Older Women's Experiences of Ageing and Health Related Issues in Ireland

A thesis presented in fulfilment of the requirements of
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by

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Declaration

This thesis has not been submitted as an exercise for a degree at any other university and the work herein represents the sole work of the author.

Signed:

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Hanora Dympna Tuohy

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Abstract

Background: A challenge of an increasing ageing population is the 'feminisation of ageing'. Worldwide women live longer than men and this pattern is replicated in Ireland. It is important that health care professionals and policy makers understand and respond to older women's views and needs so as to continue to develop and strengthen health and social care services and supports. However, this must be considered in context of the specific healthcare system. Women's health issues and experiences of ageing have been explored in other countries but there is little published from an Irish perspective.

Aim: The study explored older Irish women's experiences of ageing and health related issues.

Method: Interpretive phenomenology, specifically the "Vancouver School of doing Phenomenology" (Halldórsdottir, 2000) was chosen as an appropriate methodology to guide this study's research design. Co-researchers were selected using purposive and snowball sampling. Data were collected using individual in-depth interviews with 23 older women. Data were analysed following the 12 steps of the Vancouver School of doing Phenomenology framework. This involved developing individual case constructions and meta-synthesis of these.

Findings: Ageing and health are interlinked and impact on each other. This interconnectedness is reflected in the overall experience. 'Retaining autonomy within a process of adaptation and continued engagement' describes the essential meaning of the co-researchers' experiences. Four themes were found to comprise the overarching meaning of this experience: *'Being in control: Balancing needs and supports'; 'Navigating a changing world'; 'Being connected and involved'; 'Trying to stay well'.*

Discussion and Implications: Older women's experiences are more than the sum of the different aspects of their experiences and the findings provide a holistic view of the meaning of these. From a phenomenological perspective, the women's experiences were situated in spatiality (lived space), temporality (lived time), corporeality (lived body) and relationality (lived human relation) and contextualised within the socio-political-cultural and economic context of Ireland. The findings demonstrate that autonomy, adaptation and continued engagement are important factors to consider in planning and developing services for older women.

Conclusion: The views and needs of older women should be responded to and recommendations are provided for health and social care delivery; health care professional education and policy development.

Publications

This work has generated publications, including a published journal article, which I have drawn on in writing up this thesis.

Published article

Tuohy, D., Cooney, A., Dowling, M., Murphy, K., & Sixsmith, J. (2013) 'An overview of interpretive phenomenology as a research methodology', *Nurse Researcher,* 20 (6), pp. 17-20.

Presentations

Tuohy, D. (2010) 'Choosing a phenomenological approach', *Doctoral students' workshop on "Qualitative Methods in Ageing Research"*, University of Vechta, Germany, 26th August.

Tuohy, D. (2012) 'Undertaking research using the Vancouver School of doing phenomenology', *13th European Doctoral Conference in Nursing Science*, Graz, Austria, 14-15th September.

Tuohy, D. (2014) 'An Exploration of Older Women's Experiences of Ageing and Health Related Issues in Ireland', *Bloomberg Emerging Nurse Scholars Forum*, Faculty of Nursing, University of Toronto, Canada, 20-21st October.

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Scholarship

On the basis of this work, I was a recipient of the 'Bloomberg Emerging Nurse Scholars Forum Scholarship' awarded by the University of Toronto, Toronto, Canada in October 2014.

Glossary

Co-Researcher: This term is integral to the Vancouver School; the research process is identified as collaboration between two experts. The researcher is identified as the expert in the research process and the participant as the expert of their lived experience (Halldórsdóttir, 2000).

Dasein: Refers to the phrase *being-in–the–world*, indicating that a person is not separate from the world in which they exist but is involved in that world (van Manen and Adams, 2010).

Dialogue: Dialogue is used in preference to research interview and reflects the respect afforded the co-researcher as a collaborator in the research process.

Epistemology: "A branch of philosophy concerned with knowing [it] includes what the nature of knowledge is, how we come to know what we know, and how we demonstrate the legitimacy of that knowledge" (Green & Thorogood, 2009: 285).

Essence: Term used in phenomenology to refer to the essential meaning of a phenomenon and is defined as "the inner essential nature of a thing, the true being of a thing" (van Manen, 1990: 177).

Functional Ability: This is defined "as the health-related attributes that enable people to be and to do what they have reason to value". (WHO, 2015b:13) People's functional ability is the degree to which they can interact with their environment.

Intrinsic Capacity: "refers to the composite of all the physical and mental capacities that an individual can draw on at any point in time" (WHO, 2015b:12).

Mitsein: Refers to the phrase *being-with-others,* indicating that people's experiences are always in relation to others, and therefore people are always *being-with-other* people and are inseparable to others (Langdridge, 2007; Pascal *et al*, 2010).

Ontology: "The philosophical study of Being (existence)" (Langdridge, 2007:29).

Abbreviations

CARDI: Centre for Ageing Research and Development

CSO: Central Statistics Office

CSO & NISR Agency: Central Statistics Office & Northern Ireland Statistics Research Agency

DJEL: Department of Justice, Equality and Law Reform (Ireland)

DOH: Department of Health (Ireland)

DOHC: Department of Health and Children (Ireland)

EC: European Commission

EU: European Union

GNAFCC: Global Network of Age Friendly Cities and Communities

NCAOP: National Council on Ageing and Older People

NCPOP: National Centre for the Protection of Older People

NDA: National Disability Authority

Nvivo 10: Software analysis package

MS: Multiple Sclerosis

PHN: Public Health Nurse

PRSI: Pay Related Social Insurance

TILDA: refers to the Irish Longitudinal Study on Ageing of people aged 50 years and over (n=8,000) living in Ireland. The aim of which is to explore the health, lifestyle and financial situation of people as they grow older over a ten year period

UK: United Kingdom

UN: United Nations

USC: Universal Social Charge

WHO: World Health Organisation

Chapter 1

Introduction

1.1 Introduction

The global ageing population has caused an increased focus on age and age-related research. People's experiences of age and ageing are affected by a wide range of factors including: health status; socio-cultural and politico-economic factors; and not least, gender. Calasanti (2008:154) argues that "gender relations influences experiences of old age". This is a common theme across the literature with authors across disciplines arguing that understanding how ageing and gender intersect is important to understanding the experiences of people as they age (Ginn and Arber, 1995; Ainsworth, 2002; Cruikshank, 2003; Holstein, 2015). This study argues that health is equally important and should be considered in combination with gender and ageing i.e. that all three collectively impact on older women's experiences. This study therefore focuses on a "grey area", the intersection between and impact of health, ageing and gender on older women's experiences. The focus on older women's experiences responds to Merighi *et al's* (2013:403) call for research which explores older women's experiences of ageing so as to better understand "the implications of increased female longevity".

Given the study's focus, ageing, health and the female gender are key terms within this study. These are defined and discussed, not in isolation of each other but with reference to each other. Importantly, the way in which these concepts are viewed within the literature is dependent on the 'lens' being used, for example, biological, psychological, physiological and sociological. The intersection of ageing, health and gender and the impact of this on older women's experiences is explored briefly here but in depth in the literature review, findings and discussion chapters.

This chapter introduces the thesis and provides an overview of the demography and health status of older Irish women. The study rationale and aims are outlined. The motivation for undertaking the study is also explained. The chapter concludes with an outline of the structure and layout of the thesis.

1.2 An Ageing Female Population

Globally the population is ageing and the proportion of older people is rising (UN,[1] 2013). It is projected that by 2050 the number of people aged 60 and over will comprise 21.1% (two billion) of the total world population (UN, 2013).

There is a similar pattern in Ireland with the percentage of older people aged 65 years and over accounting for almost 12% of the population (CSO, 2012a). This figure is expected to double over the next 20 years (DOH, 2014). It is argued that global ageing is an area for concern (Phillips *et al* 2010) in so far as how best to respond to the needs of people as they age. Both international and national strategic planning in recent years have emphasised 'healthy ageing', promoting the positive aspects of ageing and the importance of taking a life course approach to optimise the health of people as they age (DOH, 2013a; WHO, 2007; WHO, 2015a).

However, it must also be acknowledged that older people may require specific care and support as a consequence of the changes associated with the ageing process (bio-psycho-social and economic factors) and the increased likelihood of having a chronic illness (WHO, 2015a). Therefore, planning for the delivery of services and supports is required to meet the different needs of older people at different times and stages in their lives. In view of the changing demographics and in an effort to meet the needs of older people, age and ageing-related research has received more attention in recent years, including a focus on gender and ageing.

[1] Terms are explained in the glossary

A characteristic of an ageing population is the 'feminisation of ageing' (WHO, 2002). Almost everywhere in the world women live longer than men and are more likely to experience serious illness and have co or multi–morbidities which adversely affect their quality of life (EC, 2014a). Globally in 2013 for every 100 women aged 60 years and over, there were 85 men (UN, 2013). This trend is also reflected in Irish figures where women aged 65 years and over account for 55% of the population (CSO, 2011). In Ireland life expectancy at birth for women is 83.2 years compared to 78.7 years for men (CSO, 2012a).

Globally these ratios are expected to change due to an improvement in mortality levels in older men (Annandale, 2009; UN, 2013). However, the ratios are very different in the oldest old population where a considerably greater number of women live longer than men (Peace *et al*, 2007). The older the population the more the female to male ratio increases, for example, for every 100 women aged 80 years and over there are 61 men (UN, 2013). The situation in Ireland is similar where women aged 75 years and over outnumber men in the same age category by a factor of 1.5 (Kamiya & Sofroniou, 2011) and for every 100 women aged 85 years there are 47 men (CSO, 2011).

1.3 The Health of Older Women in Ireland

Older people are more likely to require health care as they are more likely to experience decreased mobility; increased frailty; accidents; psychological problems; impaired hearing and vision and overall have increased morbidity due to major health problems such as cancer, cardiovascular and respiratory diseases (NCAOP & DOHC, 1998). In Ireland there is an increased incidence of chronic illness in middle aged and older people, with the major causes of death for 62% of those aged 65 years and over being cancer, circulatory and respiratory disease. Mortality and morbidity related to lifestyle practices such as smoking, alcohol, lack of exercise and obesity together with an ageing population have major implications for health care services and delivery (Cronin *et al*, 2011; DOH, 2013b; DOH, 2014). Older women are more likely to develop co or multi-morbidities as they age and this study can increase our understanding of their experiences of health and ill health as they age.

In an evaluation of the health and social services for older people (n=937, response rate of 67%) living in two different geographical areas in Ireland (NCAOP, 2001) women reported more difficulties performing activities of living; having a lower quality of life and believed their health to be poorer than men's. These women were more likely to live alone and more reported actual or borderline anxiety or depression when compared with men (20% women compared to 15% men).

Although this study was undertaken some years ago the findings are relevant as many older women live alone especially as they age (CSO, 2012a). The living arrangements and availability of support for older women may impact on their experiences of ageing and related health issues. Seventy seven percent of widowed older people are women (CSO & NISR Agency, 2011) and a significant minority of older women live alone.

In Ireland 87,000 older women live alone in comparison to 49,000 older men (CSO, 2012a). Furthermore the proportion of older women living alone increases with age with almost 75% of those living alone aged 85 years and over being women (CSO, 2012a). Living alone may adversely impact on one's ability to remain socially involved. This along with the increased likelihood of increased morbidity and increased frailty as one ages may negatively impact on one's health.

A desk-based study by Crawley (2008) identified cardiovascular disease, cancer, falls and mobility/disability problems as areas of concern for older women. Older Irish women have the second highest rate of ischaemic heart disease of all women in the EU but as cardiovascular disease is primarily seen as a problem for middle aged men (Crawley, 2008) this has implications for the health care of this cohort of older women.

Furthermore 54% of cancers in all women in Ireland occur over the age of 65 with the average age of death from breast cancer being 66 years and the 75-79 year age group has the highest number of deaths from cervical cancer. While national screening programmes for both these cancers are in place they are only available to women aged 25-60 years in the case of cervical screening and 50-64 years for breast check screening although this is to be extended to an upper age of 69 years (*Cervical check, National Cervical Screening Programme (no date); Breast Check, National Breast Screening Programme (no date)*).

Therefore, a large number of older women are excluded from these programmes which is concerning in view of the average age of death from these cancers. Crawley (2008) also found that older women experience more accidental injuries, especially falls when compared with older men and also that the proportion of women suffering disability especially mobility problems increases after 70 years.

Older women are reported to have higher incidence of osteoporosis, arthritis and high cholesterol levels than older men (Cronin *et al*, 2011) and respiratory conditions and musculoskeletal pain were more common in older females than males (Savva *et al,* 2011). Of concern was the considerable discrepancy between participants' self-reported disease and its objective measurement e.g. 49% of women with hypertension were undiagnosed (Cronin *et al*, 2011). In view of older women's increased longevity it is important to recognise the increased prevalence of chronic disease in the older age bracket with those over 75 years twice as likely to suffer chronic disease. (Cronin *et al*, 2011).

Savva *et al* (2011) identified the impact of chronic disease and multi-morbidity on self-rated health, disability and quality of life, all of which worsened with increasing numbers of chronic conditions. The findings indicated that there was little difference between males and females but that people from lower socioeconomic backgrounds were most likely to suffer chronic conditions. However, according to other sources (NCAOP, 2001; Annandale, 2009; DOH, 2014; EC, 2014a) while women have a longer life expectancy than men, they have less healthy years with increased morbidity due to chronic illness (both mental and physical).

This seems at odds with Savva *et al's* (2011) findings that there was no difference between the sexes. However, it needs to borne in mind that Savva *et al* (2011) reported on people aged 50 years and over and therefore, the sample may not have allowed discrimination of changes at different ages.

1.4 Rationale for the Study

Although women have a longer life expectancy than men this longevity presents challenges, with older women experiencing more ill health and chronic conditions as they age (WHO, 2007; Annandale, 2009; DOH, 2014; EC, 2014a; Davidson *et al,* 2011). The literature presented above makes clear that gender and ageing but also health combine to shape women's experiences of ageing.

This prompted Burt Ruzek (2004:112) to comment that population ageing "is a critical 'women's health issue'". While there has been an increase in gender specific studies, Kosiak *et al* (2006) argue that research has typically focused on younger women (particularly in relation to their childbearing) and that research with older women has not been developed to the same extent. Davidson *et al* (2011) agrees stating that in women's research there has been a focus on women's reproductive health and a lack of emphasis on older women and chronic health conditions. They further suggest that older women "face inequities related to health and often are invisible within the discourse of aging policy" (Davidson *et al,* 2011:1031). The WHO (2007:3) agrees stating that not only is current information on how gender influences "health in older age inadequate" but that in relation to "research and knowledge development older women face [a] double jeopardy" (ageism and sexism) of being excluded.

It is argued that older women have unique health needs as they age in particular the likelihood of increased co-morbidities in tandem with increased frailty associated with increased longevity (Crawley, 2008; Crawford Shearer *et al*, 2009; Byles *et al*, 2010). There are challenges for Irish older women in meeting their health needs, for example, they are likely to have less financial resources to draw upon (Ní Léime *et a*l, 2015). Furthermore there is an increased likelihood of them living alone (CSO, 2012a) which can adversely impact on the level of support they have in the home.

Exacerbating these challenges is the likelihood of their symptoms being attributed to the ageing process rather than ill health (Hurst *et al*, 2013; Song and Kong, 2015). This is further compounded by the way that older women's symptoms are often viewed as emotionally based and consequently not fully attended to (Saucier, 2004; Katz *et al,* 2008; Annandale, 2009). Furthermore it has been argued that health care professionals lack knowledge on the gender specific needs of older women (Kosiak *et al*, 2006; Byles *et al,* 2010; Davidson *et al*, 2011).

There is little published research on older Irish women's specific experiences of ageing and health related needs and concerns. Given the current and projected increase in the number of older Irish women it is important to identify their unique health related issues within the context of their experiences of ageing.

While it could be suggested that research findings from international studies could be extrapolated to an Irish context, it is argued that the unique experiences of the older women living in Ireland would not be reflected. Macfarlane and Kelleher (2002:1389) argue that health "research should attend to specific national and social histories in order to fully appreciate the nature and origins of health related views". Identifying older women's health issues within the context of ageing will better inform the health planning and health care delivery for them. Phelan and LoGerfo (2005:165) state "health care professionals have much to learn from patients about their health concerns and needs and their perceptions of how well these concerns are being addressed".

Therefore, in view of an increasing ageing female population, the vast majority of whom live in the community and in the context of a developing primary care service, it is imperative that policy makers, and health and social care professionals, understand the health needs and views of older women.

1.5 Personal Motivation for undertaking this Research

I was motivated to undertake this research for a number of reasons. I have been a nurse for over thirty years both in clinical practice and in nurse education. During this time I have cared for many older women in a variety of care settings and have taught both undergraduate and postgraduate modules on care of the older person; rehabilitation nursing of the older person; health studies and have supervised students undertaking research in the care of the older person. In addition, my master's research had an older person focus. Arising from these experiences I became increasingly aware of the intersection of ageing, gender and health. I was particularly interested in hearing the views of older women and wanted to explore further their particular views and experiences. It is important to me that the older Irish woman's voice is heard. This prompted me to undertake this research using an interpretive phenomenological approach. The rationale for selecting this research design is discussed in Chapter 3.

1.6 Research Aim and Question

The underlying premise of this research is that the interconnectedness of ageing, health and gender shapes older women's experiences of ageing. The connection between these three factors was briefly explored above but is examined in greater depth in the literature review chapter. The study aim emerged from the review of the literature but for clarity is introduced here. This study aimed to better understand older Irish women's health needs, activities and priorities as they aged. This aim was more simply articulated in the form of a research question: 'what are older Irish women's experiences of ageing and health related issues?' This format was more user friendly for the study co-researchers (the older women).

1.7 Thesis Structure

This thesis is organised into seven chapters. This chapter outlined the context for the study; the rationale and personal motivation for undertaking this research and introduces the research aim.

Chapter *Two,* reviews the literature on ageing and health in context of older women and their experience.

Chapter *Three*, 'Research Design: Methodology' explains the Vancouver school of doing phenomenology and why this research method was used to guide and frame the research design.

Chapter *Four*, describes how the Vancouver School of doing phenomenology was applied in this study, including: sampling and recruitment; data collection and analysis; ethical considerations; rigour and trustworthiness.

Chapter *Five* presents the research findings followed by Chapter *Six* which explores the findings in context of the literature.

Chapter *Seven* outlines the recommendations arising from this study and makes explicit what this study adds to the body of knowledge on older women and their experiences of ageing and health related issues.

Chapter 2

Literature Review

2.1 Introduction

A challenge of an increasing ageing population is the 'feminisation of ageing' as almost everywhere in the world women live longer than men (WHO, 2002).This pattern is replicated in Ireland (CSO, 2012a). International research has explored older women's health issues but there is little published from an Irish perspective. It is important that health care professionals and policy makers understand and respond to older women's health needs and views so as to continue to develop and strengthen appropriate health and social care services and supports.

It was argued in the previous chapter that ageing, health and gender connect to shape older women's experiences of ageing. The literature review, therefore specifically focuses on understanding gender, ageing and health in context of older women's experiences. Three key analytical themes were identified from the review of the literature: ageing is a gendered experience; the interconnectedness of ageing, health and gender; the impact of public policies and strategies on older women's experience. These themes were used to structure the literature review under three sections: 'Ageing and the Older Woman'; 'Ageing, Health and the Older Woman' and 'Public Policies, Strategies, Planning and the Older Woman'.

The literature search strategy employed to source the literature is provided in **Appendix 1**. It describes the inclusion and exclusion criteria, keywords, language and Boolean operators used. It outlines the search sources used including specific organisations, grey literature and electronic databases. Both hand searching and electronic searches were undertaken. The literature was searched numerous times over the course of the study (2010 to early 2016).

2.2 Ageing and the Older Woman

This section explores the world of older women and their views and experiences of ageing. It discusses the challenge in defining old, older, age and ageing, highlighting the multi-factorial aspects of these concepts and categorisations with specific reference to older women. Crucially it identifies that ageing is gendered and that older women's experiences of ageing should be considered from this perspective. Ainsworth (2002: 579) agrees and argues that ageing as a construct is 'fundamentally gendered' and advised that "rather than treat ... gender and age as separate social categories there is much to be gained from looking at their combined influence".

Westerhof & Tulle (2007) argue that one cannot generalise about the ageing process and it is important to recognise its complexity. Medicine, social policy and mass media are important frameworks shaping contemporary meanings of ageing and old age (Westerhof & Tulle, 2007). For example, medical interest focuses on the biological and physiological aspects of ageing and disease. However, there are also psychological and sociological dimensions to how ageing as a concept is constructed. The meaning of age and ageing is explored in the next section.

2.2.1 Age and Ageing

Phillips *et al* (2010:12) define ageing as "a process whereby people accumulate years and progressively experience changes to their biological, social and psychological functioning as they move through different phases of the life course". The various dimensions to ageing include chronological, biological, psychological, social and societal ageing (Phillips *et al,* 2010). Furthermore within these dimensions it is acknowledged that as a construct "ageing is gendered" (Bernard *et al*, 2000a:17) which is also considered.

People are often categorised according to chronological ageing (number of years since birth) e.g. for school attendance and eligibility to vote, marry and draw a pension. The terms 'old' and 'older' are very much linked with chronological ageing. However, they are categorised differently across the literature: the UN define people aged 60 years and over as older (WHO, 2002) whereas in Ireland and the UK older people are defined as aged 65 years and over.

Other categorisations are also used for example, the third and fourth ages (Phillips *et al*, 2010). The third age or 'young-old' encompasses people from 60 to 75 years. This period is seen as a time when older people are relatively independent, active and healthy (Marcoen *et al*, 2007). However, they warn that this may lead to the marginalisation of people in this age bracket who do not meet these criteria and conform to this image. A transition period is thought to occur between 75 and 80 years with people aged 80 years and over described as the 'old-old' and in their fourth age (Phillips *et al*, 2010).

The fourth age is described as "a period of ultimate decrepitude" with increased dependence and ultimately death (Phillips *et al*, 2010:215). However, it is important to acknowledge that not all people upon reaching 80 years will lose their independence and require full care and that not all those under 75 years are independent. No one individual will age or experience ageing exactly the same as another so it is with caution that older people and thus older women are categorised by chronological age.

Biological ageing refers to deteriorating cellular function (Phillips *et al*, 2010) and is associated with physiological changes resulting in declining function. Psychological ageing focuses on personality, memory, intelligence, learning and attention span. These changes should be considered in association with social and/or physical changes as these can influence an individual's psychological status e.g. a hearing deficit may hinder one's ability to socialise which may in turn negatively affect one's personality (Ponto, 2006; Phillips *et al*, 2010)**.** Furthermore, specific gender related consequences of biological ageing such as being post-menopausal may influence older women's sense of identity as a woman.

Social ageing is equated with changes and adjustments in family dynamics and relationships, retirement, death, declining function, reduced income and narrowed social world which may lead to loneliness and isolation (Eliopoulous, 2010). Social ageing can also be affected by societal influences, constructs and expectations of how an individual should age (Phillips *et al*, 2010). Societal or population ageing is defined as "changes to the age and sex structure of a population which result in increasingly higher numbers and proportions of older people in relation to other age groups" (Phillips *et al,* 2010:170). The feminisation of ageing and its significance within population ageing has been previously identified.

When researching older women populations it is important to recognise the influence and interrelatedness of these biological, psychological, sociological and gender constructs for older women while simultaneously acknowledging the heterogeneity and unique individual experiences of this population.

2.2.2 Theories and Ways of Ageing

Theories of ageing have influenced past and current thinking on how one ages. There is no one absolute theory of ageing, rather numerous exist and emanate from three perspectives: biological, sociological and psychological. Most theories refer to older people rather than being gender specific. Therefore, the relevance (or not) of these theories to older women is highlighted within the following discussion. Although "there is no one feminist theory of ageing" feminist approaches to social policy and ageing "provide insights into the gender differences ... in older age" (Pierce and Timonen, 2010:16). As these approaches are primarily categorised within a sociological perspective (Pierce and Timonen, 2010) they are discussed within the section on sociological theories.

Biological theories try to explain the physiological causes and processes of ageing. Foundational theories are regarded as either error (stochastic) or predetermined (nonstochastic) ageing theories (Jett, 2014). An ongoing accumulation of errors in the synthesis of RNA and DNA ultimately resulting in cell death is the underlying premise in 'error' theories such as wear and tear; cross-link and oxidative stress (free radical) theories (Jett, 2014).The wear and tear theory, a mechanistic theory suggests that through continued and long term use and trauma, the body eventually wears out and dies. The cross-linkage theory suggests that distortion and cross linking of collagen leads to decreased nutrient absorption and decreased nerve pathway efficiency (Jett, 2014).

Current research supports oxidative stress theory which postulates that oxygen metabolism by-products such as toxic free radicals lead to cellular damage (Jett, 2014). Exposure to environmental pollutants such as radiation, smog and chemicals can increase the production of free radicals and while these can be counteracted in youth this becomes increasingly difficult as people age (Jett, 2014). In contrast, programmed ageing/senescence (nonstochastic) theories are based on the idea of cells having a set programmed time to live and die (Jett, 2014). Neuroendocrine and immunological theory focuses on the autoimmune system suggesting that there is a gradual breakdown of immunochemical memory leading to a decrease in immune system responses as people age (Herbert, 2006; Jett, 2014).

There is evidence of accelerated ageing syndromes (progeria) and current genetic research is exploring the relationship of damage to chromosome telomeres with increased progerin (toxic protein) production and cellular death (Jett, 2014). Diet, stress, adverse living conditions, lack of exercise and disease producing organisms (bacteria, viruses and fungi) are also thought to contribute to biological ageing (Herbert, 2006).

Gender is recognised as a factor in life expectancy with women living longer than men especially in the older age group of 85 years and over (UN, 2013). However, older women are more likely to experience poorer health as they age when compared with men (Annandale, 2009; DOH, 2014; EC, 2014a). Research, medical advances, health care provision, health promotion and socio-politico-economic factors are influenced by biological theories on ageing especially when determining older people's and thus, older women's biological resources for healthy living.

Sociological theories explain the ageing process from within its social context (Phillips *et al*, 2010) and include theories on disengagement, activity, continuity, symbolic interaction, person-environment fit, modernization, life course, age stratification, social exchange theory, conflict and inequality theories, feminist views of ageing as well as critical and humanistic gerontology (Victor, 2006; Bowling, 2008; Phillips *et al*, 2010; Pierce and Timonen, 2010; Touhy, 2014).

The 1960s disengagement theory developed by Cumming and Henry argues that older people gradually withdraw themselves from life in preparation for death and to enable the transfer of power to the younger generation (Hooyman and Kiyak, 2008).This theory has little support among gerontologists (Touhy, 2014). This is not surprising as many older people enjoy and want to be engaged in life albeit at varying levels rather than be disengaged and isolated.

In contrast the activity theory derived from Havighurst's studies suggests "there is a positive relationship between activity and life satisfaction … policies derived from this view ... stress activity and interaction" (Victor, 2006: 11; Phillips *et al,* 2010; Touhy, 2014). While this theory has some support, relationships between income, personality, lifestyle, health status and activity levels and how activity can be supported within the context of individual differences and the heterogeneity of older women and men must be considered (Hooyman and Kiyak, 2008).

