialectic between social structure and embodied
791 experience, for example considering how (dis)ableist and ageist discourses, institutions and
792 systems shape the wellbeing of people with AMD, and how barriers and disablism could
793 start to be dismantled. A more contextual research agenda could also attend to how factors
794 such as gender, race, and socioeconomic status intersect with disability and ageing to
795 differentially shape the experiences of people with AMD. The analysis also points towards
796 the need for more research on quality-of-life that moves beyond what Tanner and
797 colleagues term the ‘loss focus’ in AMD research; adopting a broader approach that is
798 sufficiently open to acknowledge the losses that often do occur with AMD, without
799 assuming the experience of AMD is solely one of loss. A less ‘loss focused’ research agenda
800 could create more space for a multitude of alternative perspectives, perhaps moving
801 beyond the individual to consider how the people, institutions and societies surrounding the
802 person with AMD may affect the experience of living with vision loss. This broader
803 understanding may help consider how physical and/or social inclusion can be enhanced for
804 people with AMD, and quality of life and wellbeing potentially improved outside the clinical
805 realm within everyday contexts.

806

807

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809 **Note: Bolded references were source articles for the data extracts (N=25).**

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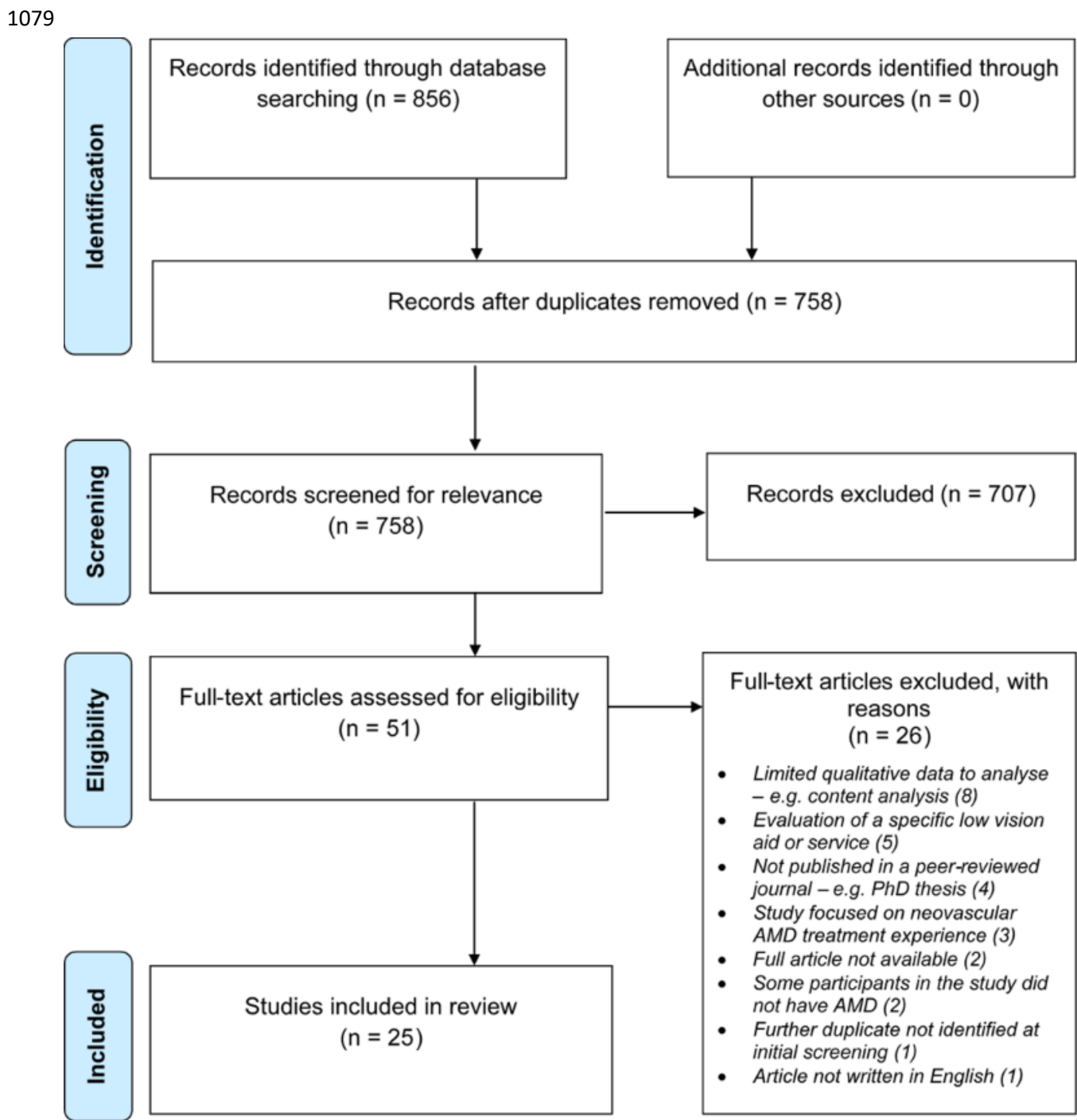
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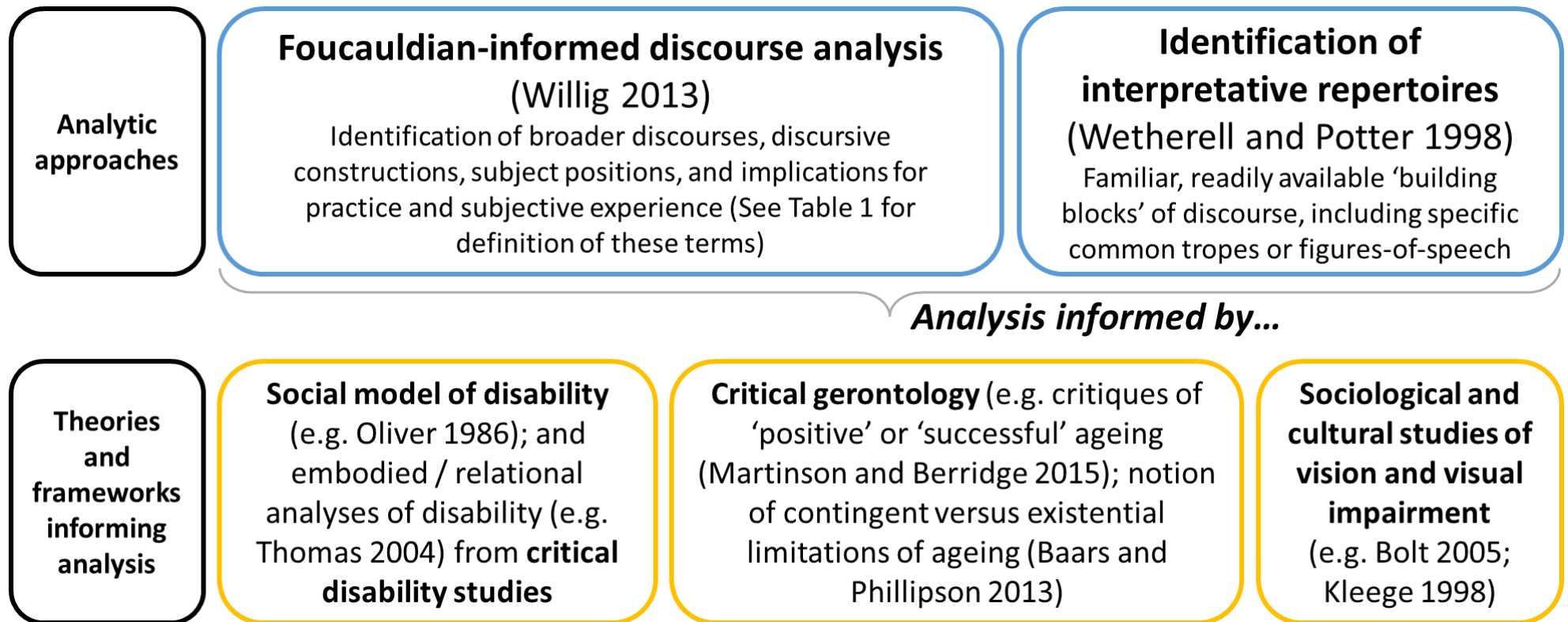
1078 Figure 1. Diagram showing study selection process