Personality and past experiences are thought to affect how one ages, Atchley's (1989) continuity theory suggests adaptation to ageing is dependent on one's past life and personality. Essentially people's interests,

levels of engagement and activity in old age are not dissimilar to when they were younger. However, a limitation of this theory is that external factors e.g. income, accessibility and support which could influence these activities are not taken into consideration (Hooyman and Kiyak, 2008). These are particularly relevant to older women in view of increased longevity and reduced likelihood of having full contributory pensions (discussed further in 2.4.3.).

Symbolic interaction theories explore how older people interact with the social world and how these interactions can affect their experiences of ageing (Touhy, 2014). Similarly the person-environment fit theory focuses on the relationship between older people's abilities and coping skills and how they adapt to their social, physical and political environments as they age (Hooyman and Kiyak, 2008).

Life-course theory based on the 1970s work of Neugarten and Hagestad remains influential and focuses on biological, cultural, social and psychological perspectives of ageing (Phillips *et al*, 2010). According to Komp and Johansson (2016) life-course perspectives have three levels. The micro-level refers to the individual's experiences and how these can affect people's lives over their lifespan. The meso-level refers to "intermediate institutions such as families and social networks" and captures the concept of linked lives i.e. what happens to one person can affect the lives of others (Komp and Johansson, 2016: 1942). The macro-level perspective of life-course refers to "the social context that is made up of societies and countries" and its effect on people's individual lives (Komp and Johansson, 2016: 1943).

Arber and Evandrou (1993:10) state that "the life course approach emphasises the interaction between the passage of individual time, family time and historical time" and recognises that individuals' experiences are influenced by personal attitudes and beliefs, family relationships and societal influences. Furthermore, Ginn and Arber (1995) argued that ageing and gender are intertwined over the life course and that not only are people's social lives influenced by socio-economic, cultural and political factors but also by gender and changes in gender relations over the course of their lives. This implies that older women's experiences are shaped by their perception of ageing, their role, their expectations, social mores and social expectations; these must be considered as integral to their experiences of ageing and health.

The modernization theory suggests that the social status of older people has declined with increased technology, industrialisation, mass education and urbanisation (Touhy, 2014) resulting in less value being placed on the wisdom and experiences of older people. As a result there can be a diminution in their status within society (Victor, 2006). Although not specifically explained by this theory, current societal views of ageing and the older woman tend to be negative; this is discussed further in 2.2.3.

The age stratification theory structures people within society according to their chronological age, determining societal roles according to age (Victor, 2006). This theory assumes that people of similar age have been exposed to the same historical and social events and may share common experiences. While there can be similarities in how particular age cohorts view the world, a challenge for this theory is that older women are not a homogeneous group and may not share the same beliefs, values, abilities and interests. In addition, their experiences will have been shaped by their individual bio-psycho-socio-economic circumstances.

The role of older people is also addressed in the social exchange theory which explores the balance between older people and society (Victor, 2006). This theory suggests that there can be reciprocity between generations regarding support, resources and needs. Older people need not be regarded as always being the recipient rather they can also contribute to society through non-material means e.g. emotional, caring support and civic engagement (Hooyman and Kiyak, 2008; Touhy 2014). This is particularly relevant to older women as traditionally the woman's role is associated with their caring and nurturing roles especially within the family (Rose and Bruce, 1995; Cruikshank, 2003; Hurd Clarke and Bennett, 2013). This role continues for many throughout their lives and indeed is extended for some when they become spousal or family carers or provide child care for their grandchildren, when they themselves are older.

In contrast, the conflict theory emphasises what divides groups rather than focusing on shared values (Victor, 2006) and in this sense can be destructive for the wellbeing of both the individual and society. Similarly, the inequality theory focuses on conflict, particularly intergenerational conflict and how it is demonstrated through ageism and inequality regarding employment and mandatory retirement ages. Eligibility for state pensions is a particular issue for older women and is discussed further in 2.4.3. It also suggests that those who are poor/wealthy before they become old, will remain so and this does tend to be the case.

Since the 1990s, thinking has shifted and increasingly theories have focused on positive ageing. Specifically, critical and humanistic gerontology explore the meaning and interpretative dimensions of ageing and provide a cultural framework for "making ageing a more positive experience" (Phillips *et al*, 2010:206*)*. The concept of positive ageing as a way of ageing is discussed in more detail later on in this section. In contrast to other theories of ageing, critical gerontology does consider the influence of gender on the ageing experience.

However, Bernard *et al* (2000a: 5) while welcoming the increased focus on the influence of gender in critical gerontology argue that "older women are still considered as other to older men", suggesting the need to focus more on older women in their own right rather than how they compare to older men.

Eminent scholars (Arber and Ginn, 1995; Bernard *et al,* 2000a, 2000b; Cruikshank, 2003; Calasanti, 2008; Holstein, 2015) have argued that historically the concerns and experiences of older women have not been addressed well by either gerontology, women's studies or feminist sociology. However, Calasanti (2008) and Holstein (2015) acknowledge that this has begun to slowly change over the last decade or so. According to Ginn and Arber (1995) ageing is gendered and there are different social effects of ageing on women's and men's roles, relationships and identity.

Ainsworth (2002: 580) concurs stating that the "meaning of ageing is culturally and socially constructed" and argues that the "growing awareness of the body as a 'hinge' in the construction of age identity has highlighted the fundamentally gendered nature of ageing" (Ainsworth, 2002: 580-581). Older women's experiences of the physical effects of ageing are interlinked with psycho-social, cultural and economic factors. The manner in which society and the individual older woman view the obvious manifestations and appearance of the ageing female body has implications for older women's experiences of ageing. This is discussed in more detail in 2.2.3.

Psychological theories typically focus on developmental aspects of life from birth to death (Touhy, 2014). Theories by Jung, Erickson, Peck, Levinson and Tornstam explore psychological changes in older age (Tornstam, 1997; Ponto, 2006; Touhy, 2014). Jung's (1971) theory of personality suggests that as people age they become more introspective, self-aware and search for personal meaning (Touhy, 2014). Similarly, Erikson's 'Epigenetic theory of development', Peck's (1968) 'Developmental tasks of ageing', and Levinson's *et al's* (1978) nine stages of adult development, describe various development tasks that one needs to accomplish through life. The task for the older person is to review their life, the positive and negatives of the past and to strive for ego integrity by accepting the life lived (Ponto, 2006; Eliopoulos, 2011; Touhy, 2014).

Peck's (1968) work has some similarities with Tornstam's (1997) gerotranscendence theory. This theory argues that during the ageing process there is an increased focus on spiritual and personal growth with a move away from everyday material concerns and physical aspects of ageing (Tornstam, 1997).

A common theme within many psychological theories is that, through the accomplishment of various developmental tasks, older people arrive at a point where they can review and accept the lives they have led and think beyond the everyday concerns of life. While this may be the case for some people, it cannot be presumed that all older people can or will want to examine their lives. Some may be unable to reconcile aspects of their lives, so this expectation may not be achievable. The theories' espoused goals are idealistic and may "place a considerable burden on the older person" as not everyone wants or is equipped to manage this level of introspection (Touhy, 2014:77).

While all theories can provide some insight into the ageing process, it is with caution that a generic approach be applied to older women's experiences of ageing. Specifically Bernard *et al* (2000a) have criticised both Levinson's and Erickson's models for making generalisations about older people by not acknowledging gender differences and failing to take account of older women's specific experiences. The same may be said for the other psychological theories.

In contrast, Baltes and Baltes (1990) have a different approach to the above theories, and highlight the importance of older people's individual and societal circumstances in how they age. Baltes and Baltes' (1990:1) psychological model is based on the premise that successful ageing is "an adaptive process involving the components of selection, optimization and compensation". It is argued that older people adapt to the ageing process by identifying what they want to achieve, having due regard to the means and abilities they have at their disposal within the context of compensating for losses or decline in functional abilities. The emphasis on individual and societal circumstances is welcomed but similar to other theories and models; there is little reference to specific gendered experiences.

The intersection of ageing and gender within theories of ageing has attracted more attention in recent years and it is acknowledged as an important dimension in understanding how ageing is constructed and experienced (Ainsworth, 2002; Calasanti, 2008; Holstein, 2015). Not withstanding the lack of a gender specific theory of ageing, it is important to recognise that the various theories of ageing have influenced contemporary ways of thinking about ageing and thus impact on older women's experiences.

There are different descriptions of how ageing as a process is experienced and **ways of ageing** have been described as: active, successful, healthy, resilient and positive ageing. These descriptions are important in shaping views about the ageing process but similar to the theories of ageing there is little specific reference to gender.

The second United Nations Assembly on Ageing's action plan identified **active ageing** as both a policy and programme formulation goal (WHO, 2002). This concept is influenced by Atchley's continuity theory and to a lesser degree by Havighurst and Albrecht's activity theory (Bowling, 2008). Active ageing is defined as "the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age" (WHO, 2002:12). It aims to facilitate ageing as a positive experience for both individuals and populations. It is not only about being physically active or being able to work, rather it means being able to participate in social, cultural, spiritual, economic and civil events (WHO, 2002).

Successful ageing is defined as "a dynamic, multidimensional process building from earlier life experiences aiming to minimise physical and cognitive functional loss in later years, while maintaining and achieving high social activity" (Phillips *et al*, 2010:209). Rowe and Kahn (1997:433) state there are three components to successful ageing: "low probability of disease and disease related disability, high cognitive and physical functional capacity and active engagement with life". However, this concept has been criticised (Phillips *et al*, 2010; Dionigi *et al*, 2011). The definition is thought to be too constraining (it does not account for different perceptions of successful ageing), is unrealistic (many older people, especially many older women have underlying health problems) and having a Western cultural bias (ignoring global cultural variations and the impact of these on people's attitudes and views of what successful ageing is and how it can be achieved) (Phillips *et al*, 2010).

According to Hansen-Kyle (2005:52) the term **healthy ageing** is often erroneously used interchangeably with the term successful ageing. In contrast, it is defined as "the process of slowing down, physically and cognitively, while resiliently adapting and compensating in order to optimally function and participate in all areas of one's life".

The concept of resilience and having a health focus is also evident in **resilient ageing.** Resilience is "the ability to achieve, retain or regain physical or emotional health after illness or losses" (Lundman *et al*, 2012; 168). The underlying premise of resilient ageing is achieving quality of life through maintenance of a wellness approach. Older people and thus older women can do this by drawing on their coping and adaptation skills which are shaped by life experiences and personal attributes of hardiness and self-concept (Hicks and Conner, 2014).The concept of resilient ageing is drawn from Antovonsky's salutogenic model of health in particular the 'sense of coherence' concept which Antonovsky (1987:19) defined as

> *"A global orientation that expresses the extent to which one has a pervasive, enduring dynamic feeling of confidence that 1) the stimuli deriving from one's internal and external environments in the course of living are structured, predictable and explicable; 2) … resources are available … to meet the demands posed by these stimuli; …3) these demands are challenges, worthy of investment and engagement".*

Resilient ageing can be enhanced by focusing on health, health needs and health promotion within ageing policies so that older people can maintain health and achieve an optimum quality of life. In addition, positive coping and adaptation skills help develop and strengthen resilience. However, resilience in ageing needs to be supported and Hick and Conner (2014) recommend that health care professionals should (1) support and encourage older people to develop social as well as physical resources; (2) advocate for health and older person policies which include and recognise the importance of social supports.

A somewhat different emphasis is identified within the concept of **positive ageing.** This is defined as helping people to think positively about their ageing, plan sensibly for older age and adopt lifestyle practices which facilitate quality of life (DOH, 2013a). Choices which help determine positive ageing are made in early and middle aged years and facilitating appropriate choices means having a good quality of life in older age. A positive ageing philosophy recognises that many factors determine this, such as health and social care, income, transport, housing, employment, education and access to information (DOH, 2013a).

Positive ageing means developing a society whereby people of all ages have the same rights and status (Age Action Ireland, 2010). In this sense positive ageing is identified as important to all the population i.e. something to plan for, support and strive for. Therefore, positive ageing reflects a pragmatic and realistic approach to ageing whereby older people maximise their abilities while recognising their limitations within a supportive environment and society. Furthermore and a welcome perspective, the DOH (2013a) emphasise that differing needs (life expectancy, health, caring roles and employment) of older women and men must be key considerations within the concept of positive ageing.

In summary, a range of concepts (influenced by theories of ageing) describe ways of ageing and while there are similarities, all have a different emphasis. Active ageing (WHO, 2000) focuses on enabling older people to actively engage in life through participation in socio-cultural-spiritual and civic events. Successful ageing (Rowe and Kahn, 1997) emphasises physical and mental wellness and engagement. In contrast healthy and resilient ageing (Hansen-Kyle, 2005; Hicks and Conner, 2014) focus on the older person's ability to positively adapt to age related changes. Whereas positive ageing (DOH, 2013a) while acknowledging the importance of

adaptation and coping, emphasise the need to plan for older age through adopting positive lifestyle choices. The extent to which any of these perspectives are accepted and/or internalised by older women are important considerations when exploring their experiences of ageing and health issues.

2.2.3 Societal and Individual Views of Ageing and the Older Woman

A societal image of ageing "refers to both how older persons are perceived by the wider society and … how older persons feel the rest of society perceives them" (Huber, 2006:14). This image is influenced by socio-cultural, economic and historical factors, and personal experiences. While policy makers must take heed of society's images of ageing, they also need to be mindful of older people's views when developing and implementing policies (Huber, 2006). Thus research which specifically explores what older women believe, want and experience is important in informing such policy and strategy development. According to Zunzunegui *et al* (2007: 199) "gender is not only an individual attribute but a structural and relational characteristic which leads to power dynamics and identity construction". Therefore, how older women are viewed both by society and by themselves is important to how ageing and health is experienced by older women.

A powerful influence on how society views ageing and older women is the mass media, however the media also reflects societal attitudes. Attitudes and values are influenced by both negative and positive imagery and there are consequences for both society and for older women depending on how older women are portrayed in the mass media. Contemporary societal and media images positively portrays youth, frequently linking youth with beauty (Westerhof and Tulle, 2007; Chrisler *et al*, 2015). The equation of youth with beauty can have negative effects on older women's views of

the ageing process. For example, there is under representation of older people in the mass media and in particular quite negative portrayal of older women and of older people in their fourth age. In contrast, older men although also under represented are not as negatively portrayed and tend to be viewed more benignly (Westerhof and Tulle, 2007 NCPOP, 2009; Chrisler *et al*, 2015). Thus older women are being sent a powerful negative message about how they are perceived by society.

Ageism is the extreme consequence of negative imagery and is defined as "the discrimination against people simply on the basis of their chronological age and ... may be implicit or explicit (Victor, 2006: 14). Ageism has been likened to racism and sexism regarding the stereotyping and discrimination of a group in society (Butler, 1969). Calasanti (2008: 155-156) argued that "ageism is embedded in institutions, including our popular culture, political process and social policies" and that "both sexes are denigrated because they are 'old' but women are targets at earlier stages in their lives". Ageism is a threat to the ability and opportunity of older people to age well (Angus and Reeve, 2006) and it is argued this is a particular threat for older women. Ageism can occur at several levels e.g. societal, institutional and individual (McGuire *et al*, 2008).

According to Peace *et al* (2007:9) "feminisation of later life has led to a widespread attitude to older women of being socially invisible and of leading a tucked–away life of little impact [on] public life". Therefore, ageism in tandem with the feminisation of ageing, has led to a double jeopardy for older women, resulting in being ignored and/or marginalised and stereotyped. Similarly, Holstein (2015:70) has argued that older women are both "hypervisible and invisible", leading them to be stereotyped and marked out by their physical appearance and at the same time ignored (Ainsworth, 2002).

Thus older women are not only seen as being physically unattractive as evidenced by their 'ageing bodies' but neither do they have significant standing in society. The notion of older women becoming invisible and of less consequence is linked in no small way to their physical appearance and the weight that society gives to looking young and healthy especially for women. This has consequences for their ageing and health experiences.

According to McCormick (2008) how a society values women is linked with how it views women's bodies. In particular ageism can negatively affect older women's body image and self-esteem and can therefore have negative health consequences. According to Saucier (2004) negative societal attitudes about the older female body can result in older women experiencing anxiety and depression. Section 2.3.3.1 discusses in more detail how negative body image can adversely affect older women's health, flagging how negative views of ageing coupled with the physical evidence of ageing can have a negative effect on older women's health.

At an institutional level, there is discrimination within housing, employment and retirement policies, and also poor institutional care. With specific reference to the healthcare arena, a qualitative study (NCAOP, 2005) on perceptions of ageism in health and social services in Ireland interviewed both older people and health care staff (n=456 older people, n=150 staff). Findings confirm that discrimination did occur and concluded "Older people tend to be stereotyped by some service providers as a homogenous group characterised by passivity, failing physical and mental health and dependency" (NCAOP, 2005:14). Hatch (2005:19) has further argued that older women are judged more harshly than older men and that "biased constructions of gender and aging [is also] .... evidenced in differential treatment of older women and men in healthcare institutions".

Evidence of negative stereotyping and ageism from an individual's perspective is age denial, age segregation, avoidance of older people, ageist humour and language, negative attitudes and stereotyping. In addition to societal images of ageing, people have personal images of themselves (such as subjective age identity and self-image) and the society in which they live (Huber, 2006). Westerhof and Tulle's (2007) assert that all people are influenced by their learning and experiences in early life and so the images that people have of ageing and of older people, acquired early in life, influence their experiences of ageing. In view of societal negative stereotyping of older women, this is particularly relevant to older women's experiences of ageing.

Furthermore, Westerhof and Tulle (2007) argue that older people's self-perceptions influence their subjective well-being. Similarly, Keller *et al's* (1989) exploratory study of older people's (n=32) experiences of ageing found that while their impressions of ageing were positive, the changes associated with ageing (both their own and those they observed in others) were viewed negatively. What was also noteworthy was that for most of the respondents (68%) awareness of ageing (mostly due to health related issues) was episodic rather than constant, suggesting that it was only when they were not feeling well that they felt old, highlighting the inter-relatedness of age and health.

Steverink *et al's* (2001) quantitative study (n=4034, 40 to 85 years, 51.2% male and 48.8% female) explored people's personal experiences of ageing. They identified the association of subjective health and the effect of hope (low or high levels) with personal growth and loneliness as important factors in how the personal process of ageing was conceptualised. An unexpected finding was that actual chronological age was identified as influencing the ageing experience e.g. the older the age the more the

ageing process was equated with fragility, social loss and physical decline. This may be due to normative expectations about ageing (Steverink *et al*, 2001) and highlights again, the influence of societal views about ageing on older people themselves. However, the sample's lower age range is a limitation as it is argued that at age 40 people may not be able to conceive what it is like to grow older in the same way an individual who is retired, perhaps widowed and more socially isolated, can.

The negative association between the physical effects of ageing and social status was identified by Day and Hitchings (20011:886) who argue that being seen to be physically old "lowers the social status of the individual" and there is a stigma about being older and growing older. However, the negative effects of physical decline may be militated against depending on an individual's social standing. Marques *et al's* (2015) 2008/2009 European Social Survey (n=6185) explored whether older people's social status influenced their subjective health. There was a significant negative association between old age identification and subjective health in countries where older people were perceived to have a lower social status. Arising from this, Marques *et al* (2015) suggest that there is a protective health function for older people where they have a higher social standing.

In addition to the influence of socio-economic factors on older people's perceptions of ageing, is the influence of gender. The negative effects of ageing for women was identified in Maguire's (2008) qualitative study of older women (n=7) working in a university. Participants felt they had to maintain an appearance of being well groomed, healthy and not obviously ageing. The participants believed that there was pressure from the mass media to look well and to be desirable, and this was equated with not looking old. Female ageing was also identified as being a barrier to being considered for promotion but in contrast male colleagues were actively groomed for senior management.

McHugh and Interligi (2015) argue that older women are doubly disadvantaged through ageism and sexism, especially so when seeking promotion, by virtue of being a woman and being older, as the number of men in senior positions far outnumber those of women in similar positions (CSO, 2011; EC, 2014b). Maguire's (2008) findings resonate with older women's experiences in general of pressures to look well and be physically healthy (Chrisler *et al,* 2015).

The relationship between societal and individual images of ageing and its impact on older women's sense of wellbeing and their attitudes to health and ageing must be recognised. In some ways, societal views are changing as reflected in positive Government ageing strategies and policies. In view of positive commitments to older people regarding services and supports but within the context of economic difficulties and ageism, insight into older women's experiences of ageing and health issues is invaluable in planning for and addressing the ageing and health needs of this cohort.

To summarise, the concept of age and ageing is quite complex and has a number of dimensions. This section has explored how old, older, age and ageing are defined and categorised; examined different theories and ways of ageing and discussed societal and individual views of ageing. Furthermore, it has highlighted that theories of ageing fail to consider gender, instead providing a generic theorising of ageing as a concept. It is acknowledged that in recent years there have been calls to consider ageing as a gendered construct, however to date there is little empirical evidence of the development of gendered theories of ageing. This review also flags the impact of individual and societal influences on women's views and experiences of ageing, further highlighting the significance of gender within the ageing experience. Ageing is clearly a gendered concept and older women's experiences need to be considered and heard from within this frame of reference. It is also evident from this discussion that ageing is

multidimensional; one of the major factors influencing older women's perceptions and experiences of the ageing process is their health. This is discussed in the next section.

2.3 Ageing, Health and the Older Woman

This section explores how ageing and health are intertwined. The focus here is on older women's views of their health and how their health concerns and health care are integral to their experiences of ageing. These experiences are framed within the context of being a woman. It is assumed therefore, that the concept of gender is fundamental to the older women's views and experiences of health, and these are further underpinned by the gendered experience of ageing. In other words, health, ageing and gender are interlinked in older women's experiences. This relationship is explored in this section.

Older women's perceptions and experiences of ageing are very much inter-related with their health status and their views about their health (Roberto *et al*, 2005; McCormick, 2008; Rohr and Lang, 2009; Foster and Neville, 2010; Terrill and Gullifer, 2010; Chrisler *et al*, 2015). In order to provide a context for how older women define and view their health as they age, this section firstly discusses the different ways in which health is defined and how different perspectives influence people's views of what health is. The various dimensions and determinants of health are outlined. It is acknowledged that health related behaviours can differ among people and theories explaining these behaviours are described. The review focuses on three areas: older women's views of ageing and health; older women's experiences of health care services and lastly the significance of 'belonging' and its impact on older women's health as they age.

2.3.1 Defining Health

Health as a concept is not easily defined and means different things to different people. An enduring definition sees health as normality and illness as not normal (Blaxter, 2010). However, there are inherent difficulties in attempting to define what 'normal' is. Blaxter (2010) suggests that it is dependent on a range of factors including chronological age, socio-economic, psychological, physiological, cultural factors as well as life experiences, expectations and individual beliefs and values.

For example, what is normal for someone aged 20 years is not necessarily normal or the same as for someone who is 80 years old, similarly what is normal for a person with a chronic condition is not the same as for someone with an acute condition. Green *et al* (2015) agree that health is a contested concept with different meanings, suggesting that defining health is dependent on the different emphasis placed on disease or wellbeing; holistic or atomistic interpretations; the individual or the collective; the lay or professional perspective; subjective or objective interpretations.

Probably the most well-known definition of health is from 1946 when the WHO defined health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" (WHO, 2016a:1). However, this definition is not without its critics. Scriven (2010) asserts that it is both unrealistic and idealistic as how can anyone claim to have complete health. She further argues that nothing is static and that this definition does not reflect changing views that people may have about their health status. Blaxter (2010:3) agrees that "the meaning of health is neither simple nor unchanging".

There are different views on what health is, it may be construed as: being an absence of illness; disease as being a deviance; having balance or homeostasis; being able to function; health can be described in terms of one's current state of health or it may be described as health status i.e.

more a long term view of one's health (Blaxter, 2010).The way in which health is described and understood is influenced in part by developments in medical science and by societal values and beliefs. The biomedical model focusing on ill health as something to be treated e.g. find and treat the cause of a disease was and is to some degree still dominant. However, more recently this view has been tempered by an acceptance that ill health is not as simple as cause and effect but rather there are "multiple and interactive causes" (Blaxter, 2010: 15).

The emergence of the social model of health and ill health reflects an expanded perspective recognising that there are social, cultural, economic and psychological aspects to health and ill health as well as biological. Blaxter (2010:17) describes the social model as being "holistic and organic rather than reductionist and mechanical". There are several dimensions to health and these can influence health behaviour. These include physical, mental, emotional, social, spiritual, societal, environmental, sexual and global health (Naidoo and Wills, 2009; Scriven, 2010). A holistic view of health typically encompasses all of these dimensions and from older women's perspective speaks to the particular interconnectedness of ageing, health and gender within their experience.

Within an Irish context the multidimensional influences on people's understanding of health is reflected in the findings of McCluskey's (1989) important exploration of people's (n=500) health beliefs and practice. The findings indicate that concepts of health, illness and behaviour patterns are socially constructed and maintained, "health and illness are defined with reference to social norms and health and illness behaviours are considerably influenced by social and cultural factors" (McCluskey, 1989:1). The various socio-cultural influences (e.g. beliefs, attitudes, expectations) on how older women perceive and manage their health needs within the context of their ageing experience are important considerations.

Furthermore it is acknowledged that "the impact of gender on health will...vary according to the cultural norms and gender-related values in each particular society" (Zunzunegui *et al*, 2007: 199). Of course, socio-cultural factors in themselves are not isolated from bio-psycho-political factors which influence older women's health as they age.

Reflecting a more holistic view of health is a later definition by the WHO (1986:1) which states that in order to reach a state of complete wellbeing,

> *"an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. ... Health is a positive concept emphasizing social and personal resources, as well as physical capacities*."

This definition emphasises that people need to adapt to and respond to changes in their environment. Having the ability to adapt and cope with the challenges of a changing environment are core concepts in Antonovsky's (1987) model of salutogenesis. This model adopts a health rather than disease orientation and identifies a health/illness continuum with 'ease' at one end and 'dis-ease' at the other. Antonovsky (1987; 1996) argued for a shift in thinking on how health is viewed, rather than focusing solely on the causes of ill health, what helps people cope mentally and physically needs to be considered so as to identify why and at what end of the continuum they are situated.

He suggested that the ability of people to cope and deal with stressors is through having generalized resistance resources (GRRs) which help them to "see the world as 'making sense', cognitively, instrumentally and emotionally" (Antonovsky, 1996:15). Underpinning one's ability to cope successfully with life stressors is the concept of having a strong sense of coherence. This, Antonovsky (1996:15) described as "a generalized orientation toward the world which perceives it on a continuum as

comprehensible, manageable and meaningful". Therefore, when confronted with a stressor, a person will assess it according to what the challenge is (comprehension), desire or need to cope with it or not (meaningfulness) and whether one has the means or resources to cope with the stressor (manageability) (Antonovsky, 1996) .

Salutogenesis is reflected in the concept of resilient ageing as evidenced in the following studies. Janssen *et al's* (2012) narrative study examined how older women (n=2) mobilised sources of strength (equated with resilience) to maintain mastery over their lives. Important sources of strength were having a positive perception of one's situation, being open about one's vulnerability and being responsive to help. Janssen *et al* (2012) argue that it is important for these strengths to be acknowledged and promoted through dialogue and partnership in care provision.