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1081

1 *Figure 2. Summary of analytic approaches used, and theories/frameworks informing the analysis and interpretation of results*



2

- 1 **Table 1.** Summary of Willig’s six-stage approach to FDA (Willig 2013) with examples relating
 2 to AMD for each stage

Stage of FDA	Description	Example relating to AMD
1. Discursive constructions	Identifying ways in which the discursive object (i.e. AMD) is constructed, especially in terms of causes and effects.	AMD constructed as mysterious, unknowable condition.
2. Discourses	Examining extracts to identify the broader discourses used to construct the discursive object (i.e AMD). At this stage, recurrent metaphors, vivid imagery, or tropes or figures of speech were noted as indications of interpretative repertoires.	Constructing AMD as a by-product of the ageing process draws on a discourse of ageing as decline. Interpretative repertoire: ‘It’s just age’.
3. Action orientation	Considering the function of discursive constructions within a particular context or point in the account.	N/A – our analysis of decontextualised extracts did not allow us to consider this.
4. Positionings	Identifying the subject positions made available within discourses or discursive constructions.	The position of the person with AMD as an ‘older adult’ becomes available within constructions of AMD as a by-product of biological ageing.
5. Practice	Considering how discourses legitimate or limit what can be said or done.	The discourse of AMD as a natural, inevitable part of ageing may foreclose understandings of how behaviours such as dietary changes and stopping smoking can reduce risk of AMD (Meyers <i>et al.</i> 2015).
6. Subjectivity	Considering ‘ways-of-being’ and possibilities of subjective experience afforded by the different subject positions, constructions and interpretative repertoires identified.	Constructing AMD as a by-product of ageing may allow the person with AMD to make sense of the condition as a ‘normal’ part of biological ageing, to consider AMD as coherent with their stage in life, and thus eschew self-blame or a potentially pathologised or stigmatised identity.

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1 **Table 2. Summary of included studies (N=25)**

Authors and year	Study population	Country	Journal	Aims/objectives (as reported by authors)	Analytic method (as reported by authors)
Bian <i>et al.</i> (2018)	21 individuals with AMD	China	<i>BMJ Open</i>	"To explore which areas of health-related quality of life were affected in Chinese patients, and to identify whether the areas are well covered by validated questionnaires."	Colaizzi's seven-stage framework
Bian <i>et al.</i> (2019)	21 individuals with wet AMD	China	<i>BMJ Open</i>	"To investigate the experience of patients with wet age-related macular degeneration (wAMD) in the treatment decision-making process."	Thematic analysis
Burton, Shaw and Gibson (2013)	13 individuals with AMD	United Kingdom	<i>BMJ Open</i>	"To examine patients' experiences of information and support provision for age-related macular degeneration (AMD) in the UK."	Thematic analysis
Burton, Shaw and Gibson (2015)	A married couple both living with AMD	United Kingdom	<i>Journal of Health Psychology</i>	To "present an idiographic analysis of a couple's experience of living and coming to terms with age-related macular degeneration."	Interpretative phenomenological analysis
Carlton, Barnes and Haywood (2019)	9 individuals with geographic atrophy secondary to AMD	UK	<i>British and Irish Orthoptic Journal</i>	"To develop a further understanding specifically of the impact of geographic atrophy (GA) on the quality of life for both patients and their families and to explore the resources GA patients most frequently access."	Thematic analysis
Cimarolli <i>et al.</i> (2012)	364 individuals with significant visual impairment due to AMD	United States	<i>Clinical Rehabilitation</i>	"To provide an in-depth assessment of challenges faced by older adults with recent vision loss and to determine changes in the nature of these challenges over time for the purpose of informing the design of vision rehabilitation services."	Content analysis
Crossland <i>et al.</i> (2007)	15 individuals with significant visual impairment due to AMD	United Kingdom	<i>Visual Impairment Research</i>	"To determine what reasons people with AMD give for their vision loss."	Generic method of inductive qualitative analysis
Dahlin-Ivanoff <i>et al.</i> (1996)	25 individuals with AMD	Sweden	<i>Disability and Rehabilitation</i>	To "learn how persons with the diagnosis of age-related macular degeneration perceived and described their disease, and how	Generic method of inductive qualitative analysis

				the disease had changed their activities of daily living (ADL)."	
Feely, Vetere and Myers (2007)	7 individuals with AMD	UK	<i>Journal of Visual Impairment & Blindness</i>	"To conduct a tentative subjective assessment of eccentric viewing by persons with AMD."	Interpretative phenomenological analysis
Kleinschmidt (1999)	12 individuals with visual impairment due to AMD	United States	<i>Journal of Visual Impairment & Blindness</i>	"To explore successful adjustment to vision loss from the perspectives of those who have accomplished it."	"Long interview"/ "Life history model"
Lane <i>et al.</i> (2019)	21 individuals with early to late-stage AMD	Australia	<i>PLoS One</i>	"To capture the range of experiences reported by AMD patients concerning the type and impact of their face recognition difficulties in everyday life."	Thematic analysis
McCloud <i>et al.</i> (2014)	34 individuals with AMD	Australia	<i>Optometry and Vision Science</i>	"To understand people's experience with age-related macular degeneration (AMD) in light of new treatment successes."	"Editing analysis style"
McGrath <i>et al.</i> (2016)	10 individuals with visual impairment, all with AMD (and some with other ophthalmic conditions)	Canada	<i>Journal of Aging Studies</i>	"To understand those attributes that older adults with age-related vision loss perceive as being the markers of a 'good old age.' The authors critically examined how these markers, and their disabling effects, are situated in ageist and disablist social assumptions regarding what it means to 'age well'."	Critical ethnography
Mogk (2008)	12 individuals with visual impairment due to AMD	United States	<i>Journal of Visual Impairment & Blindness</i>	"To suggest areas for future qualitative research that move beyond psychosocial studies of older adults with AMD that focus on discrete answers to directed questions about individual coping strategies and elicit frameworks that may not account for the range of sociocultural dynamics at play in the complexity of older adults' responses to vision loss in later life."	Narrative analysis
Moore, Constantino and Allen (2000)	8 women with visual impairment due to AMD	United States	<i>Western Journal of Nursing Research</i>	"To uncover the meaning of severe visual impairment to older women diagnosed with macular degeneration."	Descriptive phenomenology (Giorgi)
Moore and Miller (2003)	8 men with visual impairment due to AMD	United States	<i>Journal of Advanced Nursing</i>	"To gain an understanding of the experience of severe visual impairment from the perspective	Descriptive phenomenology (Giorgi)

				of older men with macular degeneration.”	
Moore and Miller (2005)	16 individuals with AMD	United States	<i>Applied Nursing Research</i>	“To present findings from a secondary analysis that explored the driving strategies used by older adults diagnosed with macular degeneration.”	Descriptive phenomenology (Giorgi)
Porter (2008)	1 woman with AMD	United States	<i>Home Health Care Services Quarterly</i>	“This case study of an older woman with macular degeneration describes her experience of dispensing daily medications over a 3-year period.”	Case study, analysed with descriptive phenomenology
Sivaprasad <i>et al.</i> (2019)	16 individuals with geographic atrophy secondary to AMD	UK	<i>Ophthalmology and Therapy</i>	“To improve our understanding of the lived experience of the disease [Geographic Atrophy (GA)], improve our knowledge of its functional impacts, and address a gap in patient-focused research in GA.	Ethnography (using quantitative measures)
Smith (2008)	1 woman with AMD	United States	<i>Journal of Visual Impairment & Blindness</i>	“To elucidate how a woman with AMD adapted to the challenges that she faced in performing everyday.”	Case study
Stanford <i>et al.</i> (2009)	37 individuals with AMD	UK	<i>British Journal of Visual Impairment</i>	“To describe the psychosocial adjustment to visual impairment of a large sample of patients with AMD over 12 months.”	Grounded theory
Stevens-Ratchford and Krause (2004)	2 individuals with visual impairment due to AMD	United States	<i>Journal of Visual Impairment & Blindness</i>	“]To explore] the effect of person-environment congruence on participation in home-based leisure activities by two legally blind older adults who lived independently in the community.”	Generic method of inductive qualitative analysis
Taylor <i>et al.</i> (2020)	27 individuals with dry AMD	UK	<i>Eye (Nature)</i>	“To investigate the impact of non-neovascular (dry) age-related macular degeneration (AMD) on the person with respect to diagnosis, vision loss and coping strategies.”	Framework analysis
Thetford <i>et al.</i> (2015)	3 individuals with wet AMD	United Kingdom	<i>Journal of Aging Studies</i>	“[To explore] the concept of resilience in the context of vision impairment using two linked sets of narrative interview data from 2007 to 2010.”	Framework analysis
Wong <i>et al.</i> (2004)	15 individuals with AMD	Australia	<i>Journal of Visual Impairment & Blindness</i>	“To conduct in-depth individual interviews to explore a range of issues and perspectives, making sense of individual experiences,	Grounded theory