Lundman *et al* (2012) also highlight the importance of identifying and acknowledging older people's sources of strength (described as their sense of coherence) within gerontological nursing. Their epidemiological study explored older people's (n=185, 85years and over, 63.8% female) inner strength in relation to functional status, disease, living arrangements and social relationships. The findings indicate that those with inner strength have better physical health and more satisfying social relationships.

Similarly, Ebrahimi *et al's* (2013) phenomenological study (n=11 men, 11 women, 67-92 years) identified the influences on frail older people's experiences of health. Participants wanted to feel assured and capable by being able to remain in familiar surroundings, self-manage, have a positive outlook, a sense of belonging and being connected. They achieved this by being resilient. Health care professionals can support older people by focusing on factors (e.g. individual resources and requirements) which strengthen this resilience (Ebrahimi *et al*, 2013).

This concept of being able to adapt and respond to changing circumstances is also evident in Wiesmann and Hannich's (2008) quantitative study (n=170, mean age 67 years, 21.8% men, 78.2% women) which explored a salutogenic view on subjective well-being in active older people. The respondents reported a high level of subjective well-being with a strong sense of coherence and identified self-esteem, self-efficacy and education as being very relevant to this.

The ability to cope and adapt is interlinked with wellbeing and quality of life. The concept of wellbeing is identified as being an integral component in defining health. It is described as being a positive physical, social and mental state; having a sense of purpose; being able to cope successfully; being able to participate in society and having quality of life (DOH, 2013a; DOH, 2013b). The relationship between adaptation and wellbeing in older people's lives is reflected in Smith's (2001) report on the effect of health on older people's sense of wellbeing. The study (n=516, 70-100+ years) explored the relationship between health factors (e.g. physical illnesses, subjective and functional health) and sense of wellbeing factors (e.g. life satisfaction, satisfaction with ageing).

The findings indicated that respondents' self-evaluations of their illnesses and their functional status were stronger predictors of 'sense of wellbeing' than the number of diagnosed illnesses. However, as acknowledged by Smith (2001) respondents' adaptive processes were 'tested' as they moved from third to fourth age. During this time they became increasingly frail and generally less well and this adversely impacted on their ability to adapt and cope. This suggests the existence of a critical point where increased frailty and ill health overwhelm the ability to adapt and cope successfully. In view of the higher proportion of older women in general as well as the higher ratio of older women to men in the older category of fourth age, this point is relevant to older women's experiences of ageing and health.

An important aspect of wellbeing is having quality of life and this is linked with the ability to adapt. Quality of life is difficult to define but most definitions include "feelings of well-being, social involvement and opportunities to achieve personal potential" (Murphy *et al* 2009:607). People have different perceptions of quality of life and these can change over time (Sprangers and Schwartz, 1999). Rapkin and Schwartz (2004) postulate that these changes result from the interaction of four elements: catalysts, antecedents, mechanisms and response shift. Catalysts refer to health and changes in health; antecedents are people's individual characteristics (personality) as well as cultural and environmental factors; mechanisms are processes (behavioural, affective and cognitive) that respond to health changes (catalysts) and response shift is a change in an individual's perception of their quality of life (Rapkin and Schwartz, 2004).

A response shift in one's perception of quality of life is dependent on both an appraisal of the situation (health status) and the coping strategies used to deal with the situation (Rapkin and Schwartz, 2004). According to Barclay-Goddard *et al* (2009:336) response shift "is evident in individuals with chronic illness or disability" who on an ongoing basis re-evaluate the quality of their lives according to their changed circumstances and their response to these. This evaluation enables the person to 're-frame' their perception of their quality of life to good.

The 'disability paradox' concept is an attempt to explain the discrepancy between poor objective health and reported good quality of life in those living with severe or chronic illness or disability. This concept acknowledges that perceptions of quality of life must consider people's evaluation and management of their own situations (McClimans *et al*, 2013). The concept of response shift is an important consideration as it may explain why older women who objectively have poor health rate their health and quality of

life as being good. In general, older people living in Ireland have a positive view of ageing and experience a high quality of life but not surprisingly, those that rate their health as poor or fair report the lowest quality of life (McGee *et al*, 2011).

There are individual perspectives on what might be considered healthy e.g. a person with chronic arthritis may consider that she is healthy if she can walk to the shop while another could consider her condition as being a sign of ill health (Scriven, 2010). International research highlights similar findings whereby participants believed themselves to be in good health despite having underlying medical problems (Evans *et al*, 2001; Foster and Neville, 2010). Bond and Caberero (2007) cite several European and North American surveys that found older people consistently rated their health as good while their morbidity data suggested otherwise. Health experiences in the context of having an underlying illness or chronic condition were explored in Lyyra and Heikkinen's (2006) hermeneutic phenomenological research of older women (n=10, 60-83 years) with rheumatoid arthritis. Good health was defined as being in a state of equilibrium and as having a general sense of well-being. Health was described as: a way of coping with everyday life, freedom, the absence of inconvenience, togetherness and mental well-being.

In summary regardless of how health is defined, Green *et al* (2015:3) emphasise that "health as it is experienced within people's lives is of central importance" and that it is essential to recognise that people's interpretations of health are multidimensional and complex. Health can mean different things to different people depending on their circumstances at a particular time. Essentially health is interlinked with a sense of wellbeing and quality of life. Integral to this is the individual's appraisal of potential and actual threats to their health and their ability to cope with these stressors.

Older women's responses and ability to adapt to changes in their health status and their perceptions of their quality of life is dependent on a range of factors (e.g. individual characteristics, coping skills and supports). Furthermore the manner in which health is defined and understood influences how health care is organised and provided (Blaxter, 2010). Thus it is important to understand how older women perceive and manage health needs as they age so that services can be planned, organised and provided to meet these particular needs and concerns. Older women's specific views and concerns about ageing and health as well as their individual experiences of the health care provision are discussed in sections 2.3.3 and 2.3.4 respectively.

2.3.2 Determinants of Health

People's understanding of health is influenced by personal, socio-cultural and economic factors (Irvine, 2010). Dahlgren and Whitehead (1991) identified various determinants that significantly affect health. These include age, genetics, hereditary factors and sex; individual lifestyle factors; social and community networks; socioeconomic, cultural and environmental factors (Dahlgren and Whitehead, 1991).

There are inequalities in health. Seminal UK research published in the Black report (DHSS, 1980) demonstrated a clear link between people's socioeconomic group and their health in terms of morbidity and mortality. There are links between people's health and their income, housing, employment/unemployment, gender, ethnic origin, place of residence and access to health services (WHO, 2013). A number of theories try to explain people's health behaviour, mainly from a psychological perspective (e.g. the health belief model; theory of reasoned action and planned behaviour; Prochaska and DiClemente's stages of change model) but also Tones' model from a health education perspective (Naidoo and Wills, 2009; Green *et al*, 2015).

The **health belief model** emphasises the importance of beliefs in deciding to change one's behaviour, this is influenced by evaluating the health risks and benefits as well as deciding whether they are able to make the change (Talbot and Verrinder, 2014). The main criticism of this model is the lack of weighting of the different factors, all elements as seen as equally important (Naidoo and Wills, 2009) for example, most people would agree that smoking cessation is important but believing that they can do it may be much more difficult.

The **theory of reasoned action and planned behaviour** is based on a number of premises. People are more likely to change their behaviour if they believe this will improve their health. In tandem with this people are thought to be strongly influenced by the expectations of those close to them as well as societal norms. A third aspect of this model centres on whether people feel they have the personal control and ability to make this change (Talbot and Verrinder, 2014). All three elements are integrated, for example, knowing that excess alcohol is not healthy does not necessarily translate into individuals changing their consumption as they may be adversely influenced by the attitudes and values of friends, family and society.

According to Talbot and Verrinder, (2014), the '**stages of change model'** (trans-theoretical approach) recognises that making a personal change in lifestyle and health related behaviour can be very challenging. The Stages of Change Model, developed by Prochaska and Diclemente (Prochaska *et al*, 1992), advocates a holistic approach to change and acknowledges that personal choice and responsibility, as well as societal and environmental influences must be considered. Tones' (1987) **health action model** emphasises the effect of self-esteem and motivation on people's behaviour. The premise being that people with high self-esteem and positive self-concept are more likely to want and have a healthy life style and vice versa. These theories can be applied to explain in a general way,

the significance of previously discussed negative societal and individual views for older women and how these can adversely influence their expectations of how healthy they can be and their adoption of healthy lifestyles as they age.

While these theories do provide insight into behavioural influences and offer reasons why people behave in particular ways (Green *et al*, 2015), they have been criticised as being "deterministic and abstracted from social settings…[and] can be seen as culturally biased" (Blaxter, 2010:78). Specifically it is argued that insufficient consideration is given to gender, culture, age, different groups of people within different settings, the complexity of people's life experiences, family beliefs and influences regarding health and health practices (Blaxter, 2010). Therefore, it is with caution that they are accepted to explain why and how people behave and modify their lifestyles.

2.3.3 Older Women's Views of Ageing and Health

Older women's perceptions of ageing and how they see themselves is influenced by the intersection of socio-cultural and politico-economic factors and personal attitudes and beliefs. These perceptions can and do impact on older women's views of health, health status and health related behaviour as they age. These views are discussed under: body image; expectations; independence; acceptance and adjustment. It is acknowledged that many of these concepts are inter-connected.

2.3.3.1 Body Image

This section focuses on the relationship between body image, ageing and health for the older woman. The physical changes associated with the ageing process generally have a deleterious effect on older women's body image which in turn has consequences for their health. Body image can empower or disempower an individual and has an important impact on

mental and physical health and general wellbeing (Chrisler *et al*, 2015). Factors negatively affecting body image include: negative societal views of ageing, older women's internalised negative attitudes to ageing and the actual physical effects of ageing. Being healthy is often identified as being synonymous with being young and the appearance of youth. This in tandem with the value that society places on attractive youthful women in preference to older women inevitably influences how older women perceive themselves.

McCormick's (2008) narrative study (n=15, 62-91years) explored older women's views and use of food throughout their lives. She argued that society devalues the older women's body because it does not fit the ideal of the youthful body and stated that "the embodied selves of post-menopausal women are dismissed and devalued jeopardizing self-esteem and increasing the potential for depression and anxiety" (McCormick, 2008: 312).

The idea that older women's bodies are devalued is exemplified by the need to cover them up identified in Hurd Clarke *et al's* (2009) qualitative study exploring older women's (n=36, 71-93 years) 'experiences and perceptions of clothing prescriptions for adults in later life'. The motivation to mask the ageing body is, according to Hurd Clarke *et al* (2009: 723) an "insidiously ageist interpretation of older bodies … [whereby] physical realities of ageing are deemed repugnant and in need of camouflage". Certain clothes were deemed appropriate for the older female body. These were chosen to mask the physical effects of ageing and present a healthy appearance while at the same time conforming to various conceptions about what older women 'should wear'. For example, a muted classical traditional style was deemed appropriate. Linked with this, is the contention that there is a societal pressure to look young but that older women have to carefully balance their efforts between not looking old

while not trying too hard to look young (Chrisler *et al* 2015; McHugh and Interligi, 2015).

However, while acknowledging the powerful influence of societal anti-ageing attitudes on older women's body image, other factors should also be considered. Liechty and Yarnal (2010) identified how interpersonal influences (e.g. family and spousal expectations and attitudes), key life events (e.g. pregnancy, menopause and educational experiences) and personal priorities (attitudinal change) also influence older women's body image. Their life course perspective study (n=13, 60-69 years) researched older women's body image and how it had been shaped over the course of their lives. Essentially they found that participants now prioritised health and internal characteristics over physical appearance and not all were dissatisfied with their appearance, albeit some were. However, women older than 69 years were not included in this study and they may well have had a different perspective especially as they are more likely to have chronic health problems which could influence their body image.

Not withstanding Liechty and Yarnal's (2010) findings it is argued that ageist attitudes by older people themselves can adversely affect their health. Day and Hitchings (2011) using interviews and participant photo diaries, explored 21 older person households' (16 female and 12 male) winter warmth related routines. They found that some participants, particularly older women refused to wear certain items of warm clothing such as hats or use a blanket or hot water bottle during the day in cold weather because of their negative views about ageing. They did not want to acknowledge their increasing age, either through appearance or action, to those outside their immediate circle. In essence "they had to balance the needs of the body against an imperative not to be seen as undeniably old" (Day and Hitchings, 2011: 892) which had adverse implications for their health.

While the effect of age-related physical change adversely affects older people, it is more marked for older women. Hurd Clarke *et al* (2008) using a symbolic interactionist approach studied body images of older adults with five or more chronic conditions (n=20, 10 men, 10 women, 68 to 88 years old) and found that these changes had a more negative effect on older women. Their increasingly frail bodies and the appearance of their bodies adversely affected their self-esteem, their views of their attractiveness and identities, and some wished that they would die as they felt trapped by their ageing bodies.

A number felt much younger that their chronological age and were dissatisfied with the dissonance between how they looked and how they felt (5 men and 3 women). These participants had multiple chronic conditions and it is accepted that this may also have negatively impacted on their sense of self. However, the findings have merit as many older women suffer from chronic conditions and the effect of these together with the effects of the ageing process upon their body image must not be discounted.

The idea of ageing as an embodied experience was also identified in Hallrup *et al's* (2009) phenomenological life-world study of fall risk in older women with previous fragility fractures (76-86 years, n=13). The findings centred on bodily changes associated with ageing and related fractures and how this impacted on participants' physical and psychological environments. Their 'lived space' or living environment became narrow as safety precautions, risk reduction and increased dependency inhibited their ability to experience the world outside their home. This study provides insight into how increased frailty and reduced abilities negatively affected older women's perceptions of themselves as independent people.

In summary, this section discussed the health consequences for older women in relation to their responses to 1) their embodiment of ageing and 2) how their ageing bodies needed to be maintained, preserved and portrayed due to societal and personal influences. The influence of cultural and societal mores is evident in how participants in these studies in general negatively viewed themselves in a world which very much values youth.

The visible effects of the ageing process had a negative effect on many older women's body image (McCormick, 2008; Hurd Clarke *et al,* 2008; Hurd Clarke *et al,* 2009; Hallrup *et al,* 2009) but not all (Liechty and Yarnal, 2010). Body image and sense of one's self was also influenced by changing abilities and increasing frailty. Being encased in an older body hinders how an older woman can move in her world. Becoming increasingly physically dependent and preoccupied with trying to stay safe and avoiding risks (Hallrup *et al*, 2009) can ultimately influence how the older women sees herself.

2.3.3.2 Expectations

Older women's expectations about their health as they age can influence their health behaviour. Horton *et al* (2007) assert that negative ageing stereotypes impact on older people's health by adversely influencing their ability to recover from disease and their participation in physical and cognitive activity. In light of earlier discussion points, this has specific relevance to older women. Horton *et al* (2007) argue if older people expect old age to be a time of decreased mental and physical activity then they are less likely to engage in these activities which ultimately has negative consequences for their health and health behaviours.

The influence of older people's expectations of their health was examined by Kim (2009) in her survey of older people living in the community (n=99, aged 61-90 years, 81.8% female). Having high expectations about ageing was associated with better mental and physical health, those who expected better health tended to engage in health promoting behaviour. Kim (2009) acknowledged the study's limitations highlighting that this was a cross sectional study and it is unclear if the results would be the same if measured periodically in a longitudinal study. The higher female to male respondent ratio impacted on the generalisability of the study findings. It is also acknowledged that an individual's socioeconomic status is a factor in one's ability to access health care. Notwithstanding these factors, personal expectations about ageing did influence their experiences.

Song and Kong's (2015) meta-synthesis of 12 studies examined older people's perceptions of health and identified five themes which captured what it meant to be healthy: having the ability to do things independently; management or absence of symptoms; having energy; being connected with others and being optimistic in adjustment and acceptance.

Nummela *et al* (2007) explored the links between self-related health and indicators of self-economic status (education, adequacy of income and disposable income) in their cross sectional questionnaire study of ageing people (n=4,272, born between 1926-1950, 66% response rate: 2,815 participants). Having an adequate income was identified as a strong predictor of good self-rated health. Similarly Humphrey's social survey (2008) explored health inequalities in older people living in an urban area in Ireland (n=1374, 65% response rate: 542 valid questionnaires) and found those of higher socioeconomic status had a better health profile. This is not

that surprising as having sufficient income to access health care services enables older people to seek help when they need it. Therefore, the more negative expectations about ageing and health for older women can be tempered by having financial resources. However, many older women are not eligible for full contributory pensions which limit health care choices (discussed further in 2.4.3).

2.3.3.3 Independence

Health and being independent are interlinked and are in ways co-dependent. Wanting to be independent is a theme that occurred in many of the studies exploring older women's experiences (Traynor, 2005; Rohr and Lang, 2009; Foster and Neville, 2010; Terrill and Gullifer, 2010; Song and Kong, 2015).

Foster and Neville's (2010) descriptive study explored older women's experiences of living alone (n=5, aged 85 years and older). The participants stressed the importance of independence and being positive. They were actively involved in social activities; were self-reliant and tried to keep healthy. The participants actively worked at being healthy and keeping well by eating nutritious food, exercising and having a positive attitude.

'Being positive' was also identified in Terrill and Gullifer's (2010) qualitative study. Using semi-structured individual interviews they explored the subjective experience of ageing from the perspective of Anglo-Australian older women (n=8, 65-75 years). Ageing was seen as a time of personal growth, increased freedom and choice. Being positive and pragmatic about growing older was identified as important. Conversely ageing was also identified as being a possible time for 'stagnation' because of loss of independence and failing health.

Ageing was something to be feared if this happened. Terrill and Gullifer (2010) highlight the interrelatedness of health and age emphasising that health status impacts on the ageing experience and vice versa, e.g. staying independent is influenced by feeling and being well. Participants from both studies were from Australia and New Zealand, suggesting that there are some cultural similarities regarding outlook on life and ageing and it is not clear if older Irish women would have a similar outlook.

An acknowledged limitation of Terrill and Gullifer's (2010) study is the use of snowball sampling which resulted in some homogeneity. However, a strength is the introduction of the 'mind-body disparity' concept. The notion of how one's desires and wishes for growth and self-development may be curtailed by an increasing frail body poses some questions about how the 'lived body' can experience ageing. The concept of an ageing body and its impact on health was discussed previously in section 2.3.3.1.

Using a feminist perspective (n=4, 76-90 years) Evans *et al* (2001) investigated whether frail older women with a positive perception of health wanted to take a more active role in their health care. The findings indicated that they wanted more control and independence in managing their health care needs. The number of participants in this study is quite small but it is identified as being a pilot study. The concepts of independence and choice were also identified in Bastiaens *et al's* (2007) large scale qualitative study in primary health care in 11 European countries (n= 406, 70-96 years, 184 male, 222 female). Older people wanted to be involved in their own care but differed in the level and type of involvement they wanted, highlighting the importance of taking an individualised and flexible approach to each person.

The importance of maintaining independence was also identified in Roberto *et al's* (2005) exploration of the experiences of older women (n=17, 69-84 years) with multiple health conditions. This study was part of a larger investigation of behavioural and psychological influences on quality of life of older rural women and employed a qualitative approach, utilising face to face interviews. The findings centred on the participants' perceptions of their health condition, their management strategies and care arrangements. While many experienced pain and reduced energy, they adopted a proactive approach by slowing down in order to maintain their independence and autonomy.

2.3.3.4 Acceptance and Adjustment

Concepts of adjustment, acceptance, being adaptable or flexible were identified in the literature (Maddox, 1999; Foster and Neville, 2010; Terrill and Gullifer, 2010; Lowe and McBride–Henry, 2012; Song and Kong, 2015). Maddox's (1999) phenomenological study explored what health meant within ageing for older women (n=25, 55-104 years). Five themes were identified: interactions with a being greater than themselves; self-acceptance; humour; flexibility and being other-centred. The findings while dated resonate with aspects of positive and resilient ageing in so far as it was found that women coped through adjustment and acceptance. Furthermore this study illustrates the intertwined nature of ageing and health for older women and the influence of one on the other.

The significance of spirituality and its relationship to resilience in older women was explored by Manning's (2012) grounded theory study (n=6, 80 years and older). Similar to Maddox's (1999) study, the findings indicate that being spiritual or having a religious belief helped older women remain resilient and adapt to their changing circumstances.

The importance of accepting life changes was identified in Terrill and Gullifer's (2010) study. Adaptation to ageing is also reflected in Traynor's (2005) grounded theory study (n=11, 60-89 years) on understanding older women's experiences of ageing. Traynor (2005) described the core category of 'searching for meaning' as being the way the participants engaged in life. Fundamental to this process was adjustment. This was not necessarily always positive and it is acknowledged that some older women actively disliked their lives in later life. Depression, managing change and intimacy with family and friends impacted on positive or successful adjustment. A strength of this study was the examination of how this theory could impact on the nursing care of these participants should they need it. Nurses were exhorted to spend time with older women so as to clearly identify their concerns and needs.

Many older women have co and multi-morbidities and adapt to these in various ways. Older women in Foster and Neville's (2010) study described themselves as being healthy even though they had chronic illnesses or disabilities. This concept of being healthy despite having health problems illustrates the subjectivity in people's definitions of health. Similarly, Lowe and McBride-Henry's (2012) descriptive study (n= 3, 80-88years) identified how older women coped with chronic illness and decreasing abilities through adjustment, adaptation and having a positive attitude. The findings of both studies compare with the concepts of response shift and disability paradox (discussed previously) whereby people re-evaluate their health status and needs according to their appraisal of the situation and their ability to cope at a given time (Rapkin and Schwartz, 2004; Barclay-Goddard, 2009; McClimans *et al*, 2013).

The health impact on older women of living longer was also explored in Cameron *et al's* (2010) prospective study (n=9164, 65 years and over). They identified that older women with functional and physical problems and living alone were more likely to be isolated and this adversely affected their ability to access medical care. However, participants in both Foster and Neville's (2010) and Lowe and McBride-Henry's (2012) studies also lived alone and their findings are relevant as it challenges the notion that the 'old-old' are very dependent.

This needs to be considered in the context of an increasing number of older women in Ireland who are in this age bracket, many of whom have chronic conditions and who may be living alone. However, living with chronic conditions can be challenging and Giddings *et al* (2007: 557) likened having a chronic condition and ageing as a "double jeopardy because ageing amplified the ongoing vulnerabilities of living with a chronic condition".

The reviewed literature suggests that the ability and desire to adapt and adjust is impacted upon not least by the ageing process but also by one's health status and the presence or not of illness or disease. It is not clear whether this is the same for older Irish women but is worthy of consideration. This section has highlighted that body image; expectations; a desire to be independent as well as acceptance of and adjustment to health difficulties and changes wrought by the ageing process were key aspects in how older women viewed their health as they aged.

2.3. 4 Older Women's Experiences of Health Care Services

This section discusses how older women's experiences of health care services impacted on their health as they have aged. It flags how being an older woman affects this experience. The literature indicates that older women felt their concerns were not heeded or not taken seriously and it was felt that this would not be the case if the participants had been younger (Tannenbaum *et al,* 2003; Hatch, 2005; Holstein, 2015). While it was reported that physical needs were taken care of, it was perceived that psycho-emotional issues were either not addressed or not well attended to (Bertera, 1999; Tannenbaum *et al*, 2003; Kinch and Jakubec, 2004; Hickey *et al*, 2005; Tannenbaum *et al*, 2005; Lee Smith *et al*, 2013).

An exploratory study (n=36, 65 years and over) using focus group interviews (Tannenbaum *et al,* 2003) with older women examined their attitudes, opinions and concerns regarding their health care experiences. While participants felt their physical needs were being met, certain issues relating to psychological health were inadequately addressed by health care professionals. These included: being validated as a person, having fears and anxieties related to ageing being taken seriously and needing more information on health maintenance. The participants felt that their concerns would have been more seriously addressed had they been younger. This raises some concerns about how health care professionals view older women. Tannenbaum *et al's* (2003) findings suggest that health care professionals may hold negative attitudes about older women in their care as expressed through not according them the respect and time to respond to their concerns.

As previously identified ageism is an area of concern especially for older women who are negatively portrayed and perceived by society and it is argued that this may be compounded when they seek and require health care provided by health care professionals who may hold ageist attitudes and values (Weir, 2004; NCAOP, 2005; Simkins, 2008). Tannenbaum *et al* (2003) argue these difficulties may prevent older women being empowered to manage their health concerns. The cohort was reasonably homogenous (all were middle/higher socioeconomic groups and most were white, one was black) and this could have had some bearing on the results as their cultural values, beliefs and expectations could be similar.

There are some similarities to this study and Tannenbaum *et al's* (2005) later cross-sectional 'what women want' health survey of community dwelling women examining health priorities and perceptions of care delivery (n=5000, 55-95 years, response rate 52%, mean age 71). Not all older women's health priorities were addressed especially those dealing with memory loss and end-of life counselling. Tannenbaum *et al* (2005) acknowledge some limitations such as sampling bias as the survey was distributed via the postal system and accounted for less than 20% representation of the population. The sample was also identified as being more educated and somewhat healthier than the average older Canadian woman.

Kinch and Jakubec's (2004) phenomenological research findings were similar to those of Tannenbaum *et al* (2003, 2005). Women (n=32, 65 years and over) were interviewed about their health care experiences. They felt their concerns were not listened to or taken seriously. These findings have implications for health care delivery by health care professionals in so far as they need to involve and include the older woman in her own health care management.

Similarly Lee Smith *et al* (2013) researched factors associated with women's chronic disease management (n=287, 34.4% were 65 years and over). Findings included: not having enough time to talk over their health problems; feeling confused; wishing they had someone with them; feeling that there was a lack of understanding about their particular health management situation and a feeling that they were on their own in how they managed their health. However, it is acknowledged that not all experienced these frustrations and in particular college educated women did not need as much help in self-care management. These findings highlight the need to promote health literacy through understanding, information giving, clarification and time by health care professionals when discussing and advising on patient self-care management.

In summary, older women's health concerns were not always taken seriously and even when care was provided, the primary focus was on the physical aspects of disease. Care of the psycho-emotional needs of the older women was lacking at times. Older Irish women like their global counterparts are likely to experience poorer health as they age. Currently it is not clear how they access health care services or how they are supported by health care professionals in managing their health care needs. Older women's health is not only influenced by their experiences of the health services but also by feeling valued (or not) within one's community and family and this is discussed next.

2.3.5 Older Women: Belonging, Ageing and Health

The desire and need to belong within a social group is an innate aspect of what it is to be human. Being connected and involved are important in promoting and maintaining health and wellbeing (Murphy, 2006; Routasalo, 2009; Ní Léime and O'Shea, 2010; Timonen *et al*, 2011; Walsh and Harvey, 2011; Pettigrew *et al*, 2014; Byles *et al*, 2015). Social groups typically include family and friends as well as wider groups. There are different ways in which to feel connected within this wider social circle, for some it is active involvement in organised groups such as active retirement groups, for others it can be less formal such as feeling that they belong to a community. There are health benefits in belonging and negative health consequences associated with exclusion.