				and to understand the specific needs in people with ARMD.”	
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1 **Table 3.** Quotations for first construction – “AMD as a mysterious affliction, linked to
 2 biological ageing”

Key discursive resources (e.g. Interpretative repertoires, metaphors, subject positions)	Examples from included studies
“I never would have expected this” – construction of AMD as unexpected	1. “I never, never dreamed that . . . I was going to have this. I never dreamed that” (Participant: Mogk 2008). 2. “To have my eyes just deteriorate like this was something I never expected” (Participant: Cimarolli <i>et al.</i> 2012) 3. “I thought, ‘I didn’t think anything was wrong with my eyes’...I’ve always had pretty good eyesight. So I suppose that it was a bit of a shock really.” (Participant: Burton <i>et al.</i> 2013)
AMD as the “unknown” eye condition	4. “I’d remembered years ago [name of friend omitted] saying she had a problem with her eyes, we had children at school together. I said oh is it glaucoma, she said no you won’t have heard of it. Then through this I said oh I’ve got that, it’s AMD” (Participant: Taylor <i>et al.</i> 2020). 5. “It sounds so common but yet nobody knows a lot about it” (Participant: Carlton <i>et al.</i> 2019). 6. “I didn’t realize that it was so common. Until you go up there and when you see the amount of people about. You know, I’d never heard of it in actual fact. But when you see the number of people at [hospital] especially, it’s always packed out.” (Participant: Burton <i>et al.</i> 2013)
“It’s just age” – AMD constructed as by-product of ageing	7. “I thought it was just age. Because I’ve always been a voracious reader and I thought, ‘Oh it’s age’” (Participant: Carlton <i>et al.</i> 2019) 8. “When I had this macular degeneration, I’d never heard of it. I suppose it’s what they used to call old age years ago” (Participant: Burton <i>et al.</i> 2015) 9. “. . . doesn’t matter if you go to dentist, doctor, optician—it’s your age” (Participant: Crossland <i>et al.</i> 2007) 10. “I think this is a natural process. I’m getting older. My children have already grown up and do not need to be taken care of anymore. I’ll stay at home, being blind” (Participant: Bian <i>et al.</i> 2019).

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1 **Table 4.** Quotations for second construction – “AMD as *a total loss of independence*”