In Ireland many older women are widowed (77% of widowed older people are women) and/or live alone (87,000 older women live alone, including almost 75% of women aged 85years and older) (CSO, 2012a). It is acknowledged that not all these women feel excluded and there can be other factors besides living alone which militate against inclusion such as health status, reduced income and transport. Therefore, it is argued that there may be fewer opportunities for some older women to be involved in social groups depending on their individual circumstances.

There are different reasons for exclusion from social activities. Walsh *et al* (2012) examined social exclusion and ageing in diverse rural communities in Ireland and Northern Ireland. The study included focus group interviews with community stakeholders (n=62) in 10 study sites as well as individual semi-structured interviews with older people from the 10 communities (n= 106, 59-93 years, 49 men, 57 women). They identified five domains of social exclusion: opportunities for social connectedness and social resources; access to health, social and general services; access to both public and private transport; feeling safe and secure, and having adequate income and finances.

While this report did not specifically connect social exclusion with the health and wellbeing of older women it does recommend that local communities be enabled to empower older people "to live more independent and connected lives" in order to reduce disadvantage and enhance capabilities as one ages (Walsh et al, 2012: iii). Timonen *et al* (2011) identified that 6% of older women in TILDA study are socially isolated and that people with poorer self-related health are most likely to be socially isolated. The connection between poorly rated health and the potential for social isolation is an important factor to consider in view of an increasing ageing female population in Ireland.

Byles *et al* (2015) surveyed older people's views (n=260, 75-80 years, 128 men, 131 women, I missing return) regarding social isolation and participation. Findings indicated that active participation and having social networks can promote healthy ageing. Factors which militate against participation were psychological problems including depression and lack of a supportive environment. In particular older women were more at risk of social isolation because of decreased mobility and being more home bound (Byles *et al* 2015).

The Society for St Vincent De Paul's report on 'Older people - experiences and issues' in Ireland (n=567) highlighted that social exclusion may result in feelings of loneliness and this was an important issue for those living alone, many of whom were widowed. In addition, a social network was lost to those who had retired (Walsh and Harvey, 2011). It is acknowledged that in general, there was good contact between older people and their children and grandchildren (Walsh and Harvey, 2011). However, this study did not provide gender specific statistical details. This is a limitation as this study could have provided insight into older Irish women's experiences.

According to Ní Léime *et al* (2013) older Irish women, especially rural dwellers have higher loneliness scores than men, and suggest this is linked to more women in the oldest age group and more living alone. Roustasalo *et al* (2009) identified that loneliness in older people is linked with low quality of life, poor health, increased mortality and increased use of health and social services. Murphy (2006) and Hunter (2012) also emphasised the link between loneliness and adverse physical, emotional and mental health conditions such as depression. These study findings highlight how health, ageing and gender intersect within the context of older women's particular experiences.

High social capital, the positive effect of belonging and being empowered is reflected in Walsh and O'Shea's (2008) study of an active retirement group. The study's hypothesis was that "by providing older people with a social support framework…individual wellbeing is enhanced and positive community attributes will be fostered" (Walsh and O'Shea, 2008:798). Data were gathered using focus groups (n=21) and postal interviews (n=43, 54% response rate). The results confirmed that belonging to this group contributed positively to the members' wellbeing and also to community cohesion.

Similarly Ní Léime and O'Shea (2010) outlined the benefits for older people of belonging to a social group in their report on the older person organisation 'Age and Opportunity'. Participation in a range of programmes such as creative arts, psycho-social activities as well as the promotion of physical activity led to increased mental and physical health and facilitated social cohesion. While many older person social clubs/organisations in Ireland have a high percentage of female membership, it is acknowledged that not all older women belong to such clubs. However, it seems what is important, is 'the belonging' to a social group or network rather than a club per se.

The strong link between having a large social network and having a better health profile was identified by Humphrey (2008). The importance of being involved in social activities and the desire to be "other-centred" and helpful is reflected in Boneham and Smith's (2006) multi-method case study (n=19 women, 55-78 years). This study explored the relationship between social capital, health and gender and focused on the health and social networks of older women in a socially disadvantaged area. Many of the women in this study were actively involved in their community often through their informal position of lay health experts. Their expertise was developed from their own life experiences as mothers and carers. The status and respect accorded the older women increased their confidence and empowered them to continue to help and support their community (Boneham and Sixsmith, 2006).

The idea of participating and being valued for their contribution provides a different vision of older women when compared with the dependent individual requiring assistance more commonly depicted. Furthermore, it highlights and in a way validates the value (both to others and to the women themselves) of their roles of carers and nurturers and how this can be extended beyond the family circle to the benefit the wider community. The studies reviewed in this sub-section indicate that social exclusion or inclusion impacts on health. While it is likely to be the same for older Irish women, it is not fully clear how older Irish women perceive the impact of inclusion/exclusion within their experiences of ageing.

The literature reviewed in this section, 'Ageing, health and the older woman' has demonstrated how ageing, health and gender are inter-related and how together they influence older women's experiences. It has highlighted that older women's beliefs and expectations about their health as they age, their experiences of the health care system and their sense of belonging are gender-specific with the power to either negatively or positively influence their health behaviour and health status.

How older women experience health is both influenced by and influences the ageing experience. Furthermore, this experience is framed by the life-course of being an older woman, influenced by life events which in turn have been influenced by how they, their family/friends and society perceive ageing older women. The major theme identified is the 'interconnectedness of ageing, health and gender'. This interconnectedness must be considered when exploring older women's experience. It is fundamental to understanding the experience, as essentially one element cannot be isolated from the others, rather the interconnection of all three are fundamental to the experience. Older women's experiences of ageing and health issues are also shaped by national and international policies and strategies. These are discussed in the following section.

2.4 Public Policies, Strategies, Planning and the Older Woman

This section examines policies and strategies at national and international level and how they have a direct effect on older women's experiences of ageing and how they manage their health care needs. Historically, health and social policies have identified increased dependency and decreased productivity as areas for discussion and management in planning for an ageing population. But over recent years there has been a shift towards perceiving older people as being healthier and more independent (Westerhof and Tulle, 2007). However, it is must be recognised that older people and thus older women are not a homogeneous group and so levels of dependency/independency are individual and unique to the person. There are various strategies and policies at international and national level which inform health care activities by and for older people. This section provides an overview of these and discusses their relevance to older women living in Ireland, including their potential effect on older women's experiences.

2.4.1 International Strategies and Policies

Significant international policies and strategies affecting older people's health and ageing have been developed over the last two decades. They include: The UN (2002) Madrid International Plan of Action on Ageing; WHO (2002) "Active Ageing" policy framework; WHO (2007) Women, Ageing and Health: A Framework for Action; EU "Together for Health" strategy (EC,2007); WHO (2009) Women and Health: Today's Evidence Tomorrow's Agenda; European Innovation Partnerships on Active and Healthy Ageing (EC, 2011); WHO (2012a) Health 2020 Policy Framework and Strategy; WHO (2012b)European Regional Strategy for Healthy Ageing (2012–2020); WHO (2015a) World Report on Ageing and Health; WHO (2015b) Global strategy and action plan for ageing and health and WHO (2016b) Global Network of Age Friendly Cities and Communities.

The aim of the 'Madrid International Plan of Action on Ageing' was to achieve a society for all ages and it called for changes in attitudes, policies and practices at all levels in all sectors so that the enormous potential of ageing in the twenty-first century could be fulfilled (UN, 2002). The 'Active Ageing Policy Framework' guided by UN principles for the older person (independence, participation, care, self-fulfilment and dignity) (WHO, 2002) identified various determinants of ageing within the context of gender and culture including: economic, social, physical, personal and behavioural determinants as well as health and social services. The three pillars upon which the active ageing policy is based are health, participation and security (WHO, 2002). It is acknowledged that there are challenges for an ageing population that need to be recognised when advancing this policy. These include increased risk of disability; care provision; ethics and inequalities; economics; communicable and non-communicable diseases and the feminisation of ageing (WHO, 2002).

Specifically focusing on women and ageing, the WHO (2007: 1) 'Women, Ageing and Health: A Framework for Action' "addresses the health status and factors that influence women's health at midlife and older ages with a focus on gender". This framework recommends that the application of both an ageing and gender perspective in policies, practices, research and programmes "can improve the health and wellbeing of ageing women" (WHO, 2007:1). The framework comprises four components: taking a life-course and determinants of health approach; focusing on the pillars of action of the active ageing policy and having a gender and age responsive lens (WHO, 2007). WHO (2009) 'Women and Health: Today's Evidence Tomorrow's Agenda' reiterated the importance for older women's health of taking a life course approach.

More recently as part of the 'Madrid +10 review' (*Progress review of the UN (2002) Madrid International Plan of Action on Ageing*), the UN Women Coordination Division (2012) reported ten recommendations to improve older women's quality of life. The overarching recommendations are: improve data on interactions between ageing and gender; protect and reinforce older women's human rights; and mainstream ageing into gender policies and gender into ageing policies. Specific recommendations include: compensation for variable labour force participation; support life-long learning; set gender specific health targets; support empowerment; improve research and policy responses to elder abuse; strengthen supports for older women living alone and within public policy prioritise the needs of rural older women (UN Women Coordination Division, 2012).

However, more recent strategies and policies have moved from the gender specific recommendations identified above to a more generic approach. These are outlined next and while the recommendations are welcome, the gender specific lens needs to be kept to the fore to meet the needs of older women.

The 'Health 2020 Policy Framework and Strategy' (WHO, 2012a:1) was agreed by the WHO European Region and its goals are

> *" to significantly improve the health and well-being of populations, reduce health inequalities, strengthen public health and ensure sustainable people-centred health systems that are universal, equitable, sustainable and of high quality".*

Within the context of an increasing ageing population in the region a number of solutions to maximize the health of the older person are offered within this framework and encompass a range of policies and strategies (both existing and new). The WHO (WHO, 2012a) identified the key needs of older people include: being heard; being autonomous and belonging within a community.

Addressing these and maximizing health and active ageing may be achieved by implementing the WHO (2012b) European Regional Strategy and Action for Healthy Ageing (2012–2020). This strategy identified a number of important areas to address. Specifically that functional capacity may be enhanced by the promotion of age friendly living environments and that a long term view of healthy ageing should be taken through a life-course approach with a focus on healthy lifestyles from an early age. Furthermore the role of social, health and economic policies in addition to legislation, is recognised as important in promoting healthy ageing through the provision of social protection, appropriate health and social care services as well as the creation of age friendly environments and labour markets.

WHO (2012b) identify as key target areas: 1) address negative societal stereotyping which adversely impact on the health and wellbeing of older people, and 2)empower older people and their families though health promotion, health literacy and self-care management of disease, disability and end of life care.

More recently the WHO (2015a) 'World Report on Ageing and Health' advocate a public-health framework for healthy ageing, the goal of which is to maximise functional ability. The WHO (2015a) acknowledge that older people may have variable capacity (from high and stable to declining to significant loss) but suggest that functional capacity can be maximised by aligning health services to the needs of the older population; developing appropriate systems of long term care; creating age friendly environments and improve monitoring, measurement and understanding of this population's needs.

The WHO (2015a) also acknowledge that countries have different levels of economic development but offer practical steps which they suggest can be adapted for use in all countries. Concrete suggestions on how to build on the WHO (2015a) 'World Report on Ageing and Health' recommendations are currently being developed in the shape of the WHO (2015b) 'Global Strategy and Action Plan for Ageing and Health'. This strategy outlines five strategic objectives: fostering healthy ageing in every country; aligning health systems to the needs of the older populations; developing systems for long-term care provision; creating age-friendly environments; improving measuring, monitoring and understanding (WHO, 2015b:2).

Furthermore, in recognition of many countries' efforts to meet the needs of their older population, the WHO through its Global Network of Age Friendly Cities and Communities (GNAFCC) provides a forum for cities and communities to share their experiences and ideas on how best to achieve age friendly communities. Essentially age friendly communities strive to support active and healthy ageing and to enhance the quality of life of their older population (WHO GNAFCC, 2016b). In tandem with WHO initiatives, are those developed by the European Union.

An aim of the European Union's (EC, 2007) health strategy for 2008-2013, 'Together for Health' is to foster good health in an ageing Europe. Actions include: health promotion for all; act on socioeconomic and environmental factors affecting health; use new guidelines on cancer screening; communicate European action on rare diseases and follow up on organ donation and transplantation communication (EC, 2007).

The significance of an increasing ageing population is recognised and as part of the Europe 2020 growth and jobs strategy, the European Commission (2011) launched 'The European Innovation Partnership on Active and Healthy Ageing' pilot programme to meet the challenge of an ageing population. Its target is to increase the healthy lifespan of EU citizens by two years by 2020 and to improve older people's lives. Through public and private partnerships, it aims to improve the health and quality of older people's lives, improve health and social care systems as well as create market opportunities for businesses to develop age related services and products.

The focus areas are: health promotion and prevention; care and cure; independent and active living for older people (EC, 2011). It is acknowledged that many of these international and European policies and strategies impact on and influence the formulation and implementation of Irish domestic policies and strategies. The achievement of these strategic aims and their implementation at national level requires commitment and ongoing monitoring and evaluation. The following section discusses national polices and strategies within Ireland.

2.4.2 National Policies and Strategies

Over the last twenty years a number of national policies have considered the needs of older people, to a greater or a lesser extent. These include: 'Adding Years to Life and Life to Years' (NCAOP & DOHC, 1998); 'The National Health Promotion Strategy 2000/2005', (DOHC, 2000); 'Quality and Fairness, A Health System for You' (DOHC, 2001a); 'National Action Plan for Social Inclusion 2007-2016' (Government of Ireland, 2007); 'Towards 2016' (Government of Ireland 2006); 'Healthy Ireland A framework 2013-2025' (DOH, 2013b); 'The National Positive Ageing Strategy' (DOH, 2013a) and 'Age Friendly Cities and Counties programme' (Age Friendly Ireland , 2015).

Other initiatives include HSE corporate and national service plans, health promotion strategic framework, national clinical programme for older people; anti-elder abuse and anti-ageism strategies and policies as well as the overall official government policy which aims to enable people to live independently in their own homes and communities and if this is not possible, to be supported to live in high quality residential care (DOH, 2016). Many of these policies and strategies are specific to the older person while others refer to the older person within the context of a broader policy or strategy document.

The health promotion strategy for older people 'Adding Years to Life and Life to Years' (NCAOP & DOHC, 1998) identified five policy and action areas: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services. Building on this strategy, the aim of 'The National Health Promotion Strategy 2000/2005', (DOHC, 2000) with regard to older people was to enhance their quality of life and to improve life expectancy. McKenna *et al's* (2005) review of this strategy with particular reference to older people indicated that there was some success in implementing recommendations from the strategy as well as the 'Adding Years to Life and Life to Years' strategy but that more needed to be done.

Considering the importance of health promotion within the context of people keeping well, it is noteworthy that the Department of Health has not published any further health promotion strategies, although it is acknowledged that health promotion initiatives are incorporated into other strategy and planning documents in particular 'Healthy Ireland–A Framework for Improved Health and Wellbeing 2013-2025' (DOH, 2013b) (discussed later). Furthermore the HSE's (2011) 'Health Promotion Strategic Framework' has identified key outcomes for health promotion for the whole Irish population including: re-orientate health and other public services; create supportive environments for health; reduce health inequalities; improve health and prevent and reduce disease.

In the early 2000's, the Government launched two further important strategies. The wide ranging strategy document, 'Quality and Fairness, A Health System for You', committed to increased investment in community, hospital and residential care as well as providing an action plan to develop rehabilitation services for older people (DOHC, 2001, a). The Government (DOHC, 2001, b) also published its primary care strategy which focused on shifting the focus of care delivery from secondary and tertiary care to primary care for the majority (including older people) of the population's health care needs.

To date, the initial targets for primary care services have not been realised but rather are ongoing. The Government's 'National Action for Social Inclusion, 2007-2016' (Government of Ireland, 2007) committed to invest in community care and to provide income support for older people so that they could have a high quality standard of living. Keeping these promises may prove difficult in current straitened economic times. However, the Programme for Government 2011-2016 (Department of the Taoiseach, 2011) specifically targeted the needs of older people by its commitment to increase investment in community and residential settings and by identifying this population as a priority.

The more recent 'Healthy Ireland–A Framework for Improved Health and Wellbeing 2013-2025' (DOH,2013b) aims to improve the population's health and wellbeing through a life course approach. The framework focuses on four goals: increase the population's health, reduce inequalities, protect the population from threats to health and wellbeing, and facilitate the participation of all in society. There is specific reference to positive and healthy ageing through its emphasis on the facilitation of early adoption of healthy habits and lifestyles in life (DOH, 2013b). An important aspect of this framework is an annual survey to evaluate whether the goals and programmes are being achieved (DOH, 2015a). This is welcome as heretofore there has been a paucity of published evaluations of strategies apart from McKenna *et al's* (2005) review mentioned previously.

The concept of a life course approach is also evident in the National Positive Ageing Strategy (DOH, 2013a). The aim of which is to provide direction for policies, programmes and services for older people, enabling them to enjoy a good quality of life through promoting and planning for positive ageing (DOH, 2013a). Similar to the 'Healthy Ireland' framework, this strategy recognises that the multi-dimensional nature of health and wellbeing requires a multi-sectorial approach with planning and collaboration across voluntary and statutory organisations as well as at national and local level.

It is important that policies and strategies relating to housing, transport, financial support, health and social services, societal values and attitudes towards older people are implemented so as to maximise the potential for a positive ageing society (DOH, 2013a). Key stakeholders including the DOH, Atlantic Philanthropies, the HSE's Health and Wellbeing Division and Age Friendly Ireland have jointly agreed the 'Healthy and Positive Ageing Outcomes Initiative' (HaPAI) to monitor the implementation of the National Positive Ageing Strategy from 2014 to 2017 (DOH, 2015b).

In addition, Age Friendly Ireland (previously Ageing Well Network) through its membership of the WHO GNAFCC network is co-ordinating the 'Age Friendly Cities and Counties' programme. The aim of which is the development of communities supportive and responsive to the needs of older people (Age Ireland Friendly, 2015). The issue of ageism has been discussed previously (2.2.3) and it is acknowledged that policy and strategy decision makers recognise it as being a problem in Irish society. At national level, the "anti-ageism week" initiative developed by the Equality Authority and the Health Service Executive and supported by the Office for Older

People, the public transport sector and older people's organisations, aims to highlight ageism and its consequences in service provision (Equality Authority, 2011). Furthermore, age discrimination is addressed within equality legislation and initiatives which increase awareness and offer guidance regarding elder abuse, have been developed by the HSE and the HSE funded national centre for the protection of older people (NCPOP).

Partnership and collaboration of the various stakeholders in any of these initiatives must include the older person population through research and through public consultation with older people groups. In determining the priorities for healthy ageing, O'Shea (2006:93) appealed for "genuine partnership between older people and policy makers and to address ageism concerns". The implementation of these national policies and strategies requires a cross sectional approach and collaboration of key stakeholders including but not exclusive to the Health Service Executive (through its corporate, national service plans and national clinical programme for older people) and the Department of Health.

2.4.3 The Impact of Public Policies and Strategies upon Older Women's Ageing and Health

Public policies, strategies and planning at both international and national levels have wide reaching consequences. They affect the overall wellbeing and health of populations and not least that of older women from socio-cultural, economic and environmental perspectives. This section focuses on those that are of particular relevance to older women in Ireland including the National Women's Strategy 2007-2016; the Women's Health Council position papers/reports; HSE and National Council for Women in Ireland; the socio-economic impact of the marriage bar and incomplete pension years or lack of pension entitlements.

Lack of recognition of gender differences and lack of gender sensitive policy heretofore has had negative consequences for older women. Annandale (2009:91) asserts there has been a male bias in health research and treatment as "clinical and social epidemiological researchers alike typically have taken the male body and male experience as the 'gold standard' for the population as a whole… [and] that this is generalisable to women". Katz *et al* (2008:153) described this bias as "institutionalised prejudice" and argued that women have been discriminated against because of this. According to Saucier (2004) older women's health concerns are more likely to be trivialised or labelled as psychosomatic. This bias has resulted in incorrect assumptions being made about women's health, for example until relatively recently cardiovascular disease was synonymous with men and consequently was under researched in women (Doyal, 1995; Williams *et al*, 2003; Annandale, 2009). It is now acknowledged as a leading cause of death in women in many western countries.

Williams *et al's* (2003) Irish study examined whether there was gender bias in the prescription of secondary preventative therapies for ischaemic heart disease in primary care (n=15,590). Findings indicate that women were less likely to receive beta blockers, aspirin and ACE inhibitors but more likely to receive anxiolytic benzodiazepines. Older women do not necessarily present with the same clinical signs and symptoms as men therefore, the severity of the problem may not be recognised or they may be diagnosed as something else (The HSE and the National Women's Council, 2012). In addition, those (men and women) over 65 years were less likely to be prescribed aspirin and statins.

Williams *et al* (2003) conclude that there is both a gender and age bias and that this may lead to increased mortality in these cohorts. This report highlights the double jeopardy for older women with heart disease and is a cause for concern with serious implications for their health and wellbeing. This study is somewhat dated, however its findings are still relevant considering the longer life expectancy of older women and that 35.2% of deaths in the older population are caused by circulatory disease and specifically 16.9% of deaths are from ischaemic heart disease (DOH, 2014).

Furthermore, women are still less likely to be diagnosed with cardiovascular problems when compared with men (HSE and the National Women's Council of Ireland, 2012). Similarly, Cameron *et al* (2010) suggests that the way in which older women communicate their health problems and needs may be a militating factor in early assessment and contrasted this with how male patients tended to be quite factual in their descriptions of their health problems. Therefore, how information is elicited by health care professionals needs to be tailored to the individual and be gender sensitive.

The National Women's Strategy 2007–2016 (DJEL, 2007) outlined the Government's priorities regarding the advancement of women in Irish society. The Government's vision is "An Ireland where all women enjoy equality with men and can achieve their full potential, while enjoying a safe and fulfilling life" (DJEL, 2007: i). The strategy's 20 key objectives are clustered under three themes: equalise socio-economic opportunities for women, ensure the well-being of women and for women to engage as equal and active citizens (DJEL, 2007).

The Women's Health Council (2002) identified three specific proposals to ensure health gain for women: to focus the women's health agenda for the 21st century; to achieve national agreement on structures and procedures and to ensure gender equity in health services and initiatives. Furthermore the Women Health Council (2002) identified four priority action areas affecting women's health, namely cancer, cardiovascular disease, disadvantaged women and mother/children, all of these with the exclusion of the last, have implications for older women in Ireland**.**

The importance of a gender sensitive policy has been recognised in Ireland in recent years. The '*Equal but Different: A framework for integrating gender equality in health service policy, planning and service delivery*'' was published by the HSE and the National Women's Council of Ireland in 2012 and recommends the development of gender sensitive policy, planning and service delivery within the HSE. This welcome initiative recognises the unique health needs of men and women.

The framework set out recommendations for the HSE in developing gender-sensitive policy making, planning and service delivery. In response to this and overseen by a gender mainstreaming advisory group, resources have been published by the gender mainstreaming project including training material for HSE employees. This framework acknowledges the

interaction between gender and other determinants of health including age and highlights that older women live longer but have more health problems (HSE and the National Women's Council of Ireland, 2012). To date there is no published evaluation of the implementation of this framework and so it is difficult to determine the current situation and whether older women's care has been improved or not.

As previously discussed, there are many influences on an individual's health including socioeconomic group, income, housing, employment, ethnicity, place of residence, access to health service and gender (Naidoo and Wills, 2009). Many of these elements are interlinked e.g. if a person has sufficient income to purchase good food, lives in a well-constructed comfortable house in a safe affluent environment, has access to health care as and when needed, then the likelihood is that person will have better health overall. The opposite is also true and many of these factors can be the source of health inequalities e.g. no job, minimal income, poor living conditions and so on, may adversely affect a person's health. Older women's socioeconomic status has implications for education, income, housing, access to services, including health care; all of which impact on how older women age and how healthy they are.

There are a number of reasons why older women may have reduced incomes. The Women's Health Council (2003) identified older women as one of a number of specific groups of disadvantaged women in Irish society and stated that they were at particular risk of poverty especially those older households headed by women. The average income of older women living alone was lower compared with other households.

Furthermore, the risk of poverty for older women (whose income was 60% below the median) was 10% higher than for men in the same age bracket. Older women are more likely to be impoverished because of their increased life expectancy and also because of their increased level of ill health associated with ageing (The Women's Health Council, 2003). O'Connor and Murphy (2008:38) referring to the Pension Board review of 2006 state "women are more likely than men to have inadequate or no pension coverage" drawing attention to women's low pension coverage and the implications of this for older women.

Many older women worked full time in the home. Others may have incomplete years of service in paid employment due to the marriage bar[2] and/or taking time out to care for children and/or parent(s). They are therefore, not eligible for full contributory pensions. While it is acknowledged that the 1994 Housemaker's Scheme does allow for the disregarding of up to 20 years if caring for an incapacitated person and/or children up to 12 years when applying for the old age contributory pension (O'Connor and Murphy, 2008), many are still not eligible for full contributory pensions. According to O'Connor and Murphy (2008) women who have worked with their spouses in family business or family farms are identified as 'relatives assisting' and therefore, do not make PRSI[3] contributions and are not eligible to claim old age contributory pensions.

O'Connor and Murphy (2008) further state that the majority of older women in Ireland are completely reliant on the state pension for their income because many of these women are defined as 'qualified adults' and as such get their pension rights through their husband's contributions record and accordingly receive reduced payments as a 'qualified adult'.

[2] The marriage bars refers to policy in place in Ireland until 1973 when women employed in the public of civil service upon marriage had to resign their jobs.
[3] PRSI: Pay Related Social Insurance

Ultimately all of these factors may adversely affect older women's health (The Women's Health Council, 2003). However, it is acknowledged that there are a number of state supports for older people in Ireland including the non-contributory pension, free GP card for those aged 70 years and over, medical cards are available to the majority of older people and in addition, there are a number of allowances such as fuel, living alone allowance as well as free travel and household benefit package (electricity/gas allowance and free television licence).

Barrett and O'Sullivan (2014) explored whether the economic recession in Ireland had an adverse impact on the health and wellbeing of older people. Not unsurprisingly there were large reductions in wealth (related to house prices) but unexpectedly levels of self-reported health and wellbeing had not declined although people were less optimistic about future living standards. Suggested reasons for these findings are that older people's pensions and allowances were not adversely affected in general although there were some exceptions e.g. reductions in home help hours, and loss of telephone allowances.

However, and not discussed within this report, is how the impact of the recession on state services as a whole (such as reductions in funding) may adversely affect older people's access to and provision of health and social care services. For example, delays in admission to hospital and delays or reduced provision of post- discharge auxillary services. In addition, waiting times have increased for elective procedures and outpatient appointments as well as extended periods where patients have had to wait on trolleys (DOH, 2014), all of which impact on older women and possibly exacerbated by the fact that they are also more likely to suffer from co-morbidities.

The introduction of the universal social charge[4] and rising health insurance costs may also adversely impact older people's ability to continue to pay privately for certain services. Historically women have been placed at a disadvantage regarding their socio-economic status which has implications for their health and wellbeing. These disadvantages become more apparent as women age as there is more likelihood of increased morbidity as well as being reliant on a fixed income which if it is a contributory pension is unlikely to be a full income.