Key discursive resources (e.g. Interpretative repertoires, metaphors, subject positions)	Examples from included studies
“Losing independence” due to AMD, independence most often constructed as functional, physical activities such as driving	<p>11. “To begin with, you lose all independence. I was a very independent person. I worked all my life, I was, ah, self-supporting. I made all my own decisions. I went where I wanted to go, when I wanted to go. Now, if I want to go to the drug store, I have to ask someone to take me... You have no more independence. Because there is always something that somebody must do for you.” (Participant: Moore <i>et al.</i> 2000)</p> <p>12. “I was independent all my life, I’ve done everything by myself, and now I have to depend on someone... it’s [vision loss] taken away my ability to perform a normal functional life, because I now have to rely on other people to help in many, many ways.” (Participant: McCloud <i>et al.</i> 2014)</p> <p>13. “I don’t want to feel that I’m incapable of doing things myself ... I haven’t really accepted that there are things I cannot do. And I feel that there are things I still can do but only after experimentation or after a while I find out I can’t...I’ll never, I’ll never lose that. I’ll never lose that type of independence, cause you still want to be an independent person.” (Participant: McGrath <i>et al.</i> 2016)</p> <p>14. “What upset me was erm I had to give up driving. I’m such an independent person, I have been all my life and I hate having to ask people.” (Participant: Carlton <i>et al.</i> 2019)</p> <p>15. “Well, horrible that you can’t see, you can’t drive... You have to depend on other people for taking care of you. You lose your independence.” (Participant: Sivaprasad <i>et al.</i> 2019)</p>
Dependence on others constructed as source of loss and disappointment	<p>16. “All the plans that I had for our family have all gone and it’s now all reliant solely on [my wife]. She makes the decisions and takes them here and takes them there and I kind of think I hide in the background and I didn’t—don’t like that.” (Participant: Taylor <i>et al.</i> 2020).</p> <p>17. “I was disappointed that I could not choose my own birthday card for my granddaughter. I had to rely on my daughter to do this for me.” (Participant: Stanford <i>et al.</i> 2009).</p>
The person with AMD as a “burden”	<p>18. “Being independent for a long time, most of your life, you feel as if you are putting your carer to an unnecessary burden at times.” (Participant: Wong <i>et al.</i> 2004)</p> <p>19. “Most of the time, I really don’t want to call for help. I feel like that I am rubbish and have to rely on others for everything. I have put too much burden on the family.” (Participant: Bian <i>et al.</i> 2018)</p>

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1 **Table 5. Quotations for third construction – “AMD as grievous loss”**

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AMD as a “prison”	<p>20. “I’m totally isolated; I’m totally imprisoned because of my vision” (Participant: Cimarolli <i>et al.</i> 2012).</p> <p>21. “You’re kind of tied down...A self-imposed prison, basically” (McGrath <i>et al.</i> 2016).</p> <p>22. “I have to think my eyes cut off everything.... Before it [life] was full of energy; now it is full of nothing” (Participant: Wong <i>et al.</i> 2004).</p>
AMD as “a site of no future”	<p>23. “And do what you want to do now because it’s not going to get better, it’s going to get worse.” (Participant: Moore and Miller 2003)</p> <p>24. “My life has not changed at all. If I stop and think about it too much, and what the future’s going to be like, it’s not very nice. But I’m staying away from those thoughts.” (Participant: Taylor <i>et al.</i> 2020)</p>
The before AMD and after AMD self	<p>25. “I always prided myself... that I could recognise all the people who came in to talk, I would say ‘this is so and so’... It used to be my pride, I could recognise people and give him the name . . . [now I can’t do that anymore] it feels as though it’s not me” (Participant: Lane <i>et al.</i> 2019)</p> <p>26. “This isn’t me—I mean, I’m a very visual person” (Participant: Mogk 2008).</p> <p>27. “You get very low moments, so I think you reminisce and you probably think about what you have been able to do and the curtailment now...” (Participant: Thetford <i>et al.</i> 2015)</p> <p>28. “I shave with an electric razor... I take the head off, undo the head and then clean it out that way, blow it with a brush and all the rest of it. But I can’t do that anymore because I can’t see how to undo it and I can’t locate it back again because I can’t see where they are”. (Participant: Taylor <i>et al.</i> 2020)</p> <p>29. “I can’t drive anymore. . . . I can’t read the paper. I can’t [socialize]. What can I do out there? I can’t knit, I can’t sew, I can’t [do] embroidery anymore. Sew, or read, or knit or do any of the things that I used to love to do.” (Participant: Moore <i>et al.</i> 2000)</p> <p>30. “I can’t sew anymore, I can’t thread the needle” (Participant: Cimarolli <i>et al.</i> 2012)</p>
AMD as “a fate worse than death”	<p>31. “Some days I think, well, suicide is far better than going through this.” (Participant: Wong <i>et al.</i> 2004)</p> <p>32. “I just felt upset, why... why couldn’t I have died when I still could see everything.” (Participant: McCloud <i>et al.</i> 2014)</p> <p>33. “What’s the likelihood of my dry turning into wet? I don’t know. I would take an overdose if that went wet.” (Participant: Taylor <i>et al.</i> 2020)</p>

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1 **Table 6.** Quotations for fourth construction – “AMD as a condition to be stoically accepted”