This section of the literature review explored the international influences on national policies, action plans and strategies for older people in Ireland. Government policy recognises the multifaceted nature of people's perceptions of health, their particular health needs as well as the various determinants of health. In advocating a life-course approach, Government policy acknowledges that promoting and supporting healthy lifestyles is a long-term commitment which should also facilitate positive ageing.

However, the review has highlighted the absence of a national strategic focus on identifying and providing for older women's needs and views. While it is acknowledged that a gender sensitive policy has been published, to date there has been no evaluation of this initiative. In the main, there is a generic approach to planning for health and ageing in Ireland and this does not address the specific concerns of older women including among others: increased life expectancy with increased co-morbidities, financial status and carer role. More worryingly from a health care perspective, both at international and national level, there remains a tendency to consider the older woman as 'other' to the male, whereby presentation and treatment of health problems is measured against the male perspective as being the 'gold standard'. This in itself has implications for diagnosis,

[4] The universal social charge (USC) was introduced in 2011, it is a tax on gross income and is in addition to income tax and pay related social insurance (PRSI)

treatment and support. Furthermore, the literature reported here flags the impact of public policies and strategies on older women's experiences of ageing and health related issues. These are significant and affect older women's experiences in terms of how they view themselves and how they manage and are supported to manage their age and health concerns as they age.

2.5 Chapter Conclusion

This literature review provides a context for older women's experiences of ageing and health related issues and this study, and demonstrates how gender, ageing and health interconnect to shape older women's experiences.

An overview of theories of ageing and their influence on concepts explaining the ageing process was given. These theories are not gender specific but do influence current ageing policies and strategies. However, it is argued in common with eminent scholars (Arber and Ginn, 1995; Bernard et al, 2000a, 2000b; Cruikshank, 2003; Calasanti, 2003; Holstein, 2015) that ageing must be recognised as a gendered experience. Several factors account for the lack of a specific gendered theory of female ageing. Many of the theories predate the 1990s and reflect the dominant thinking of the time i.e. the biomedical model of ageing. Furthermore, little inter-sectoral collaboration between relevant bodies such as gerontology, nursing, sociology and women's studies was a feature of work at this time resulting in silos of academic research, study and practice. This militated against a mutual sharing of ideas regarding older women's experiences (Calasanti, 2003).

The discussion on health and the meaning of health illustrates that as a concept, health is nuanced and influenced by a number of factors including health beliefs, expectations and experiences of individuals as well as wider determinants of health. This review has highlighted how interwoven the relationship between ageing and health is for older women and emphasised the multidimensional aspect of the intersection between ageing, health and gender.

The review has demonstrated the differences in how individual women perceive ageing and its subsequent effect on their health. The influence of society and its negative attitude to ageing and the ageing woman, is manifested in ageism and negative stereotyping which can have detrimental effects on older women's self-esteem, body image, health and experiences of ageing. While there are some diverse views and opinions about the ageing experience there are also commonalties such as the recurrent themes of wanting personal control of health management, to be listened to and have support through advocacy to live independently.

This review has highlighted that national strategies and policies aimed at meeting the needs of both older people in general and older women specifically are influenced by international and national organisations but also by societal and individual views on ageing. Older women do not live in isolation of the wider community. They and their health care needs and service provision are influenced by societal attitudes and views of the older population which has direct impact on policy and strategy decisions. This review has identified specific international and national policies and strategies on ageing and health. Current thinking advocates a life course approach to being healthy as one ages and emphasises the need for initiatives to promote healthy ageing.

It also reveals the impact of these policies and strategies on older women's experiences. While there have been increased calls to recognise the importance of having gender sensitive and gender specific approaches to planning for an ageing population, to date there has been a lack of a gender specific focus in many of these especially at national level. It is argued that older women's voices must be heard and their experiences should be seen as theirs in their own right and not as compared as the 'other' to the male perspective. Traditionally, the male perspective was identified as the 'gold standard' and the norm to be measured against. This indicates a lack of awareness and knowledge of the need to understand older women's particular experiences from their perspective.

Specific challenges are identified for supporting an ageing female population in respect of higher life expectancy; increased likelihood of chronic illnesses and decreased functional abilities; older women's continued role as informal care-givers as they age and having lower financial resources to meet their ageing and health needs.

In summary, the literature review has demonstrated the paucity of published research from an Irish perspective of older women's experiences of ageing and health related issues. The focus of this literature review demonstrates the interconnectedness of ageing, health and gender and the impact on the experiences of older women. It is argued that there is a lack of substantial literature exploring the older women's experience from this perspective. Three key analytical themes have been identified from the literature, namely: Ageing is a gendered experience; Interconnection of health ageing and gender, and Public policies and strategies impact on older women's experiences of ageing and health related issues. These

themes have informed the research framework and the research question, for this study, 'what are older women's experiences of ageing and health related issues in Ireland? The following chapter discusses the research methodology for this research question.

Chapter 3

Research Methodology

3.1 Introduction

This study aimed to understand older Irish women's health needs, activities and priorities as they aged. Interpretive phenomenology specifically 'the Vancouver school of doing phenomenology' (Halldórsdóttir, 2000) was chosen as an appropriate philosophy and research methodology to answer this question. This chapter explores the methodological literature to demonstrate 1) why interpretive phenomenology using the 'Vancouver school of doing phenomenology' was an appropriate choice for this study and 2) how the Vancouver School informed the research design. Sampling strategies and recruitment of participants, data collection, analysis and issues of rigour and trustworthiness are discussed in the context of this research approach. The ethical issues to be considered when recruiting and interviewing older women are also discussed.

3.2 Aims and Origins of Phenomenology

Edmund Husserl is generally acknowledged as the father of phenomenology having introduced this movement at the beginning of the 20th century as a way of "doing philosophy" (Moran, 2000). Phenomenology is described as a "style of philosophising, which emphasises the attempt to get to the truth of matters" essentially it is a way of describing phenomena as they appear to the person experiencing those phenomena (Moran, 2000:4). The aim is to understand and describe the phenomenon in its purest sense i.e. how it appears to consciousness (Moran, 2000). Therefore, a central tenet of phenomenology is to put aside

any factors e.g. religious, cultural, day-to-day or scientific thoughts or beliefs which may influence and thus change the description of the phenomena.

Phenomenology is commonly referred to as a study of the life-world or lived experience, it explores what an experience is like pre-reflectively (Laverty, 2003; Dowling, 2007). Husserl described the life-world (lebenswelt) as the "world as concretely lived" and argued that it should be the basis for all phenomenological investigation (Langdridge, 2007:23). Phenomenology as a philosophical movement and as a method of qualitative research inquiry has many different strands and interpretations (Moran, 2000).

Related but different parallel streams of phenomenology have stemmed from the works of Husserl and Heidegger and have been understood and applied in different ways by researchers in nursing and the human and behavioural sciences (Mackey, 2005). However, phenomenology is typically categorised into three schools of thought: descriptive, interpretive and mixed (also known as the Dutch School) (Dowling, 2004). Mixed phenomenology is described as a mixture of both descriptive and interpretive phenomenology and is guided by the work of van Manen among others (Dowling, 2004).

Table 3.1 below lists different descriptive, interpretive and mixed strands of phenomenology. It also identifies the founders of these schools of philosophy.

Descriptive Phenomenology	***Interpretive (Hermeneutic) Phenomenology***	***Mixed Phenomenology***
Husserl: *Transcendental phenomenology*	***Heidegger*** : *Primary exponent or founder of interpretive phenomenology*	***King***: *Template analysis*
Merleau Ponty, Giorgi, van Kaam, Colaizzi : *Duquesne Phenomenological Research Method*	***Gadamer*** : *Particular focus is on the art of interpretation*	***Smith, Flowers and Larkin***: *Interpretative Phenomenological Analysis (IPA)*
Dahlberg: *Life-world phenomenology*	***Ricoeur*** : *Phenomenological theories of interpretation of text*	***van Manen***: *Phenomenolgy of practice, A human science approach*
Garza: *Dallas school of phenomenology*	***Benner***: *Particular focus is interpretive phenomenology within health, illness and caring practice research*	
	Halldórsdóttir: *The Vancouver school of doing phenomenology*	
	Langdridge: *Critical narrative analysis*	

Table 3-1 Examples of descriptive, interpretive and mixed strands of phenomenology

Descriptive phenomenology focuses on 'knowing' the reality of an experience through description of the experience whereas interpretive phenomenology is focussed on identifying 'what is the meaning' of the experience through the study of being. According to Doyle (2007: 892) the aim of interpretive phenomenology is to "uncover and interpret the meaning of being in the world" and states that the meaning of the experience is a shared understanding or interpretation between the participant and the researcher as opposed to describing the experience alone.

Common to all types of phenomenology is the philosophical basis from which they originated. However, each different type has evolved in different ways for example; the Vancouver school of doing phenomenology belongs to the interpretive school of phenomenology. The following sections explore the philosophical basis of phenomenology and trace the evolution of interpretive phenomenology.

3.3 The Philosophical Basis of Phenomenology

The philosophical basis of phenomenology is grounded in the interpretive-constructivist paradigm, the underlying assumption of which is that reality is subjective and relative. A key principle of this paradigm is that truth or reality is not static and that there can be more than one truth or reality depending on different views at different times (Denzin and Lincoln, 2005). For example, people interpret life events differently from one another and so may have different perspectives about an event or an experience.

Creswell (2009) explains that social constructivists assume that people seek to understand (interpret) and ascribe (construct) meaning to the world in which they live. Therefore, knowledge viewed from this perspective is derived from people's understanding of their unique experiences (Holmes, 1990).

Consequently the aim of this type of research is to understand human behaviour from participants' point of view (Green and Thorogood, 2009). Furthermore, this knowledge needs to be considered within the socio-cultural, political and historical context of the experience i.e. the socially constructed reality within which the experience occurred (Green and Thorogood, 2009). It is acknowledged that researchers too, interpret and construct meanings from their worlds. Therefore, in interpretive research it is considered impossible to separate the researcher from the research, suggesting that knowledge can only be gleaned through shared meanings, language and consciousness (Begley, 2008).

Denzin and Lincoln (2005) indicate research using this approach enables both the researcher and the participants to co-create understandings within a natural setting. Thus the epistemology of interpretive-constructivism is about understanding different views. It is predicated on an acceptance that there can be multiple meanings constructed from people's experiences and their interpretation of these experiences. The ontology of interpretive-constructivism is that there are multiple realities and that reality is subjective and relative to individual perspectives and experiences. This thinking is appropriate to the aims of this study which focuses on understanding ageing and health from the perspective of older women.

Specifically, the aim of phenomenological research is to explore and determine the meaning of participants' experiences. This is achieved through engaging with participants and developing an understanding of the meaning of the experience (phenomenon).

3.4 Evolution of Interpretive Phenomenology

The following sections trace the evolution of interpretive phenomenology from its origins in descriptive phenomenology. It is important to first understand the shared core concepts between interpretive and descriptive phenomenology before discussing how they differ.

3.4.1 Descriptive Phenomenology

Descriptive or eidetic phenomenology is guided by the work of Husserl (Dowling, 2007). Rapport and Wainwright (2006:232) state that Husserl's transcendental phenomenology "claims to describe the way we see, clarify and determine meaning in the world". Husserl's goals are said to be epistemological, the aim being to describe or study events as they appear, so as to obtain knowledge of the phenomenon (Dowling, 2004; Lopez and Willis, 2004; Mackey, 2005; Flood, 2010).

Crotty (1996) emphasises that the aim of **descriptive phenomenology** is to describe phenomena and determine the essence of these phenomena. The aim is to describe the general characteristics of the phenomena rather than the individual experiences (Giorgi, 2008). Essence is an important concept within descriptive phenomenology and Van Manen (1990:177) describes essence as meaning "the inner essential nature of a thing, the true being of a thing….. [it] is that what makes a thing what it is (and without which it would not be what it is)". According to Langdrige (2007) a key aspect of descriptive phenomenology is to identify the essence which he terms the invariant properties of the phenomenon. While there are different strands of descriptive phenomenology (outlined in Table 3.1) (De Castro, 2003; Dahlberg and Dahlberg, 2004; Garza, 2007; Giorgi, 2008) all share certain core concepts of consciousness, intentionality and bracketing.

The concept of **consciousness** in all phenomenology is important and one of its cornerstones. Langdridge (2007) likens being conscious to being aware. According to Giorgi (2005), consciousness has to be the focus of phenomenological philosophy and that it is only through consciousness that people are open to the world. van Manen (1990) concurs arguing that human beings can only access the world through consciousness and that to be aware one must be conscious of the world or at least part of the world. Consciousness is therefore said to be the foundation of all understanding. The objective of descriptive phenomenology then is to "describe things as they appear to consciousness" (Moran, 2000:6). Another cornerstone of all phenomenology is **intentionality** and this is directly related to consciousness.

Rapport and Wainwright (2006) state that there is intentionality to consciousness, in that it is always directed at and related to something. Langdridge (2007:13) concurs, describing intentionality as referring to the fact that when people are aware or conscious, they are always conscious of something, whether that something is a "cat, another person or an idea". To set aside the natural attitude i.e. the everyday taken for granted assumptions so as to get back to the pre-reflective state, is the aim when conducting descriptive phenomenology. The phenomenon must be described "in its purest form as it occurred before being corrupted by attitudes, prejudices and other influencing factors" (Tuohy *et al* 2013:18). To do this researchers need to adopt what is a called a phenomenological attitude and focus on the uniqueness of the phenomenon (Finlay, 2008; van Manen and Adams, 2010).

The phenomenological attitude is achieved when researchers go beyond their natural attitude by suspending or **bracketing** their pre-suppositions (Cohen, 2000a; Langdridge, 2007). In order to achieve this bracketing, researchers are required to be aware of their biases and make an effort to set them aside as much as possible (Finlay, 2008). This leads to information that is epistemological in so far as it describes the experience and thus provides knowledge of the experience (McConnell-Henry *et al*, 2009). It is deemed necessary in **descriptive phenomenology** to bracket all one's preconceptions and prior understandings so as to distil the meaning of the phenomenon (Hamill and Sinclair, 2010).

Koch (1995) argues that the emphasis within descriptive phenomenology, on the description only of an experience reflects a positivist influence. Describing an experience as it occurred 'pre-reflectively' is stressed and indicates an objective approach (Koch, 1995). Within descriptive phenomenology it is only through bracketing out factors such as beliefs, knowledge, socio-cultural influences, can the meaning of an experience be isolated. However, Dowling and Cooney (2012) argue that the notion that there can only be one objective truth is at odds with current phenomenological thinking. This is particularly true of interpretive phenomenology whereby bracketing as understood from a descriptive phenomenological perspective cannot happen (Pascal *et al,* 2015).

Furthermore it is argued that all lived experience is influenced by one's background, culture, and beliefs and that similarly the researcher is also influenced by these (Langdridge, 2007; McConnell-Henry *et al*, 2009; Flood, 2010). These influences are important in sense making and interpreting the meaning of the lived experience with interpretive phenomenology.

3.4.2 Interpretive Phenomenology

Interpretive phenomenology, often referred to as hermeneutics (interpretation), is influenced by the interpretive paradigm (Dowling, 2004). The aim of interpretive phenomenology is to understand and interpret the meaning of participants' experiences. Moran (2000:197) states that with hermeneutical (interpretive) phenomenology "...the phenomena of existence always require interpretation and hermeneutics is the art of interpretation".

Interpretive phenomenology has many influences e.g. Gadamer, Habermas, Ricoeur and particularly Heidegger (McCance and Mcilfatrick, 2008). The strong influence of Heidegger on interpretive phenomenology is seen in the focus of interpretive phenomenology which is ontological (as opposed to the epistemological focus of descriptive phenomenology) and is concerned with understanding or asking for the meaning of, or interpreting a phenomenon (Mackey, 2005; Dowling, 2007). The ontologist aims "to uncover and unravel the meaning of being" and knowing (epistemology) comes through interpretation and understanding (McConnell-Henry *et al,* 2009: 10). There are a number of key philosophical concepts within interpretive phenomenology that warrant attention such as: **being–in-the-world** (dasein), **being-with-others** (mitsein), **fore-structures** (pre-understanding), **life-world existential themes,** and the **hermeneutic circle** (van Manen, 1990; Moran, 2000; Mackey, 2005; Dowling, 2007; Pascal *et al*, 2010; Pascal *et al*, 2015).There are described in the following sections.

3.4.2.1 Being-in-the world & Being-with-others: Dasein and Mitsein

Heidegger introduced the word 'Dasein' which loosely translates into the phrase 'being-in–the–world', to show that a person is not separate from the world in which they exist but is involved in that world (van Manen and Adams, 2010). Essentially throughout life people experience different situations and ascribe meaning to these experiences according to how they respond, understand and make sense of these experiences that are peculiar and unique to them (Reed and Ground, 1997; van Manen and Adams, 2010).

Furthermore, Langdridge (2007) explains that from a Heideggerian perspective, people's experiences are always in relation to others, and therefore people are always 'being-with' other people. This concept is referred to as **Mitsein.** Therefore, not only are people's experiences reflective of their being-in-the-world (dasein) but are also reflective of their relationships with others (being-with-others).

Thus both dasein and mitsein, important concepts in interpretive phenomenology can be captured in the following "being-in-the-world-with-others" (Langdridge, 2007: 32). Pascal *et al* (2010: 176) explain that "*mitsein is fundamental to our being–in–the-world. We are ultimately inseparable; there is no us and them...* [people] *...experience things in relation to other people.* This does not cease even when people are alone as *"others become conspicuous through their absence".* Even then people are still with other*s* through their relationships with them and *"through the man made things that surround us* [them]*"* (Pascal *et al,* 2010:176).

The focus of interpretive phenomenology is on exploring the lived experience and it is considered important to recognise that people's realities are influenced by the world in which they live in and their experiences are linked to social, cultural and political contexts (Flood, 2010). The researcher is seen as part of the research i.e. seen as 'being-in-the world' of the participant and the researcher's prior understanding and previous knowledge or 'fore-structure' helps interpretation (McConnell-Henry *et al,* 2009). Finlay (2008**)** states that in order to understand we (researchers) have to recognise what has influenced our understanding and view of the world.

Therefore, rather that setting these influences aside, we must bring them to the fore to be recognised as our influences and biases and through this acknowledgement be open to the other person's meanings (Walker, 2011). According to Finlay (2008) this acknowledgement of one's influences and biases is a type of reduction or bracketing, but not bracketing as understood in **descriptive** phenomenology. Therefore, as the first part of beginning to understand (as far as possible) the pre-reflective experience one must reflect on one's pre-understanding of being.

3.4.2.2 Fore-structure/Pre-understanding

Fore-structure or pre-understanding is referred to as 'prior awareness' i.e. that which is known or understood prior to interpretation (Mackey, 2005). Fore-structure stems from past experiences (Standing, 2009). Fore-structure is also referred to as fore-conception or pre-awareness. Moran (2000: 235) suggests that fore-conception is where "all our assertions and judgements are taken in the context of the background of prejudices (pre-judgements) we hold".

Nystrom and Dahlberg (2001) use the terms prejudice, pre-understanding and presupposition interchangeably and they emphasise the importance of dealing with one's presuppositions so as to remain open during the research process. Nystrom and Dahlberg (2001:340) argue that we need to "overcome our prejudices [so] that we can expand the horizons of meaning".

A central tenet of interpretive phenomenology is that the researcher is "considered inseparable from assumptions and preconceptions about the phenomena under investigation" and that these must be acknowledged and integrated into the research findings (McCance and McIlfatrick, 2008:235). According to Flood (2010) researchers cannot ignore what they know or think. This knowledge can be a valuable guide to enquiry and he (Flood) emphasises the concept of co-constitutionality i.e. meanings are a blend of both the participants and the researcher; this was what Gadamer termed as 'a fusion of horizons'. Researchers must acknowledge and outline their pre-understandings so that those reading the research are informed as to the study's aim, context and possible influencing factors.

3.4.2.3 Life-World Existential Themes

van Manen (1990) referring to phenomenological literature, in particular Merleau Ponty's work, suggests that there are four fundamental lifeworld existentials or themes to be considered which enable phenomenologists to reflect on how people experience the world. These existentials are lived space (spatiality), lived time (temporality), lived body (corporeality) and lived human relation (relationality). While these are discussed separately in the following section, it is important to remember that each has an effect on the other and together impact on people's individual experiences of being-in-the-world (dasein) and being-in-the-world-with-others (mitsein).

These are important concepts in interpretive phenomenology as people's past experiences of these can and do influence and shape present and future experiences.

Lived Space (spatiality) grounds the person in a location and refers to whether participants' experiences are brought to the fore of their attention or whether they are kept to the background (Mackey, 2005). van Manen (1990) refers to lived space as felt space i.e. the space in which we are located affects us e.g. the size and type of building, being in the city or countryside and so on. There is a difference in how we feel in the comfortable space that is our home compared to a more impersonal space such as that for work or business (Tuohy *et al*, 2013).

Lived Time (temporality) is referred to as subjective time as opposed to objective clock time (van Manen, 1990). Subjective time or lived time can seem to speed up (when we are busy or enjoying ourselves) or slow down even drag (when we are worried, bored or waiting for something e.g. an appointment). According to Mackey (2005) understanding can only be achieved if grounded in time. The experiences we have when we are children or young adults can influence how we navigate our present and future worlds. The way in which we interpret or ascribe meaning to events that occur at a particular time in our lives may influence understanding or perceptions e.g. positive experiences of education or the health care system may positively influence our views of these services as an adult or vice versa (Tuohy *et al*, 2013).

According to van Manen (1990) **Lived Body** (corporeality) is the concept of embodiment i.e. we are always in our body. Lived body or embodiment is an important concept within interpretive phenomenology and is central to our experiences of 'being-in-the–world' and 'being-with-others'. Embodiment not only encompasses the biological and capability aspects of the body but also how people through their bodies interact with the world in which they live (Merleau-Ponty, 1962; Csordas, 1999; Dreyfus & Dreyfus, 1999).

This world is shaped by wider environmental, socio-cultural, politico-economic factors and also by how people through objective (biological) and subjective (personal moral, beliefs and values systems) of their 'bodies' respond to their world. People's experience of the world is peculiar and specific to each person because of their individual objective and subjective bodies. When we meet people, we (them and us) both reveal and conceal something about ourselves, both consciously and unconsciously. van Manen (1990) states that one's body can change because of an encounter with another e.g. become animated, awkward, self-conscious etc.

Lived Human Relation (relationality /communality) is "the lived relation we maintain with others in the interpersonal space that we share with them" (van Manen, 1990:105). This relationality or relationship we have with others includes how all of us in a communal sense experience our world. It is through our relationships with others in our communal world that others influence our experiences and we in return influence theirs (Tuohy *et al*, 2013). In particular this life world existential has resonance with mitsein (being-with-others) and how the presence and even absence of others impact on people's individual experience.

3.4.2.4 Hermeneutic Circle

Within interpretive phenomenology, both the researcher and the participant engage with and interpret the experience and ultimately identify the meaning of the experience, this process of interpretation is achieved through the use of the hermeneutic circle. According to Dowling (2007: 134) Heidegger believed that "understanding is a reciprocal activity and proposed the concept of the "hermeneutic circle" to illustrate this reciprocity" (**Figure 3.1**).

This concept is described as a circular process where fore-structures are made explicit and are considered in context of the whole understanding of something and may then be reconsidered in new ways (Dowling, 2007). Rapport and Wainwright (2006:233) describe the hermeneutic circle as "the manner in which interpretation through understanding is achieved by the circular process of continuous re-examination of propositions" i.e. the aim is to ask relevant questions of these interpretations so as to ascertain the meaning of being.

This process involves back and forth questioning which leads to an expanding circle of ideas known as the hermeneutic circle and through the use of this hermeneutic circle, the researcher tries to discover the true meaning of the experience (McConnell-Henry *et al*, 2009). Koch (1996) explains that the hermeneutic circle requires the researcher and the participant(s) to engage in a dialogue e.g. the research interview so as to explore and understand the participant's experience. Understanding occurs when the researcher and the text (the participants) meet through dialogue and openness about the meaning of the experience (McConnell-Henry *et al.* 2009). This interpretation and understanding [of the experience] is referred to as a fusion of horizons (Koch, 1996).

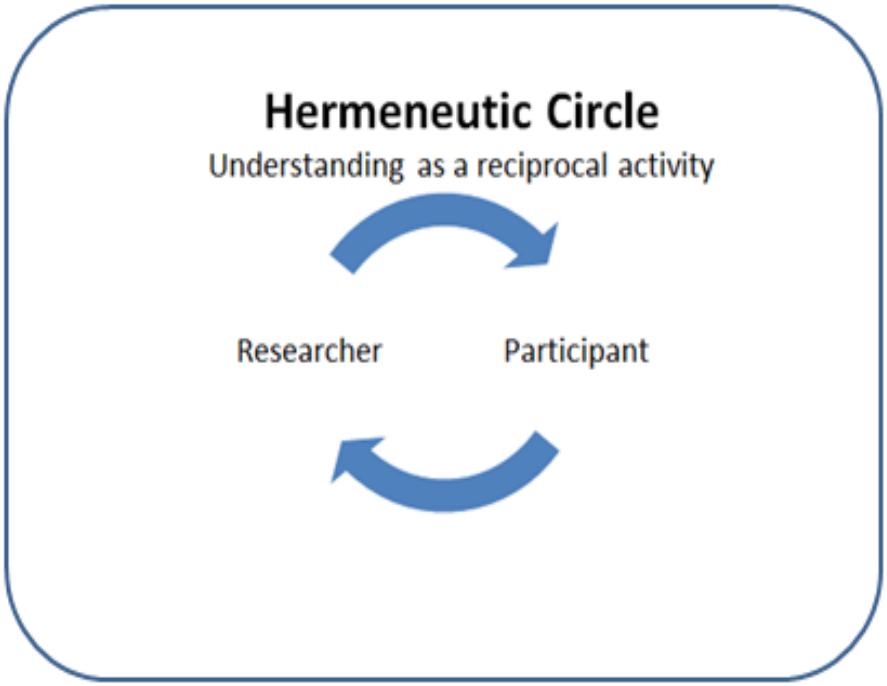

Figure 3:1 Hermeneutic Circle

To summarise, the aim of interpretive phenomenology is to understand and interpret lived experience so as to ascertain the meaning of being. Essentially "it is through accessing lived experience that researchers may gain understanding of the meanings and perceptions of another person's world" (Pascal *et al*, 2010:175).

Interpretive phenomenology as a movement is strongly associated with Heidegger but has many influences including Gadamer, Ricoeur, and more recently Halldórsdóttir. Core philosophical concepts of interpretive phenomenology include dasein (being-in-the-world), mitsein (being-with-others), fore-structures/pre-understandings (the need for researchers to

acknowledge and bring to the fore their knowledge, biases and influences of the experience), the life-world existentials (including: lived body (corporeality, embodiment), lived time (temporality), lived space (spatiality) and lived human relations (relationality), and the hermeneutic circle (which recognises that interpretation occurs from the perspective of both the researcher and the participant via a cycle of understanding).

3.5 Appropriateness of Interpretive Phenomenology for This Study

It is argued that an interpretive phenomenological approach is suitable for the study as a central premise of this philosophy and research approach is to understand and interpret participants' experiences. It is an appropriate choice as its focus is compatible with this study's aim i.e. to explore the reality of older women's experiences of ageing and health related issues and to understand what these experiences mean to them within the context of a changing body, specific times, places and relationships that are peculiar to these women. Interpretive phenomenology as a research approach is typically used in studies which want to answer questions about meaning, according to Cohen (2000a:3) "this method is most useful when the task … is to understand an experience as it is understood by those having it".

Over the last twenty years or so, interpretive phenomenology has been used in health related research when the aim has been to understand the meaning of patients' and health care professionals' experiences of illness and caring. Through this understanding, nurses and other health care workers can respond and provide appropriate care to meet these needs.

Similarly in this study through understanding the participants' experiences it can be determined what their needs and support requirements are, if any. According to Mackey (2005:183) "the researcher must situate themselves, the participants and their experiences in time and so reveal the experience of time, in the search for ontological understanding". Therefore, through the exploration of existential themes of lived space, lived time, lived body and lived human relation previously described are considered important in this study in a number of ways.

Older women's '**lived space'** needs to be considered as it can influence their experience of ageing and related health issues. For example, the type of house that one lives in may prove challenging when one is ageing and may have co-morbidities e.g. size, type and age of the house may impact on maintenance and heating. Living alone or sharing may affect one's sense of safety and security. Older women's ability to mobilise safely will impact on whether their lived space has shrunk (confined to home) or remained the same (ability and wherewithal to get out and about).

'**Lived time'** may drag if they are unable to manage everyday activities or participate in events or organisations. They may also feel bored because they may not have as many commitments as previously, alternatively they may feel pleased with the prospect of having more time for themselves. They may feel this is a time for remembering their past lives and perhaps a time for introspection. All of which may impact on their experiences of ageing.

'Lived body' is affected by the ageing process and by co-morbidities. The effects of ageing and health related conditions may negatively impact on older women's body image and their sense of self. Altered body image may result from the obvious physical changes but also may adversely impact on their ability to do what they used to do e.g. household chores, self-care, drive a car etc. Therefore they may need to adjust their activities and their expectations of what they can or cannot do. Essentially older women's view of themselves as capable independent women may be fundamentally altered and this new reality would need to be accommodated.

Furthermore, **'Lived human relations'** may reflect changes in relationships with family and/or friends due to death or changed living arrangements e.g. living alone or with extended family as well as the possibility of caring for grandchildren or dependent family members. These changes may impact on older women's sense of their role in the family or within friendships. It may lead to feeling of being valued or conversely not being valued leading perhaps to feeling of isolation and loneliness.

Interpretation is acknowledged as a crucial element of interpretive phenomenological research process and occurs from the perspectives of both the researcher and the participant. According to Alvesson and Sköldberg (2000:84) "every individual is enmeshed in her meaning-field, intentional in time and space…she is never free from pre-conceptions inherited from the past preconceived meaning" and all understanding is "coloured by emotional moods". Therefore, it is important to remember that this applies not only to the researcher but also to the co-researcher who is recounting her experience.

The meaning of the experience is explicated through negotiation between the participant and the researcher (Doyle, 2007). This is achieved through researcher-participant engagement resulting in the development of an understanding of the phenomenon through interpretation and dialogue. This study aims not only to describe but also to understand through interpretation the experience of ageing and related health issues from the perspective of older women. A descriptive phenomenological approach with its focus on the description of the pre-reflective experience without acknowledging influencing factors such as beliefs, knowledge, socio-cultural issues will not facilitate this. Therefore, an approach i.e. interpretive phenomenology, which recognises and acknowledges the subjective nature of researching people's experiences, is appropriate for the purpose of this study. This approach emphasises the interpretive nature of the research process and how it is through this that the meaning of the experience can be understood.

Within interpretive phenomenology there are different philosophical and research strands and there are several options available to choose from including those drawing on Heideggerian principles, those influenced by Gadamer, Ricoeur or Benner, Langdridge's critical narrative analysis and Halldórsdóttir's Vancouver school of doing phenomenology. The next section explains why the Vancouver school of doing phenomenology was chosen for this study.

3.6 The Vancouver School of doing Phenomenology

This section provides an overview of the Vancouver school of doing phenomenology for this study and explains why this interpretive phenomenological approach is appropriate for this study.

3.6.1 Description of the Vancouver School of doing Phenomenology

Halldórsdóttir (2000) describes 'the Vancouver school of doing phenomenology' as both a phenomenological philosophy and a research methodology, belonging within the interpretive/constructivist paradigm. The Vancouver school of doing phenomenology is a blend of description, interpretation, explication and construction (Halldórsdóttir, 2000). The philosophical beliefs underpinning this school are that meanings make up the world and affect people's life experiences, with people deriving meanings from experiences and others in turn deriving meaning from these interpretations or constructions (Halldórsdóttir, 2000). A central tenet of the 'Vancouver school of doing phenomenology' is a commitment to studying the world from the point of view of the participants with the "production of reconstructed understandings" (Halldórsdóttir, 2000: 47).

According to Halldórsdóttir (2000:47) "the Vancouver School stands for moderate realist ontology (even if it embraces multiple co-existing realities within a subjective domain), a transactional epistemology and a hermeneutic dialectical methodology". **Moderate realist ontology** from the perspective of the Vancouver School recognises that each co-researcher (participant) experiences the world in an individual way and this is the reality of their 'being-in the-world'. Furthermore, it is understood that from each co-researcher's individual experience, a common essential structure can be elicited which captures the essential meaning of all co-researchers' experiences.

Transactional epistemology reflects the view that there is a relationship between the knower and what they know i.e. the knower cannot be separated from what they know. Within the Vancouver School, it is understood that there is a relationship and an interaction between both the researcher and the co-researcher as 'knowers' and the knowledge they have about the phenomenon.

It is recognised that both the researcher and co-researchers are influenced by their views and previous experiences of their worlds and these factors influence how they interpret and ascribe meaning to the experience being researched. The researcher, co-researchers and the experience "are interactively linked [and] the findings are literally created" (Guba & Lincoln, 1994:111) during the research process.

This knowledge and thus the meaning of the experience is distilled through a **dialectical hermeneutic methodology**. According to Halldórsdóttir (2000: 53) "the social dialogic nature of inquiry is central to constructivist thinking". Through dialogue between both the researcher and the co-researcher, and hermeneutic analysis by the researcher, the meaning of the experience is understood, specifically through processes of description, interpretation, explication and construction. Through the use of the hermeneutic circle, the meaning of a phenomenon is explicated by understanding both the parts and the whole. Within the Vancouver School of doing phenomenology each co-researcher (participant) is seen as a separate case and also as a co-researcher for that case (Sigurgeirsdottir and Halldórsdóttir, 2008). This facilitates the construction of individual cases that are in turn compared with other cases, leading ultimately to a meta-synthesis of all the case constructions in order to explicate the meaning of the phenomenon.

Essentially, the individual case constructions of the co-researchers' experiences "can be elicited and refined only through interaction between" the researcher and co-researcher (Guba & Lincoln, 1994: 111). The meaning of each individual case construction is discussed, "compared and contrasted through a dialectical interchange" (Guba & Lincoln, 1994:111).

Ultimately, through a meta-synthesis of all the individual case constructions the essential meaning of the experience is constructed (Halldórsdóttir, 2000). The perspective within dialectical hermeneutics methodology "emphasizes both the subjective meanings for individual actors and the social structures which condition and enable such meanings and are constituted by them" (Myers, 2008: 57). This approach reflects the strong influences on the Vancouver School of hermeneutics and constructivism (Sigurgeirsdottir and Halldórsdóttir, 2008: Blondal and Halldórsdóttir, 2009).

For clarity, it is important to explain two key terms used within the Vancouver School i.e. co-researcher and dialogue. The term **co-researcher** is integral to the Vancouver School; the research process is identified as collaboration or partnership between two experts. The researcher is identified as the expert in the research process and the participant (co-researcher) as the expert of their lived experience and is thus identified as a co-researcher in the research. Halldórsdóttir (2000: 53, 55) states that "research participants ...are seen as dialogue partners and co-researchers ... [and]...together they collaborate and try to make sense out of the varying profiles of the phenomenon referred to".

Dialogue is used in preference to research interview and reflects the respect afforded the co-researcher as a collaborator in the research process. Furthermore, it is in line with the hermeneutic dialectical methodology used in Vancouver School and previously discussed. According to Halldórsdóttir (2000: 60)

"A true dialogue is a subjective experience of empowering communication where the dialogue partners: confirm and value the personhood of each other; are totally free and nonselectively present to own self and to the other; feel free to speak and listen; feel listened to and heard; feel understood; and are empowered by the dialogue"

It is recommended within the Vancouver school that there is a temporal overlap with the literature review, data collection and data analysis as the construction of new themes leads to simultaneous literature search and analysis (Sigurgeirsdottir and Halldórsdóttir, 2008). However, it is acknowledged while much of this is carried out simultaneously, some further data analysis is required after all the interviews have been completed (Figure 3.2)

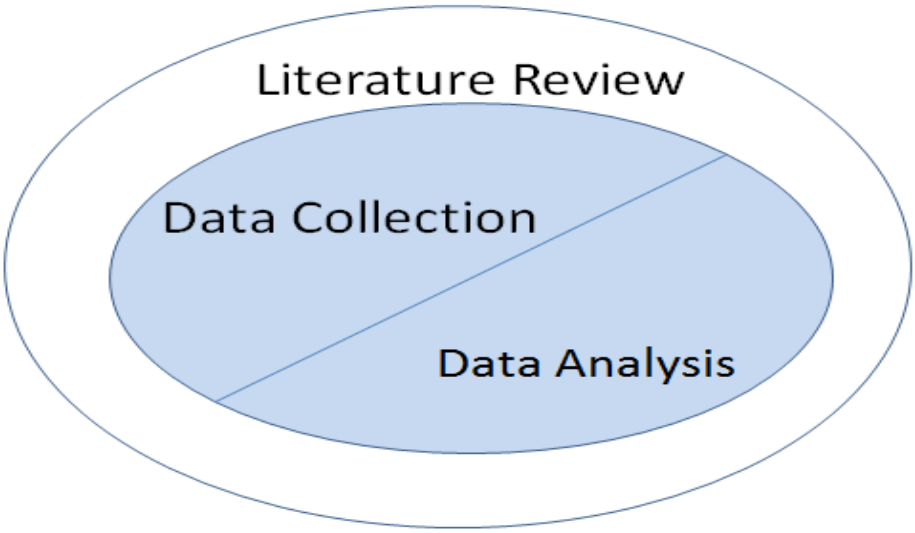

Figure 3:2 Overlapping of literature search, data collection and data analysis, (adapted from Halldórsdóttir, 2000)

Figure 3.2 demonstrates the overlap of the literature search, data collection and data analysis, illustrating the importance of ongoing reading of the literature throughout the research process from inception to completion. It illustrates how data collection is not a 'once off' but rather a prolonged engagement with data analysis. Initial dialogues (interviews) are analysed and these are then followed by further data collection. The aim of which is to verify and expand on the interpretations made about the essential meaning of the experience before a final decision is made.

Halldórsdóttir (2000) developed a framework to guide the research process comprising a number of steps (Table 3.2). Frameworks can offer some guidance on practical approaches to doing phenomenological research (van Manen, 1990).

Steps of the Vancouver School of doing Phenomenology

(adapted from Halldórsdóttir, 2000)

1. Selecting the sample
2. Silence
3. Data collection via dialogue
4. Data analysis
5. Coding through consideration of the essences
6. Individual case construction
7. Verification of individual case constructions with the co-researcher
8. Meta-Synthesis of all of the individual case constructions
9. Comparing the essential structure with the data
10. Interpretation of the meaning of the phenomena
11. Verification of the findings with some of the co-researchers
12. Write up the findings

Table 3-2 Steps to the Vancouver School of doing Phenomenology (Halldórsdóttir, 2000)

While the steps within the framework (Table 3.2) illustrate the progression from data collection, analysis to identification of the meaning of the phenomenon, the 'doing' of the research i.e. the thinking, reflecting, decision making, essentially the research 'work' is guided by a cyclic process. This cyclic process has seven stages (Figure 3.3).

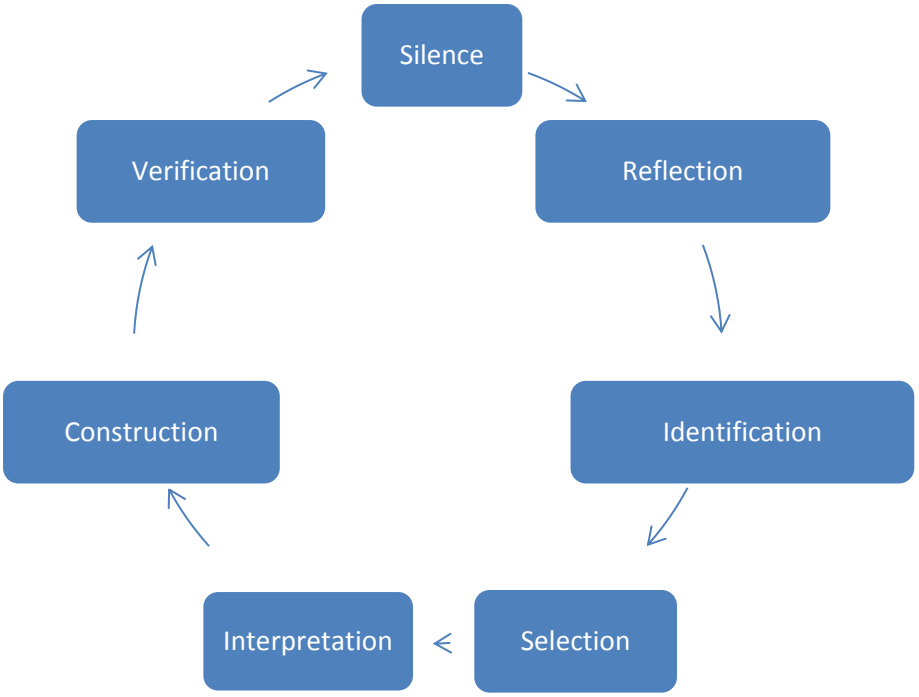

Figure 3:3 The process of doing phenomenology within the Vancouver School of doing Phenomenology (adapted from Halldórsdóttir, 2000)

These stages are entered at repeatedly throughout the twelve steps of the research process. This cyclic process facilitates the researcher to interrogate the data as well as question, defend, modify/change if needed, their interpretation and conclusions. This process ensures thoroughness and helps prevent premature conclusions being drawn (Halldórsdóttir, 2000; Blondal and Halldórsdóttir, 2009; Gudmannsdottir and Halldórsdóttir, 2009; Skuladottir and Halldórsdóttir, 2010).

3.6.2 Influences on the development of the Vancouver School of doing Phenomenology

The works of three authors are the main influences on the development of this philosophy and research approach: Spiegelberg (phenomenology, it is fundamental that the phenomenon as experienced by the participants is described); Ricoeur (hermeneutic/interpretive phenomenology, it is essential to recognise that both the researcher and the participants interpret the experience i.e. through dialogue, the researcher seeks to understand the phenomenon through interpretation of the participants' interpretation of the experience); Schwandt (constructivist, the researcher needs to make sense of their interpretation of the participant's experience and through initial individual case constructions followed by meta-synthesis of these, constructs the essential meaning of the experience (Halldórsdóttir, 2000).

Spiegelberg (1982) invoked the often used phase 'to the things themselves' when outlining the aim of phenomenology, stating its aim is to reclaim the immediate experience. In order to do this a number of steps are taken. These include investigating particular phenomena and general essences; apprehending essential relationships; watching modes of appearing; watching the constitution of phenomena in consciousness, suspending belief in the existence of phenomena and finally interpreting the meaning of phenomena.

According to Spiegelberg (1982: 712) this last stage involves hermeneutics and is seen as "an attempt to interpret the 'sense' of certain phenomena" by interpreting the phenomena and determining their meaning. Spiegelberg (1982: 716) argues that phenomenology has merit as it is an original way of looking at phenomena, stating that there is "something essentially new about the study of the stages by which phenomena establish themselves in our consciousness and gradually crystallize before our inner eye".

The notion of describing an experience and determining the meaning of this experience through interpretation as described by Spiegelberg has influenced how the Vancouver school has developed its approach of doing phenomenology (Halldórsdóttir, 2000). Halldórsdóttir (2000) explains this thinking is reflected in the Vancouver school of doing phenomenology through the emphasis placed on firstly describing people's lived experience and then through a process of questioning and interrogating the data, being open to the emerging themes within the data.

The second major influence on the Vancouver school of doing phenomenology is **Ricoeur's** work on hermeneutic phenomenology. Ricoeur (1981:114) states "the central question of phenomenology must be recognised as a question about meaning" According to Langdridge (2007), Ricoeur's work is an elaborate theory of interpretation and its primary concern is interpreting text. The aim of interpretation is to genuinely make one's own what was once alien (Ricoeur, 1981). Discourse is at the core of Ricoeur's interpretation theory and refers to spoken speech (Langdridge, 2007) e.g. the dialogue that occurs within an interview between the researcher and the participant. Geanellos (2000:113) describes research interviews as where "lived experience is expressed through language then transcribed into a text and interpreted".

Discourse is described as having a number of characteristics: it is seen as being active, as being an event; it is always temporally located; it is always about something, and "it refers to a world which it claims to describe, express or represent" (Ricoeur, 1981:133). The discourse or dialogue is recorded as text and it is this text that one aims to interpret so as to determine the meaning of the lived experience. Four core concepts need to be considered when interpreting a text; these are distanciation, appropriation, explanation and understanding (Ricoeur, 1981).

These are germane to the application of the Vancouver school of doing phenomenology. Geanellos (2000:113) describes 'distanciation' as the "distance between the self and the other…that interpretation and understanding attempt to reduce". 'Appropriation' is described by Langdridge (2007: 49) as the way in which we try to determine meaning; it is "the act of capturing the meaning being expressed by a text…through a fusion of horizons" (defined previously).

Geanellos (2000) describes 'explanation' as being what the text says, and 'understanding' as to what the text actually talks about, this understanding uncovers the meaning of the lived experience. The influence of the interpreter on interpretative decision making is critical (Langdridge, 2007).Therefore, it is important that the values, beliefs and culture of both the researcher and the participant are considered and to recognise that these need to be explored both during the data collection and analysis (Charalambous, 2008). Furthermore it is important to acknowledge the researcher's preconceptions and experiences and the influence of these on the research (Charalambous, 2008).

With regards to interpretation, Ricoeur is credited with making a distinction between two types of interpretation, a hermeneutic of empathy and a hermeneutic of suspicion (Smith *et al,* 2009) and this is relevant to the application of the Vancouver school of doing phenomenology. A hermeneutic of empathy is defined as taking the participant's insider view of the experience. The aim of which is "to grasp the understanding of the research participant" (Langdridge, 2007: 45). In contrast, a hermeneutic of suspicion is defined as "using theoretical perspectives from outside to shed light on the phenomenon" i.e. taking the outsider view (Smith *et al*, 2009: 36). Langdridge (2007:44) elaborates, explaining the researcher "seeks to understand by peeling back the layers of meaning - digging beneath the surface for what is hidden, which may lead to suspicion over the initial empathic account of meaning".

These two positions may be seen as being in opposition but it is argued that they should be viewed as a continuum. If one agrees that interpretive phenomenology requires co-constitutionality between the participant (the co-researcher in the Vancouver School of doing phenomenology) and the researcher, then both insider and outsider views must be considered and incorporated to determine the meaning of the experience.

Interpretive phenomenology requires the researcher to engage with the participants, interrogate and interpret the data, seek clarification from the participants through member checking and identify the meaning of the phenomenon through the hermeneutic circle. Of course, the researcher as the outsider must also acknowledge and attend to factors such as beliefs, attitudes, theoretical knowledge and own experiences which have influenced his/her interpretation of the data.

The importance of dialogue in the Vancouver school of doing phenomenology is evident not least in use of the term dialogue as opposed to interview per se but more particularly in how participants are seen as dialogue partners and co-researchers (discussed previously). Ricoeur believed that the hinge between language and lived experience is interpretation. Charalambous (2008) highlighted the importance of dialogue as a way of ascertaining the meaning of the lived experience. Dialogue as signifying partnership is further emphasised within the Vancouver school by the recommendation to return to the co-researchers to verify the individual case constructions (Halldórsdóttir, 2000).

According to Charalambous (2008), Ricoeur recognised that one person cannot transfer an experience as it was experienced to another as this is essentially private but rather the meaning of the experience can become known or public. It is argued that the approach within the Vancouver school of doing phenomenology, (of initially developing individual case constructions and then a final meta-synthesis of these different case constructions) is aimed at making known publicly the meaning of the

lived experience (Halldórsdóttir, 2000). In order to do this, the researcher "must learn the art of being open and receptive to that which he or she is trying to understand" (Halldórsdóttir, 2000: 53). In this way the researcher can engage with the data by thinking beyond one's preconceptions (albeit acknowledging them) and "see the world afresh through the co-researcher's eyes" (Halldórsdóttir, 2000:53).

The third major influence on the development of the Vancouver school of doing phenomenology is **Schwandt's** work on constructivism. Schwandt (1994:118) argues that both constructivists and interpretivists aim to understand, through interpretation, the "complex world of lived experience from the point of view of those who live it"; this interpretation involves constructing "a reading of these meanings". According to Schwandt (1994) constructivists believe that truth and knowledge are created by the mind and are the result of perspective.

Therefore, there are different versions of the world or truth depending on different interpretations within particular contexts. Schwandt's influence on the Vancouver school of doing phenomenology is evident in its aim to produce "reconstructed understandings" of the phenomena being explored (Halldórsdóttir, 2000: 47). This is done through initial individual case constructions and then through a meta-synthesis of all of the case constructions explored (Halldórsdóttir, 2000). The essential structure of the experience can be constructed. This is captured in an over-riding theme which is recognisable by all co-researchers as capturing the meaning of their experiences.

3.6.3. Research application of the Vancouver School of doing Phenomenology

In the last decade or so, the Vancouver school of doing phenomenology has gained some prominence and a number of studies have been undertaken using this approach. Many of these research studies have been undertaken in Nordic countries in particular Iceland and the developer, Dr. Sigridur Halldórsdóttir has been a researcher on a number of these studies. Most of these studies have researched the experience of health or illness from the perspective of patients.

An analysis of studies using this design (See **Appendix 2**) revealed that this approach was used to study patients' experiences of living with chronic or life threatening conditions (e.g. pain, cancer, diabetes, osteoarthritis, end of life), being autonomous and self-caring. In particular a number of studies have explored older people's experiences of: undertaking physical activity, chronic pain and end of life care.

Crucially all of these studies highlight the centrality of the co-researcher to the research by emphasising the importance of listening for and hearing the voice of the co-researcher both in the dialogue (interview) and within the findings through the inclusion of a multi-voiced text. Underpinning all of these studies is the core concept within the Vancouver school of doing phenomenology of valuing and respecting the participant as a co-researcher and an expert in their own experience.

3.6.4 Appropriateness of the Vancouver school of doing Phenomenology for current study

The Vancouver school of doing phenomenology is particularly suited to this study because the aim of this school of philosophical inquiry is "the production of reconstructed understandings…and a commitment to the study of the world from the point of view of the interacting individual" (Halldórsdóttir, 2000:47). This is an important concept as regards the study, as the primary aim is to understand the older women's unique experiences of ageing and health related issues within the context of their specific individual lives. The Vancouver school of doing phenomenology has been chosen for a number of reasons.

Primarily it is a way of systematically explicating human experiences (Halldórsdóttir, 2000) and according to Petursdottir *et al* (2010) researchers can increase their understanding of human experiences using this approach. In this sense it is suited to the current study as the aim is to develop an understanding of older women's health related issues within the context of their experiences of ageing and from this, identify what their needs and supports are. In section 3.6.3 above, it is clear that the Vancouver school of doing phenomenology has been used in studies with a similar focus i.e. experiences of health related issues.

The moderate realist ontology and transactional epistemology of the Vancouver school (3.6.1.) is an excellent 'fit' for this study. It values and recognises that for each co-researcher their reality, their 'being-in-the-world' is particular and individual to them. Furthermore, there is the conviction that an essential structure or meaning of older women's experiences of ageing and health related issues can be constructed from studying all individual case constructions. Through this reconstruction, the meaning of their lived experience can be articulated.

The Vancouver school of doing phenomenology is a holistic and humanistic methodology (Sigurgeirdottir and Halldórsdóttir, 2008) and its hermeneutic dialectical methodology (3.6.1.) speaks to this. This is reflected in the commitment to the participant's point of view and an appreciation that individual experiences are a reality for those that live them (Karlsson *et al,* 2008; Skuladottir and Halldórsdóttir, 2010). Participants are respected as experts in their own experiences and as such are regarded as co-researchers within the research process (Sigurgeirdottir and Halldórsdóttir, 2008; Gudmannsdottir and Halldórsdóttir, 2009). In this way the Vancouver school of doing phenomenology is suitable for this study as respecting the person is critical in older person's research.

A frequent criticism of older people research is that research is done on older people rather than with them (Fudge *et al,* 2007; Walker, 2007). Increasingly, the active involvement of older people in research has been advocated as a means of empowering older people (Walker, 2007; Doyle, 2007). Respect for the participants is reflected in the interview research approach. Co-researcher empowerment is fundamental to the research process, therefore, it is important that the co-researcher feels comfortable and free to speak, feels listened to and feels understood (Halldórsdóttir, 2000). This is primarily achieved by developing trust and a rapport with the co-researcher.

The Vancouver school of doing phenomenology allows opportunities for co-construction of the meaning of the phenomenon through verification with the co-researchers of individual case constructions and the development of a meta-synthesis of all case constructions (Blondal and Halldórsdóttir, 2009; Gudmannsdottir and Halldórsdóttir, 2009). In this way the older woman's voice is valued. It is argued that active engagement

by older people through dialogue enriches the research as it is "based on older people's interpretations of their own lives and experiences and the researcher's" (Walker, 2007: 482). The Vancouver school of doing phenomenology emphasises that the collaborative nature of the research process is crucial as the aim of its philosophical inquiry is "the production of reconstructed understandings…and a commitment to the study of the world from the point of view of the interacting individual" (Halldórsdóttir, 2000:47).

A core aspect of the Vancouver school of doing phenomenology is to contribute to increasing the social good (Halldórsdóttir, 2000). Endeavouring to do this, through dissemination of the research findings, is an important way of respecting the co-researchers for their commitment. Therefore, this study's findings will be made known to health service providers, policy makers and educators through publications and presentations.

3.7 The Vancouver School of doing Phenomenology Framework

This section discusses the methodological considerations which informed and guided the implementation of the Vancouver school of doing phenomenology for this study. The Vancouver School of doing phenomenology framework comprises twelve steps these are described and discussed here. Chapter 4 discusses the research process and the implementation of the Vancouver school of doing phenomenology for the study.

3.7.1 Sample selection: Step 1. Selecting dialogue partners

The aim in interpretive phenomenological research sampling is to identify participants "who offer a picture of what it is like to be themselves as they make sense of an important experience" (Steeves, 2000a:50). The aim therefore, is to recruit people who have experienced the phenomenon being studied and who are willing to discuss their experiences. Purposive and snowball sampling are appropriate sampling strategies for phenomenological studies (McCance and Mcilfatrick, 2008).