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The stoic position	<p>34. “Oh, it’s alright. It’s passable. It’s not terrific, you know. But I like doing different things.” (Participant: Stevens-Ratchford and Krause 2004)</p> <p>35. “...and it’s just going to become part of my life as I go along, and uh, I’ll accept it, what happens, will happen.” (Participant: Moore and Miller 2003)</p> <p>36. “It was a tremendous psychological shock. I used to write stuff about how I felt, I felt very devastated by it and then gradually you realise it’s not happening immediately and you can go on doing everything normally.” (Participant: Taylor <i>et al.</i> 2020)</p> <p>37. “I am not depressed about it [ARMD], I just accept it. I mean, I am 75 years old. Goodness gracious me, I have done very well, I think, to be where I am. But then again, it really does upset your life.” (Participant: Wong <i>et al.</i> 2004)</p> <p>38. “I just leave it at the back of my mind and I think, don’t think of it too much at the moment and hope it will be alright.” (Participant: Burton <i>et al.</i> 2013)</p> <p>39. “It doesn’t affect me at all. I am happy reading with one eye; many people have one eye for a lot of reasons. I have been coping with it quite well right from the beginning, right from the start. It hasn’t proved to be any sort of handicap” (Participant: Wong <i>et al.</i> 2004)</p> <p>40. “I don’t let it bother me. I’m not going to. I’m going to live...So I do have hopes.” (Participant: Moore and Miller 2003)</p>
“There’s always someone worse off”	<p>41. “But I thank God, see I think there’s always somebody that’s in worse shape than you or me” (Participant: Moore <i>et al.</i> 2000)</p> <p>42. “No matter how bad your problems are, you can find someone with worse things” (Participant: Kleinschmidt 1999).</p> <p>43. “You just have to think well we’re not the only ones. There are people a lot worse off.” (Participant: Burton, Shaw and Gibson 2015)</p>
AMD as a “critical juncture”	<p>44. “You either get up and go or you sit in your chair and die, and I think I’d rather get up and go” (Participant: Lane <i>et al.</i> 2019).</p> <p>45. “I see the world through rose colored glasses. Life is to be lived, not cried about” (Participant: Moore <i>et al.</i> 2000).</p> <p>46. “Yeah well we have to joke about it...You can’t cry about it. What good is that gonna do? I’m not used to feeling sorry for myself. There’s things you can do to pep out of it. You don’t have to be miserable. There’s always something you can do” (Participant: McGrath <i>et al.</i> 2016).</p>
“Fighting” AMD	<p>47. “I fought [AMD] until the blob came. That convinced me. I think of it as a living creature” (Participant: Mogk 2008).</p> <p>48. “I’m going to get older, if I continue to live. It will continue to get a little worse, I suppose, because my eyes are failing more. I suppose the time will come, but I’m fighting it off just as long as I can” (Participant: Porter 2008).</p>

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1 **Table 7.** *Quotations for fifth construction – “AMD as an opportunity for discovery”*

<p>Growth and new discoveries</p>	<p>49. “I’m a more balanced person. I’m a lot more empathic when dealing with other people, and I’ve developed a better sense of humour than I had before; it’s usually targeted at myself. I haven’t got sulky or negative in my feelings.” (Participant: Feely <i>et al.</i> 2007)</p> <p>50. “If I go to the buffet, it’s kind of interesting. If I can’t tell by looking at it, what little I can see, I always say this is going to be a treasure hunt. Let’s see what I came out with when I get back to the table.” (Participant: Smith 2008)</p>
<p>“You live and learn”</p>	<p>51. “Another thing, a new thing that I’m trying to do now, is to try and find ways around doing something without using your sight.” (Participant: Moore <i>et al.</i> 2000)</p> <p>52. “I have dropped a lot of things, thinking that I am on the bench, but I am not on it. And I have dropped cups, plates, and mugs. Well, it’s trial and error. You have to learn instead of just plonking your things down; you have to get to the edge with one hand and then place it with another.” (Participant: Wong <i>et al.</i> 2004).</p> <p>53. “You learn to know yourself and develop as a human being.” (Participant: Dahlin Ivanoff <i>et al.</i> 1996).</p> <p>54. “You learn to live with your disability using the vision that is left.” (Participant: Dahlin Ivanoff <i>et al.</i> 1996)</p>