Purposive sampling targets participants who have information relevant to the topic under study (Joyce, 2008). McCance and Mcilfatrick (2008) state snowball sampling enables the researcher to identify potential participants who are thought credible by other participants. They are recommended on the basis that they are able to provide specific information on the topic. Generally sample sizes in phenomenological studies tend to be in the single or low teen figures (Steeves, 2000a). Halldórsdóttir (2000) broadly recommends from five to fifteen people with two dialogues or interviews per co-researcher, however, she does emphasise it is not always as simple as this.

Essentially the number of dialogues is dependent on when "a richness of data has been reached and a clear picture of the phenomenon has been formed in the researcher's mind, which depends on the aim of the study and upon the researcher" (Halldórsdóttir, 2000: 58). The sample should comprise of those who have experienced the phenomenon and in an effort to avoid homogeneity, it is important to seek out individuals "who have both typical and atypical experience" of the phenomenon (Halldórsdóttir, 2000: 58).

3.7.2 Preparation for Data Collection: Step 2. Silence (before entering a dialogue)

Preparation for data collection is an important step in the research process. According to Halldórsdóttir (2000) reflective silence is important in phenomenological studies as the researcher needs to consider the phenomenon under investigation. This silence facilitates the researcher to think about their own preconceptions and understanding of the topic and to prepare them to hear and listen to what the co-researcher has to say.

Part of this preparation is the expectation within the Vancouver school of doing phenomenology that the researcher has read widely on the phenomenon so as to have a broad frame of reference from which to listen to the co-researcher's experiences rather than having in their own mind a "narrow preconstruction of the phenomenon" (Halldórsdóttir, 2000:59). According to Green and Thorogood (2009:271) being familiar with the literature on the topic being studied is essential for "insightful analysis".

3.7.3 Data Collection: Step 3. Participating in a dialogue

Within the Vancouver school of doing phenomenology framework, data is collected through interviewing the co-researchers (these interviews are referred to as dialogues). According to Halldórsdóttir (2000: 60) "true dialogues… [are] a subjective experience of empowering communication". This experience entails being conscious of one another's personhood, being free to speak, to listen, to feel listened to, to feel understood and empowered.

The aim of the dialogue for the researcher is to understand the co-researcher's experience and to 'build a bridge' of understanding to the co-researcher's world and from this and the researcher's analysis make the phenomenon accessible to those that want to understand it (Halldórsdóttir, 2000). Dialogues between the co-researcher and researcher reflect the principle of collaboration within the

Vancouver school of doing phenomenology (Magnusdottir, 2005; Sigurgeirsdottir and Halldórsdóttir, 2008; Blondal and Halldórsdóttir, 2009) with both parties being recognised as experts; the co-researcher as expert of their particular lived experience and the researcher as expert because of his/her research knowledge and experience (Halldórsdóttir, 2000). This emphasis on dialogue has important implications for how interviews are conducted in this type of study.

Kahn (2000a) explains that the elicitation of narrative data is important in interpretive phenomenological research to ensure that an understanding of the participants' experiences may be developed. Facilitation of this narration by the researcher through in-depth interactive interviews is integral to interpretive phenomenological research (Kahn, 2000a).

This type of interview is congruent with data collection using the Vancouver school of doing phenomenology as it enables the co-researchers to recount their experiences by being encouraged to speak freely, be listened to and feel understood (Halldórsdóttir, 2000). Benner (1994) recommends that interviews are conducted in a conversational style as this helps the participant narrate their personal experiences through 'storytelling'. Kahn (2000a:61) agrees, arguing that "a conversational type interview which is not tightly structured and in which the researcher listens rather than controls the interview best achieves this aim" (Kahn, 2000a:61).

Halldórsdóttir (2000) advocates initially using broad questions which concentrate on hearing the co-researchers' story of their experiences. Further questions are asked in response to the co-researchers' descriptions. A topic guide to trigger these broad questions is useful in facilitating in-depth interactive interviews as opposed to a list of tightly structured questions (Kahn, 2000a; Smith *et al* (2009). In addition, making

field notes after the dialogues are “invaluable in writing about the context of the findings, allowing detailed description of the circumstances surrounding the specific lived experiences studied” (Kahn, 2000a:68).

As the researcher is the research instrument, a number of issues are identified as relevant to the interview process including empathy and the use of self (Bulpitt and Martin, 2010). Being empathic helps achieve the aim of the research as the researcher tries to understand the participants’ world through checking and clarifying understanding with them (Bulpitt and Martin, 2010).

Being the research instrument enables the researcher to guide and facilitate the interview through in-depth discussion and clarification of any misunderstandings (Gijbels and Burnard, 1995). Within the Vancouver school of doing phenomenology, co-researchers are encouraged when answering questions to express themselves freely (Petursdottir *et al* 2010). The dialogue requires the researcher to be attentive not only to the phenomenon being discussed but also to the co-researcher and demands total concentration on the part of the researcher, involving discussion of views and points with the co-researcher.

The respect accorded the co-researcher is reflected in how the researcher conducts the interview. The researcher must be sincerely attentive to the co-researchers both as a person and also to his/her experience (Halldórsdóttir, 2000). According to Benner (1994) when the researcher displays a genuine interest in the participant’s experiences, the participant is empowered to tell his/her story. A rapport needs to be developed between the co-researcher and the researcher so as to make the experience as non-threatening as possible and to elicit information from the co-researchers (Roberston and Hale, 2011).

Furthermore, the development of a rapport with co-researchers displays an interest in their stories and experiences. Integral to conducting a successful interview is the possession of appropriate interpersonal and interviewing skills (Moule and Goodman, 2009).The use of both verbal and non-verbal prompts such as silence, head nods, eye contact, tone, pitch are used to facilitate and encourage discussion. The use of open ended questions facilitates the discussion of new topics raised during the course of the interview (Walker, 2011). Benner (1994: 111) also recommends that "engaged active listening leads to probes to clarify whether understanding has occurred". In line with the Vancouver school of doing phenomenology framework and in an effort to "increase the depth of data collection", Sigurgeirsdottir and Halldórsdóttir (2008: 386) recommend that in some situations the co-researchers should be interviewed more than once.

3.7.4 Data Analysis

The aim of hermeneutic phenomenological analysis is to provide "a thick description that accurately captures and communicates the meaning of the lived experience for the informants being studied" (Cohen *et al*, 2000:72). The following steps of the Vancouver school of doing phenomenology, from four to eleven inclusive address how the data is analysed and includes coding and verification of themes.

Step 4 Sharpened awareness of words (data analysis): In line with the Vancouver school of doing phenomenology framework, data collection and data analysis occurs simultaneously for much of the research process (Halldórsdóttir, 2000). There is of course, a final stage of analysis and this is described as "a period for bringing final order into previously developed ideas" (Halldórsdóttir, 2000: 62). The data analysis begins with the researcher reading and re-reading the transcripts so as to get feeling for the experience. This requires the researcher being open to what is being

said and requires a considerable amount of time (Halldórsdóttir, 2000). It is recommended that notes are not made at this stage but rather the researcher should immerse him/herself in the data by "listening attentively to the dialogues and reading the transcripts attentively" (Halldórsdóttir, 2000:62).

Step 5 Beginning consideration of the essences (coding): The aim of this step is to identify the meaning of what the co-researcher is saying and this is done through a coding system of which there are two elements. The first requires the identification of the co-researchers' key statements regarding the phenomenon being studied. This facilitates the second element where the themes of the key statements are identified and then coded (Halldórsdóttir, 2000). Essentially the aim is to identify the meaning of what the co-researcher is saying.

Step 6 Constructing the essential structure of the phenomenon for each case (individual case construction)*:* This step requires the development of individual case constructions. It is achieved through grouping the various themes within each case construction and "constructing the essential structure of the phenomenon for each dialogue partner" through the researcher's thought processes such as "reasoning, intuition and introspection" (Halldórsdóttir, 2000: 63, 64).

Each case construction must reflect the individual lived experience of the individual co-researcher. Halldórsdóttir (2000:63) describes this phase as "drawing up a conceptual picture of the phenomenon in the way [the] co-researcher has experienced it". It is advised that within each case construction that the different concepts are identified and it is shown how they relate to each other (Halldórsdóttir, 2000).

Step 7 Verifying the single case construction with the co-researcher: Halldórsdóttir (2000) acknowledges that the researcher will have been influenced by their own preconceptions and that their choices will be selective. This is recognised and therefore, it is advised that individual case constructions should be verified with the co-researcher because the co-researcher's individual experience has been constructed by the researcher through the analytical process.

This verification process can be facilitated by a second interview with the co-researchers. In addition, following an examination of the first interview transcripts, a second interview can be useful to facilitate clarification of points, provide opportunities to ask an obvious question which may have been inadvertently omitted earlier and to explore points raised in the first interview in more depth (Benner, 1994).

Step 8 Constructing the essential structure of the phenomenon from all of the cases: This requires the "meta-synthesis of all the different case constructions" (Halldórsdóttir, 2000:64). This is achieved through the comparison of different dialogues (interviews) so as to determine the commonalities and the differences and ultimately bring to consciousness what the phenomenon is, what its essential structure is. The aim of this step is to understand what the phenomenon is i.e. what is the actual lived experience. According to Halldórsdóttir (2000) the meaning of the phenomenon is constructed through the use of the hermeneutic circle firstly in the individual case constructions and secondly in the meta-synthesis of all the cases.

Step 9 Comparing the essential structure with the data. Once the essential structure has been identified: According to Halldórsdóttir (2000) it is important to compare the 'essential structure' with the actual data (the transcripts) and see if it 'fits'. Questions which guide this process include: seeing if all the themes are accounted for, should they all be included or should some be excluded?

Steps 10 and 11 Identifying the over-riding theme which describes the phenomenon (interpreting the meaning of the phenomenon) and Verifying the essential structure (the findings) with some research participants: According to Halldórsdóttir (2000) the aim of this step is to identify one over-riding theme which interprets the meaning of the phenomenon, it should be able to describe and reflect the meaning of the phenomenon from the view of those who have lived it. This process of interpretation is likened to an art and the time required for this step should not be underestimated (Halldórsdóttir, 2000).

Halldórsdóttir (2000) recommends that the findings should be shown to some of the co-researchers to see if they recognise their own experience from the analytic description of the phenomenon. Halldórsdóttir (2000) acknowledges that it is important to recognise the final analysis of the phenomenon is a composite of a number of case constructions analysed by the researcher so it may not be reflective in a narrow way of individual experiences but rather it should be broadly reflective of the co-researchers' experiences.

Step 12 Writing up the findings

The final step of the Vancouver school of doing phenomenology is the write up of the findings. Halldórsdóttir (2000) states it is important when writing up the findings that all involved have their voices heard and accordingly the findings must be constructed as a 'multi-voiced text'.

This incorporates directly quoting the co-researchers in an attempt to tell the story of co-researchers' experiences so as to illustrate what the phenomenon is.

3.7.5 Trustworthiness and Rigour of the Study

The concept of trustworthiness is typically discussed in relation to the rigour of qualitative research. According to de Witt and Ploeg (2006:227) "criteria of rigour are necessary to ensure an accountable, systematic and high-quality research methodology". While it acknowledged that there is considerable debate about how rigour may be addressed within interpretive phenomenology (de Witt and Ploeg, 2006; Pereira, 2012), what is of central importance is that "a phenomenological study must take into consideration methodological congruence (rigorous and appropriate procedures) and experiential concerns that provide insight in terms of plausibility and illumination about a specific phenomenon" (Pereira, 2012:19).

While the Vancouver school of doing phenomenology does not offer a specific framework for ensuring the trustworthiness of a research study, Halldórsdóttir (2000:71) describes Lincoln and Guba's (1985) guidelines "for ascertaining truth value, applicability, consistency and neutrality" as being helpful in determining the trustworthiness of a study's findings. Furthermore, Blondal and Halldórsdóttir (2009) identify that the Vancouver school of doing phenomenology has a number of 'inbuilt' aspects within the various steps of the research framework which assist in ensuring the trustworthiness of a research study. These include several readings of the interview transcripts, comparing themes and concepts with each other, and verification with the co-researchers of the findings.

According to Magnusdottir (2005:265) trustworthiness is ensured when using the Vancouver School of doing phenomenology by using "audit trails, reflective journals, reflective silences, disciplining of preconceptions, member checks, constant comparison and selection".

The following criteria capture how rigour and trustworthiness are ensured within the Vancouver school of doing phenomenology: dependability/ auditability/ consistency; confirmability/ neutrality; transferability/ fittingness/ applicability, credibility/ truth value, and reflexivity (Lincoln and Guba, 1985; Sandelowski, 1986; Halldórsdóttir, 2000; Magnusdottir, 2005; de Witt and Ploeg, 2006; Blondal and Halldórsdóttir, 2009; Moule and Goodman, 2009). Using these criteria, this section discusses the trustworthiness within the Vancouver school of doing phenomenology and demonstrates the efforts which need to be made to ensure rigour.

3.7.5.1 Dependability/Auditability/Consistency

Auditability and dependability of a study is "concerned with the consistency of the findings if the research is replicated" (Sin, 2010:307). It is ascertained if readers of the study can clearly follow the researcher's decision trail (Sandelowski, 1986), this can be demonstrated through keeping meticulous records of data collection and analysis.

Sigurgeirsdottir and Halldórsdóttir (2008) referring to the Vancouver school of doing phenomenology, recommend keeping a reflective journal to help provide an audit trail in which thoughts, reflections and the use of verbal and non-verbal expressions during the dialogues (interviews) are noted. Lincoln and Guba (1985) state that there are two main auditing tasks within naturalistic inquiry, namely examining the process of the research study to determine dependability (examining the appropriateness of the decisions made and the extent to which data has been explored) and secondly to examine the 'product', that is the findings and recommendations so as to determine confirmability.

3.7.5.2 Transferability/Fittingness/Applicability

According to Sin (2010:307) fittingness is "concerned with the applicability of the findings in other contexts", that is the degree to which these findings can be used within other situations. Transferability may be achieved if the representation of the data is recognised by prospective readers as meaningful and applicable in terms of their own experiences and settings (Kahn, 2000b). Transferability judgements are made possible if the researcher provides a sufficiently thick description of the data through the inclusion of the widest possible range of information (Lincoln and Guba,1985) but ultimately the decision as to the transferability or not of the findings lies with the reader (Graneheim and Lundman, 2004).

3.7.5.3 Credibility/Truth Value

Credibility reflects the accuracy and believability of the data collected (Parahoo, 2014). Sin (2010) states it is concerned with the truth aspect of the findings. Readers of the research must be confident that the data provided is "a true representation of the participant's view, experience or belief" (Moule and Goodman, 2009:188) and in the Vancouver school of doing phenomenology, it is emphasised that the findings represent the co-researchers through presenting a multi-voiced text through inclusion of direct quotations (Halldórsdóttir, 2000; Karlsson *et al* 2006).

In this sense the credibility of the study can be judged by readers of the research (Sigurgeirsdottir and Halldórsdóttir, 2008). Member checks are advocated for adding to the research's credibility whereby the researcher returns to the participants to check out their interpretations and to determine whether these themes/reconstructions of the experiences are recognisable to the participants (Lincoln and Guba, 1985; Kahn, 2000b; Doyle, 2007).

Adhering to the iterative processes of the Vancouver school of doing phenomenology ensures credibility whereby there is engagement with the co-researchers at several stages during data collection and analysis in order to verify that findings capture the meaning of their experiences. Credibility is further enhanced by rechecking the data to ensure that the conclusions being drawn are correct.

Using the hermeneutic circle helps ensure trustworthiness. By avoiding premature closure on data interpretation, it challenges the researcher to examine the data several times and to modify and change as appropriate by "returning repeatedly to the transcripts and the constructions for rereading and modifications" (Magnusdottir, 2005:265). This is enhanced by the verification and validation processes discussed above as there is an opportunity to clarify, elaborate or explore new areas identified from the data analysis of both interviews and the findings summary.

3.7.6.4 Confirmability/Neutrality

Sin (2010:307) defines confirmability as being concerned that "the findings are not a function of the biases and motives of the researcher". Within interpretive phenomenology it is recognised that the researcher's assumptions, pre-conceptions and biases cannot be set aside rather they are "clarified and becomes an integral part of the study's findings" (de Witt and Ploeg, 2006:222). Confirmability refers to the level of agreement by experts and/or participants with the researcher's interpretation (Parahoo, 2014) and according to Sigurgeirsdottir and Halldórsdóttir (2008) participants should be consulted with during the analysis phase to ensure confirmability. Specific steps within the Vancouver school of doing phenomenology framework speak to this (steps: 7, 9 and 11). The findings are a meta-synthesis of all of the individual case-constructions and therefore, aim to capture the essential meaning of the experience which is recognisable and has resonance for the co-researcher.

Verification and member checking are important in addressing the confirmability of the research findings and have been discussed in the section on credibility. According to Lincoln and Guba (1985) an assessment of confirmability should ensure that the research findings are grounded in the data. According to Moule and Goodman (2009) audit trails are closely linked with confirmability and demonstrate the decisions and actions taken within a study. Confirmability is ensured when issues of credibility, transferability and dependability have been addressed (Koch and Harrington, 1998).

3.7.5.5 Reflexivity

Reflexivity is described as "the process in which researchers are conscious of and reflective about the ways in which their questions, methods and very subject position (as white/black, middle class/working class, heterosexual/homosexual, insider/outsider, etc.) might impact on the ... knowledge produced in a research study" (Langdridge,2007:58, 59) Having a reflexive approach allows researchers to "call upon their own subjective experiences" (Pascal *et al*, 2015: 3) so as to recognise how these impacted on the research process (Langdridge, 2007).

Reflexivity is an important concept within the Vancouver school of doing phenomenology (Halldórsdóttir, 2000; Sigurgeirsdottir and Halldórsdóttir, 2007; Blondal and Halldórsdóttir, 2009; Gudmannsdottir and Halldórsdóttir, 2009). It is crucial from the outset that the researcher is aware of their preconceptions (Sin, 2010) and listens attentively to the co-researcher's account of their experiences as well as clarifying points so that assumptions are not made nor are conclusions prematurely arrived at. Furthermore, it is important that the researcher reveals how far his/her

beliefs, views and experiences affect the research process to ensure that readers of the research can make informed decisions about the quality and credibility of the research (Lincoln and Guba, 1985; Jootun *et al*, 2009).

This may be achieved by maintaining "a reflexive account of their research ... by signposting to readers what is going on" during the research process (Koch and Harrington, 1998:882). Langdridge (2007:61) strongly advocates that researchers should demonstrate reflexivity to readers of the research by involving "the reader in the reflexive process". He suggests the following as a means of doing this: at the outset outline their position on the topic being investigated; bring themselves into the analytical process and at the end reflect on the process and outline how their position influences the work (Langdridge, 2007).

Halldórsdóttir (2000) highlights the importance within the Vancouver School of doing phenomenology for the researcher to be aware of their preconceptions and assumptions and the impact of these upon the research process. Increasing this awareness can be facilitated by being reflexive and is aided by keeping a journal "about their own reflection and methodology" (Halldórsdóttir, 2000:56).

The researcher needs to be open and receptive to what is being said by the co-researchers and to seeing the world a new from their perspective. The charge of potential researcher bias within interpretive phenomenological research must be addressed. While all researchers are products of their environment and thus are influenced by this, it is important to try to identify preconceptions and influences when interpreting the data.

Within the Vancouver school of doing phenomenology, it is recommended that the researcher try to lay aside (in so far as possible) preconceptions before starting the interviews/dialogues (Blondal and Halldórsdóttir, 2009). The reflexive process is aided by using a reflective diary/journal. The use of a reflective diary "not only reminds the researcher in retrospect of how the whole process was but also shows how the researcher's ideas have changed in the process...Such a process can be one way of laying aside preconceived ideas" (Gudmannsdottir and Halldórsdóttir, 2009: 321). Furthermore, Blondal and Halldórsdóttir (2009) highlight the importance of keeping a reflective diary when using the Vancouver school of doing phenomenology in ensuring the trustworthiness of the research. This helps identify the audit trail through the provision of an accurate account of the process as well as outlining the thinking and reflections which occurred (Sigurgeirsdottir and Halldórsdóttir, 2007; Gudmannsdottir and Halldórsdóttir, 2009).

Within interpretive phenomenology the aim is not to distance the researcher from the research but rather to acknowledge this inter-connection. However, this does not negate the need for rigour and trustworthiness with qualitative research. The measurement of the research against concepts such as dependability/ auditability/ consistency, confirmability/ neutrality; credibility/ truth value, transferability/ fittingness and reflexivity is an attempt to ensure rigour in qualitative research.

3.7.6 Ethical Considerations

It is essential that research is conducted according to ethical standards (Emanuel *et al,* 2000; An Bord Altranais, 2007). This section discusses the ethical considerations which need to be addressed when undertaking this research study. The application of these considerations is described in chapter 4. There are a number of aspects to a study which have to be considered from an ethical perspective and include: value, methodological rigour, fair sample selection, data protection, favourable risk-benefit ratio, self-determination, disclosure and informed consent, respect and justice.

The value of the study has to be made overt and includes providing a strong rationale as to the need and merits of the research. This is addressed in the research approval application to the research ethics committee which sanctions the research study. For research to be ethical it must be methodologically rigorous (Emanuel *et al,* 2000). Therefore, it must be clearly demonstrated that the Vancouver school of doing phenomenology framework was adhered to for this study.

The detailed discussion provided earlier on the Vancouver school of doing phenomenology approach speaks to this methodological rigour and thus scientific validity. Integral to this is fair sample selection. This includes the types of sampling process (purposive and snowball), the inclusion and exclusion criteria as well as the recruitment process. It is imperative that research is informed by data protection laws. According to the office of the Data Protection Commissioner (2014), data protection is

> *"the means by which the privacy rights of individuals are safeguarded in relation to the processing of their personal data. The Data Protection Acts 1988 and 2003 confer rights on individuals as well as placing responsibilities on those persons processing personal data".*

and a data controller

> *"is the individual or the legal person who controls and is responsible for the keeping and use of personal information on computer or in structured manual files"*

The researcher can be identified as the data controller. According to the Office of the Data Protection Commissioner (2014), a data controller has eight legal responsibilities regarding information held about people. These responsibilities are outlined below:

1) Obtain and process the information fairly: This involves explaining who the researcher is, what the nature and purpose of the research is, how findings are to be disseminated and the maintenance of participant anonymity and confidentiality. Participant informed consent must be obtained before proceeding with the research. ***2) Keep it only for one or more specified and lawful purposes:*** The data collected should only be used for the purposes of the specific research study and this should be made explicit in the participant information sheets.

3) Process it only in ways compatible with the purposes for which it was given to you initially: The data must be collected and analysed using a research design congruent with the methodology outlined in the ethics application and explained to participants. ***4) Keep it safe and secure:*** Electronic files must be stored on password protected computers and hard copies stored in a secure location**.** Access to these anonymized files is limited to the researcher and on occasion through the researcher to appropriate personnel e.g. research supervisor and on occasion to an Nvivo support expert. Furthermore identifying names and addresses are stored separately.

5) Keep it accurate and up-to-date: This refers to making sure that personal information is accurate and up to date for the duration of the study. ***6) Adequate, relevant and not excessive:*** Participants should only be asked questions that are relevant to the aims and objectives of the research study. ***7) Retain it no longer than is necessary for the specified purpose of purposes:*** The information is retained in accordance with the terms of approval of the relevant Research and Ethics Committee. Upon expiration of this time period, all electronic information should be deleted and hard copy information shredded. ***8) Give a copy of his/her personal data to any individual on request:*** All co-researchers are entitled to request and be provided with copies of their interview transcripts and/or any personal information being stored for the purposes of the research study.

Within research there must be a favourable risk-benefit ratio. Potential risks to participants are minimised and potential benefits of the research are "proportionate to or outweigh the risks" (Emanuel *et al,* 2000: 2705). In this study it must be made explicit to the co-researchers that there are no direct benefits for them rather that they will have contributed to the body of knowledge on this topic.

There is a widely held view that older people are a vulnerable group along with children, people with intellectual disability, people with chronic illness to mention a few, and are in need of protection within qualitative research studies (Hewitt, 2007; Fischer, 2012). However, Fischer (2012:4) states "participation in a research study can be seen as a dimension of civil and human rights" in so far as people have the right to express an opinion and have the right to participate in research. Russell (1999: 414) argues that older people are not necessarily powerless stating that some if not all, can and do "exercise considerable power over the course of the research" and are "not passive respondents" but rather active participants within the research process.

None the less, there are some specific concerns that must to be considered when interviewing older people. In particular, Cutcliffe and Ramcharan (2002:1005) identify the need to explore the outcomes for the participants of taking part and the "sensitive handling of relationship ending", both of which have resonance for this study through its engagement with older women. According to Cutcliffe and Ramcharan (2002:1003) it is important that the research process does not "traumatise" the participants through their recounting of their experiences and states that while there can be some risks because of this, there can also be a "therapeutic value of telling one's story and being listened to".

Similarly Birch and Miller (2000) state that when participants are invited to recount their experiences this can lead to an exploration of private and /or difficult experiences. However, this in its self is not necessarily harmful and some research participants have identified this process as therapeutic in helping them develop new understandings of their experiences. There are similarities between research interviews and therapeutic relationships (Hewitt, 2007) in so far as communication and interpersonal skills are required for engagement with either a research participant or a patient. Furthermore Cutcliffe and Ramcharan (2002:1005) highlight the importance of "sensitive handling of relationship ending in qualitative research" in particular with vulnerable and/or lonely people as there can be a danger of having created "a form of interpersonal dependency" during the research process.

This means there is the potential for research participants to experience loss when the study concludes (Hewitt, 2007). This must be carefully handled and the purposes of each stage of data collection, verification processes and final conversations should be explained clearly. Gudmannsdottir and Halldórsdóttir (2009:319) state that the Vancouver School of doing phenomenology greatly emphasises the "reverence for

participants as persons and for their experience". Within this school, the research process is identified as a collaborative venture, respecting that the participants are experts regarding their own experiences (Gudmannsdottir and Halldórsdóttir, 2009).

Cohen (2000b: 40) states "regard for people is at the heart of the philosophies that guide hermeneutic phenomenological research….trust is vital to obtaining the data we seek, researchers need to keep the informants' vulnerability in mind and do nothing to violate their trust". Respect for a person's autonomy means ensuring that the person has the right to self-determination, has the right of full disclosure so as to make an informed decision on whether to participate or not in a study and has the right to withdraw from the study at any time without any consequences (An Bord Altranais, 2007; Moule and Goodman, 2009). Respect for and empowerment of the participants is further demonstrated by holding the interviews at times and places of the participants' choosing (Elwood and Martin, 2000).

Informed consent is a fundamental aspect of research. It requires the participant [co-researcher] to be fully informed about the research aims and research process (through the provision of written and oral information) , be deemed competent to make a decision and to have independently consented to being a research participant without any pressure or coercion (Green and Thorogood, 2009; Moule and Goodman, 2009). However, there are inherent difficulties in obtaining informed consent in this type of research.

The researcher cannot at the beginning of the research process always predict what will be elicited during the research process (Green and Thorogood, 2009). The Vancouver school of doing phenomenology involves having more than one interview (dialogue) with co-researchers if they are willing. Therefore, consent is not a once off activity rather it is ongoing. This type of consent is referred to as process consent. It is an ongoing consensual process with the participant [co-researcher] being kept informed at all stages of the research and consenting to continued participation as well as having the option to withdraw at any time (Usher and Arthur, 1998; Cutcliffe and Ramcharan, 2002).

O'Reilly *et al*, (2011: 180) refer to consent in a research study conducted over a number of meetings or sessions as "an iterative, ongoing process" whereby it is revisited and negotiated at each meeting. In this way, participants are reminded of the nature of the research and their decision to continue to engage is sought. Participants' interpretation of what the researcher asks or notes may not be quite what the researcher meant and therefore, as O'Reilly *et al* (2011) argue it is important to safeguard research participants' rights by frequently revisiting the consent process. When consent is ongoing, participants can withdraw parts or all of the data (O'Reilly *et al*, 2011). In addition, it is paramount that participant anonymity and confidentiality is maintained. Confidentiality requires "safeguarding the personal information…gathered in the study" (Moule and Goodman, 2009:57).

Therefore, the use of pseudonyms to protect participants' identities and not using information which would identify the participants is crucial. Issues regarding storage and access to the data have been described earlier. In summary, this section has identified the ethical issues which need to be addressed when undertaking this research study. These have been discussed within the context of utilising the Vancouver school of doing phenomenology framework. Their application is discussed in the chapter 4.

3.8 Chapter Conclusion

According to Charalambous *et al* (2008:637) "hermeneutics is recognised as a philosophy that supports an approach to health research which focuses on meaning and understanding in context". A core concept within phenomenological philosophy is the value and worth of human experience as a source of knowledge (Mackey, 2005). Furthermore the use of phenomenology as a method of research reveals the meaning of people's unique experiences through interpretation and understanding (Lopez and Willis, 2004; Mackey, 2005).

This chapter has provided an overview of descriptive phenomenology and interpretive phenomenology specifically the aims, origins and philosophical basis of phenomenology have been outlined. In addition, a rationale has been provided for choosing an interpretive phenomenological approach for the study.

A rationale has been provided for using the Vancouver School of doing phenomenology as an appropriate philosophy and research method to guide the study and an overview of this has been included. Issues concerning sampling and recruitment; ethical considerations; data collection; data analysis and trustworthiness have been discussed. The application of the Vancouver school of doing phenomenology as the research design for this study is discussed in the next chapter (Chapter Four).

Chapter 4

Application of the Vancouver School of doing Phenomenology Research Design

4.1 Introduction

This chapter describes how the Vancouver school of doing phenomenology was applied in this study. The reasons for the decisions taken in designing this study were described in the previous chapter. This chapter describes: sample selection, recruitment including a description of the co-researchers; the pilot study; the use of silence in preparation for data collection and analysis; data collection; data analysis; how ethical issues were addressed and how trustworthiness and rigour were maintained.

4.2 Step 1. Selection of dialogue partners

4.2.1 Sampling

Both purposive and snowball sampling were used in this study. Women aged 65 years and over were initially recruited using purposive sampling. The heterogeneity of older women as a group was reflected in the sample: women aged 65 and over are a diverse group in terms of age, domicile, health and socio-economic background. Therefore, it was decided to include both rural and urban dwellers and to target different social groups through health centres, day centres, retirement social clubs and church congregations.

A somewhat larger sample (n=23) than usual in phenomenology was recruited. Deciding to have a slightly larger sample number was influenced by a number of factors. Primarily, I wanted to ensure that I obtained rich data so as to be confident that the meaning of the experience could be explicated.

I also wanted to factor in the possibility of attrition from the study as some of the co-researchers could have decided to withdraw from the study or their circumstances could have changed so that it would be no longer possible for them to continue to participate. While purposive sampling was the primary sampling strategy, snowball sampling was also used.

Two co-researchers were alerted to the research by co-researchers who were already participating in this study. Three researchers were informed about the study by relatives who had heard about the study. These co-researchers were recommended on the basis that they were able to provide information on ageing and their health related issues. The five co-researchers wished to know more about the study and gave permission for their contact details to be forwarded to me and which I followed up on. The specific sample inclusion and exclusion criteria are outlined in Table 4.1.

Inclusion Criteria	**Exclusion Criteria**
• Women aged 65 years and over living in the community • Willing to participate in the study and recount their experiences • Able to given informed consent • Able to converse in English without an interpreter	• Women younger than 65 years • Unable to give informed consent

Table 4-1 Inclusion and Exclusion Criteria

4.2.2 Recruitment of Co-researchers

Recruitment for this study occurred in mainly in Limerick[5] (city and county), North Tipperary and to a lesser degree Clare. Co-researchers were recruited in the following way. A number of organisations (both urban and rural) were approached (through gatekeepers such as managers or priests/ministers) and informed about the study. These included: retirement groups (3), day care centres (3), health centres (via the Director of Public Health Nursing), churches (6, including Roman Catholic and Church of Ireland) and older person organisations (3).

They were asked to help with recruiting older women to take part in the study (**Appendix 3**), to this end they were provided with information about the study (**Appendix 4**). If they agreed, permission was sought to either display a poster (**Appendix 5**) about the study on their notice board and/or allow me to speak with potential co-researchers attending the organisation. While a number of the gatekeepers either did not respond or refused my request, the majority agreed and either displayed the poster or allowed me to meet with possible co-researchers (or both). In some instances this access followed gate keeper consultation with the older women attending these organisations. An information pack was made available to those gatekeepers contacted via email/ post / telephone who agreed to assist in recruitment.

Once the gatekeepers granted access, older women were alerted to the study in a variety of ways i.e. via poster advertisement, information from the gatekeeper and in four cases through an informal presentation about the study delivered by me (where I also handed out information packs about the study).

[5] Limerick, Tipperary and Clare are counties in the mid-west region of Ireland. Limerick is also a city

All of the women who volunteered were provided with an information pack which included a letter of introduction (**Appendix 6**), an information sheet (**Appendix 4**), an expression of interest form (**Appendix 7**) and a consent form (**Appendix 8**). Following agreement to participate, co-researchers were contacted to make arrangements regarding time, date, place (in one organisation i.e. a day care centre, this was through the manager).

There was an intentional time lag of at least a week between the initial agreement to participate and follow up contact to arrange the date and time of the first interview. Allowing at least a week to elapse meant the older women had time to further consider their decision to participate in this study. The rationale for this 'cooling off' period is further discussed in the ethics section of this chapter.

4.2.3 The Co-Researchers

The study sample comprised of 23 older women. They were: aged between 66 to 92 years; three were single, six were married, one had a partner and thirteen were widowed; eleven lived alone and twelve lived with family; twelve were urban dwellers; five, rural and six, semi-rural (Table 4.2). Personal perceptions of their health are reported in Table 4.2. It is important to emphasise that from a medical perspective all had chronic medical conditions and many had co-morbidities. For many co-researchers, their subjective view was at odds with their objective health status. Data was collected between 24th October 2012 to 2nd December 2013 and comprised 40 interviews (17 were interviewed twice and 6 once).

P	Age	Marital Status	Employment	Living Arrangements	Domicile	Perception of health	Club/Organisation membership
1	76	Widowed	Retired	Alone	Urban	Poor	• 2 Senior Citizens Clubs • Bingo
2	77	Widowed	Retired	Alone	Rural	Good	Senior Citizens Club
3	91	Single	Retired	Alternated with niece and nephew and their families	Rural Village	Poor	• Senior Citizens Club • Day Care Centre
4	75	Married	Part time	Husband	Rural	Good	• 2 Church groups • Bridge Club
5	66	Married	Retired	Husband	Rural Village	'OK'	Multiple Sclerosis Society
6	79	Widowed	Retired	With daughter and her family	Rural Village	Poor	Day Care Centre
7	75	Married	Retired	Alone	Rural Village	Very good	None
8	65	Widowed	Retired	Alone	Rural Village	Good	None
9	73	Married	Retired	Husband	Suburban	Good	None
10	86	Single	Retired	Partner	Rural	'OK'	None
11	76	Married	Retired	Husband	Suburban	'OK'	• Irish Country Women's Association • Church group

P	Age	Marital Status	Employment	Living Arrangements	Domicile	Perception of health	Club/Organisation membership
12	92	Widowed	Retired	Alone but family member at night	Rural	Very good	• Irish Country Women's Association • Day Care Centre • Church group
13	87	Widowed	Retired	Alone	Urban	Very poor	3 Senior Citizens Clubs
14	82	Widowed	Retired	Alone	Rural	Poor	None
15	81	Married	Retired	Husband	Urban	Did not give an opinion	None
16	73	Widowed	Retired	With her son	Urban	'OK'	• Day Care Centre • Senior Citizen Club
17	77	Single	Retired	Alone	Urban	Poor	Day Care Centre
18	76	Widowed	Retired	Alone	Urban	Good	3 Day Care Centres
19	73	Widowed	Retired	Alone	Suburban	Good	• Senior Citizen Club • 2 Choirs
20	69	Widowed	Retired	With her son and daughter	Urban	Good	• 2 Day Care Centres • Soccer Club
21	67	Widowed	Retired	With her son	Urban	Very poor	Day Care Centre
22	72	Single	Retired	With her religious community	Urban	Poor	None
23	78	Widowed	Retired	Alone	Urban	Poor	None

Table 4-2 Demographic details of the co-researchers

To provide insight into the lives of the co-researchers and describe the context of their views, perceptions and experiences, a brief description of each of the co-researchers is provided in Table 4.3.

	Pseudonym	**Description *** *(*Age of the co-researcher at first interview)*
1	Kelley	Kelley was a 76 year old widow who lived alone in a socially disadvantaged urban neighbourhood. She had good family support especially from one daughter. She was a member of two 'senior citizen' clubs and also went to weekly bingo. However, she often felt lonely. She enjoyed watching television but had few hobbies. She had literacy problems. In the main her neighbours were supportive but she had been burgled by a man from the locality. She was nervous of this happening again and had installed security lights and alarms. She had chronic health problems and described her health as being poor.
2	Aoife	Aoife was a 77 year old widow who lived alone in a rural area near a village. She had good family support and weekly attended a retirement social club and a day care centre. She was very involved in church activities. Her hobbies included reading, crocheting and using her computer. She had home security. She had some health problems but described her health as being good.
3	Saorcha	Saorcha was a 92 year woman who lived with a family carer and moved between her own home and her carer's home. She also had home help support. Her primary residence was in a large village. She enjoyed socialising and weekly attended a retirement social club and day care centre. Her religion was very important to her. Her hobbies included reading and watching television. She had chronic medical conditions including failing memory and mobility problems. She was very frail and described her health as being poor and required full time care.

	Pseudonym	**Description *** *(*Age of the co-researcher at first interview)*
4	Sinead	Sinead was a 75 year old married woman who lived with her husband in a rural area. Her husband was in the early stages of dementia and while not his carer, she worried about his memory problems. She had good family support. She worked part-time in her children's businesses. She was very involved in church groups including the choir. Her hobbies included playing cards, current affairs and travel (less so in recent years). She had some health problems but described her health as being good.
5	Ellen	Ellen was a 66 years old married woman who lived with her husband in a large village. She had good family support. She described herself as being a 'house-mouse' and did not like big social gatherings. She had a number of close friends and valued these relationships. She occasionally attended MS society events. Her hobbies included knitting and current affairs. She had a number of health problems including multiple sclerosis but described her health as being fairly good.
6	Aisling	Aisling was a 79 year old widow who lived with her daughter and her family in a small town. She and her husband had retired to this area and Aisling had moved in with her daughter following her (Aisling) husband's death. She kept in contact with old friends and relatives mainly by phone. She attended the local day care centre several times a week primarily for the social opportunities. She had a number of health problems and described her health as being poor. While self-caring, she was frail and needed the support afforded by her daughter and felt she could not live alone.
7	Niamh	Niamh was a 75 year old married woman who lived alone in a housing estate in a medium sized town. Although her husband lived overseas, they were in regular contact. She had little local family support. Niamh was very interested in the arts and social sciences and regularly undertook further education programmes and attended related events. She was not a member of any social club or organisation. While she had a number of health problems, she was very proactive in minding her health and described her health as being very good.

	Pseudonym	**Description *** *(*Age of the co-researcher at first interview)*
8	Rebecca	Rebecca was a 66 year old widow who lived alone on the outskirts of a large village. She had good family support especially from one daughter who lived close by. Rebecca had multiple sclerosis and was confined to a wheelchair. She had the support of a daily home help and had adapted her house to help meet her needs. She used a scooter to get out and about. She attended MS society events but mainly socialised with family. She described her health as good.
9	Noirín	Noirín was a 73 year old married woman who lived on the outskirts of a city. She volunteered as a docent in a local museum. She was interested in overseas travel, rugby, women's rights and documentaries. She was in regular contact with her children and grandchildren. She had cardiac and musculo-skeletal health problems but overall described her health as being good.
10	Jane	Jane was an 86 year woman who lived with her partner and pet dog in a detached house in a rural area with houses close by. She had a number of chronic medical conditions in particular severe back problems which have adversely affected her mobility. She described her health as being 'okayish'. She required a lot of support from her partner and home-help to attend to her care needs. She had a close relationship with her health care professionals and neighbours. She said that she would not be able to live in her own home without support but dreaded the idea of having to go to a nursing home. She enjoyed socialising with her extended family and friends.
11	Siobhán	Siobhán was a 76 year old married woman and lived with her husband in suburban housing estate. She had a very close relationship with her husband. She worked as a volunteer with a local charity and was very involved in church activities. She was also a member of the Irish Countrywomen's Association (ICA). Her hobbies included walking and science fiction films. She enjoyed visiting with family and friends. She had some health problems but described her health as being 'ok'.

	Pseudonym	**Description *** *(*Age of the co-researcher at first interview)*
12	Agnes	Agnes was a 92 year old widow who lived alone in a very rural area. However, a family member did stay at night. A home help attended five days a week and she had modified her house to meet her physical needs. She was a member of the ICA and involved in church activities. She attended a day care centre weekly for the last 25 years. She was interested in national and local affairs. She enjoyed visiting with family and friends. Although she had health problems in particular mobility difficulties, she described her health as very good.
13	Eleanor	Eleanor was an 87 year widow who lived alone in a terraced house in the city. She had good family support however; she had been burgled and was very nervous of being alone at night. She attended three senior citizen clubs as well as availing of free travel for inter-city trips. Her religion was important to her. She had chronic health problems and described her health as very poor. Owing to mobility and severe back problems she moved her bedroom to the ground floor and required the support of a home help.
14	Winifred	Winifred was an 82 year old widow who lived alone in a detached house in a rural area. Family lived very nearby. She enjoyed her own company and was not interested in attending the local day care centre or clubs. However, she did like socialising with family and attending local events including weekly mass. She had a good relationship with her home help who came a couple of times a week. She described her health as being poor and had several chronic conditions including worsening mobility and sight problems.
15	Roisin	Roisin 81 year old married woman lived with her husband in a suburban housing estate, husband had dementia; she worried and felt responsible for him as his condition worsened. Had very good family support and increasingly relied on them as both her health and her husband's deteriorated. She did not give an opinion on how she perceived her health but said she had many health problems. She said she was practically blind and found it very hard to cope & she had withdrawn from certain outside interests e.g. choir. She depended on her family to take her wherever she wanted or needed to go.

	Pseudonym	**Description *** *(*Age of the co-researcher at first interview)*
16	Joan	Joan was a 73 year old widow who lived with her son in an urban area. Since becoming redundant, her son looked after the housework and shopping, which Joan was happy with. She liked socialising and attended a day care centre three times a week as well a senior citizens' club weekly. Although Joan has poorly controlled diabetes, poor sight, respiratory problems and a recent history of falls, she described her health as being 'ok'.
17	Michelle	Michelle was a 77 year old single woman who lived alone in a supported apartment complex in the city. She was socially reserved but regularly attended a day care centre and had a couple of close friends. She had a good relationship with her siblings and nieces. She had underlying health problems particularly musculo-skeletal and described her health as poor. She privately paid for home help.
18	Éilis	Éilis was a 76 year old widow who lived alone in a city housing estate. She had a good relationship with her children and grandchildren. She also had supportive neighbours. Since her husband's death, she was very determined to 'get out and about' and didn't want to 'get in a rut'. She weekly attended three different day centres. Although she had some medical conditions she described her health as being good overall.
19	Úna	Úna was a 73 year old widow who lived alone in a suburban housing estate. She was very involved with her family and supported them by providing afterschool child minding as well as cooking meals for her adult sons. She was very outgoing and enjoyed meeting family. She was in two choirs and attended a senior citizens' club. She drove and valued the freedom this afforded her. Although she had chronic health problems including tinnitus and osteoporosis, she described her health as being good.

	Pseudonym	**Description *** *(*Age of the co-researcher at first interview)*
20	Hilary	Hilary was a 69 year old widow lived with two adult children, one of whom (her son) had special needs. She was outgoing and attended two day care centres four times a week. She was also a member of her local soccer club. Her hobbies include baking, music, and walking. Although she did have health problems, she described her health as being good especially so since she and her daughter had embarked on a successful weight loss programme. Although her other children had assured her that her son would be cared for by them when she was dead, she still worried about him.
21	Avril	Avril was a 67 years old widow who lived with her son (who had special needs) in an urban housing estate. Although she had good family support she very much missed her husband's company and that of another son who had emigrated. She described herself as being reserved but made an effort to go out primarily for her son but also for herself. She attended two day care centres. She had multiple chronic health conditions and described her health as being very poor. She worried about her son's welfare after she was dead even though her other children assured her that they would care for him.
22	Suzanne	Suzanne was a 72 year old single woman who lived as part of a religious community in the city. She was outgoing and had been a member of various clubs and organisations until recently. She intended on going back to some of these in the future when her immediate health problems were resolved. Although retired for some years she still found retirement difficult to adjust to. She was able to drive and valued being able to come and go as she pleased. Overall she had a number of health problems and described her health as poor.
23	Rosy	Rosy a 78 year old widow lived alone in an urban terrace. She was socially reserved and not a member of any club or organization. She had little immediate family living close by apart from an elderly sibling who lived about 25 kilometers away. Most of her children lived overseas apart from a daughter who lived 150 kilometers away. She kept in regular contact with her family and visited fairly often, frequently for extended periods of time. She worried about having to go to a nursing home and believed her children wanted her to do this. She had several health problems and described her health as being poor. She privately paid for home-help. She had limited knowledge on how to access health service supports and relied primarily on her pharmacist and GP for advice.

Table 4-3 Co-Researchers Description

4.3 Preparation

Preparation is important in undertaking research. This section discusses the use of a pilot study and the importance of 'silence' in preparation for the study as a whole and also for specific stages of the research process.

4.3.1 Pilot Study

Being prepared and having a clear plan when undertaking research is important. While acknowledging that unforeseen events can occur it is prudent to minimise any difficulties regarding data collection and analysis by undertaking a pilot study. This is defined as "a small-scale methodological test conducted to prepare for a main study and is intended to ensure that methods or ideas would work in practice" (Kim, 2011:190). The pilot study involved one co-researcher and trialled the research questions and my interviewing skills. I was quite nervous about how to conduct the interview, wanting to ask various questions but not wanting to be didactic, rather to engage with the co-researcher to hear her narrative.

This was challenging as at times the co-researcher recounted experiences which were unrelated to the research topic. I did not feel comfortable with interrupting these stories and therefore, later on I had to bring the conversation back to particular points that I wanted to explore. I was trying to keep several things in my head at the same time, recognising that it was important to be respectful and attend to what the co-researcher was saying as well as not forgetting the points that I wanted to come back. I was worried about the tape recorder failing and if that happened how would I remember all that was being said. I felt that I needed to be clearer in how I asked my questions, and concerned that some of my questions could be considered to be so broad as to be vague.

Evaluating my interviewing skills was important given that the researcher is the primary data collection instrument in phenomenological research. An important part of this evaluation was reflecting on the interview and making sense of how I felt, what went well and what could be improved.

I discussed my evaluation of the pilot study with my supervisor. Four main issues were identified which assisted in the research design. I needed to increase the clarity of my questions and pose these in a more conversational way which meant reframing some of the questions. Secondly adopting a more conversational approach (which is congruent with interpretive phenomenological research interviewing (Benner, 1994; Kahn, 2000a)) enabled me to feel more at ease and this in turn positively impacted on the co-researcher and enhanced the interview as a whole.

Thirdly, I needed to let the conversation 'run' while keeping points for clarification or discussion in mind to return to later. Lastly, I decided not to write notes while the interview was in progress as this can be distracting and interrupt the flow of conversation (Walker, 2011). I decided to note down anything relevant immediately after the interview. In the unlikely event of the recorder failing I decided against using a 'back up' recorder, as using two recorders could have been "off putting" to the co-researcher rather I decided that I would write up the interview if necessary.

The learning from conducting a pilot interview was invaluable for the actual interviewing process. It assisted in the research design in a number of ways. I clarified some of the research questions and it helped me to adopt a more conversational style. This supported the development of rapport with the co-researchers and enabled them to speak freely about their experiences. This was further enhanced by making the decision not to write notes during the interview and by using only one small tape recorder. Undertaking a pilot study helped me 'relax' and to be comfortable with pauses and silence as I recognised that co-researchers sometimes need time to think about the question(s) being asked. Essentially I needed to keep to the fore that I wanted to engage in an interactive conversational style interview so that I could listen and develop an understanding of the co-researchers' experiences (Kahn, 2000a).

4.3.2 Step 2. Silence (before entering a dialogue)

An integral aspect of phenomenological research is taking time to consider all aspects of the research process from original inception of the research question to final write up of the study. In order to do this, it was important for me to be 'silent' to spend time contemplating the why, what and how of this research process. This was facilitated by the cyclic process referred to in Figure (3.3). A key aspect of this silent time is being reflexive and this is discussed in 4.6.5.

It was also important that I was familiar with the literature on this topic. Therefore, in addition to extensive reading for the literature review and methodology, I also teach modules on 'health' and 'rehabilitation nursing of the older person' on third level programmes, all of which has increased the breadth and depth of my knowledge of this area.

Specifically in relation to my preparation for the data collection I made sure that I took some 'quiet time' to prepare for the interview so that I was not rushing into the dialogue (interview) straight from work. It was important to be organised and give myself plenty of time to reach the interview location. I needed the time to be silent and free my mind of my preoccupations regarding work or everyday matters before engaging in dialogue with the co-researcher. It was crucial that I did this so that I could be open and receptive to hearing the co-researcher's narrative.

4.4 Data Collection: Step 3.Participating in a dialogue

In-depth narrative interviews using a topic guide (**Appendix 10**) were used to collect data. The topic guide comprised of relevant open-ended questions which were asked but not in a set order. The aims and objectives of the research study informed the guide. All of the topics were addressed e.g. some directly posed; others were answered by the co-researcher within the course of the interview. Face to face one-to-one interviews were used in this study (a family member was present in interviews with two of the co-researchers as decided by the co-researchers).

The times and locations of the interviews were determined by the co-researchers so as to ensure maximum comfort. The locations included the co-researchers' homes (16), day care centre (5) and a meeting room where I work (2). Essentially the location needed to be a place that the co-researchers felt comfortable in.

When I first met the co-researchers I was conscious that neither of us knew each other and that the co-researchers were being generous with their time in agreeing to speak with me. In a sense they were doing me a 'good turn' and I was in their debt. In addition, for those whom I interviewed in their homes, I was conscious of being a guest in their home and therefore was not as at ease as I would have been in my own office or own home. It is not usual for people to have researchers visit their home and there are no social rules as such associated with how either participant or researcher behaves (Steeves, 2000b). For example, I could not offer to make tea/coffee or arrange seating. Typically, I sat at a right angle or in front of the co-researcher either at eye level or below and on two occasions I sat on the floor near the co-researchers as the chairs or sofas in the room were far away from where the co-researchers were sitting. It would have been difficult to move these (both in the sense of heavy furniture but also it could be construed as being presumptuous if I reorganised their furniture without an invitation to do so).

In order to overcome any awkwardness in the interviews, I introduced myself, thanked them and used 'small talk' as an icebreaker such as talking about weather, finding the house etc. before explaining again about the study (they had already received written information) and setting up the tape recorder. I was also mindful of not presenting myself as an 'intimidating official' quizzing them about their lives, in that sense I did not wear overly formal clothes such as a suit but rather non-threatening clothes such as trousers and shirt/jumper.

When developing trust with the co-researchers, it was important that I explained again about maintaining their anonymity and confidentiality (all co-researchers were given pseudonyms) as well as assuring them that they could withdraw from the study at anytime and that they did not have to give any reason if they chose to do this. The generation of trust is enhanced by developing a rapport.

This was achieved by the use of icebreakers as discussed above and by answering the co-researchers' questions about myself. Most asked me some questions about myself (in addition to information about my researcher role) e.g. where I came from, had I children and so on. These exchanges helped set the conversational tone of the interview. I was also mindful not to over-exert the co-researchers and so was alert to any verbal and non-verbal signs of tiredness or wanting to finish by the co-researchers. The length of the interviews varied but averaged around an hour.

The strategies to develop a rapport with the co-researchers (described above) using my verbal and non-verbal communication and interpersonal skills showed my interest in what was being recounted to me. I felt that I achieved a good rapport with co-researchers, for example Eleanor said she liked talking to me and was glad she had done the interview. Initially she was quite reserved and had scrutinised the topic guide and the consent form. I had reassured her several times that I would stop the interview anytime she wanted, after which she relaxed and was very talkative.

The flexibility of a conversational style facilitated the exploration of issues raised by the co-researchers. For example, when I interviewed Sinead it was near the 1st November which she remarked was a church holiday, "All Saints" day and she began to recount how various people (friends and family) had died. This led to a discussion on her thoughts about death, faith and her fears about suffering a stroke and how she would cope with this.

Allowing the conversation to 'run on' was important as sometimes points were being made in a circuitous route such as telling a story to make a point. For example, Ellen spent time telling me about past events in her life as a way of explaining how she coped with loss and bereavement and how these skills helped her cope with current health problems and influenced her outlook on life. Sometimes, concerns can be raised by participants that may not have been anticipated by the researcher but may be relevant to the research (Green and Thorgood, 2009; Roberston and Hale, 2011). For example, Roisin found her visual problems more distressing to live with than having had treatment for three different types of cancer.

While it is important to interrupt the narration as little as possible, it was sometimes necessary for me to re-focus the direction of the interview (Moule and Goodman, 2009). This can be difficult as it is important not to 'cut off' the conversation and inadvertently cause offence, therefore I listened to the anecdote and when a natural break came asked a question or made a comment to link back to the research questions.

All the interviews except one (at the co-researcher's request) were audio-recorded with permission and transcribed verbatim. One co-researcher asked me to stop recording for part of the interview as there was some information she did not want included in the research and two of the co-researchers asked that some of their interview transcripts be omitted, this was done and is reported upon in the section on ethical issues (4.7.6.) For the non-transcribed interview, I made detailed notes directly after the interview in order to capture what the co-researcher had said. Interview field notes (made directly after all the interviews) were used to document any observations about the interview e.g. the atmosphere, the environment and other relevant points which may have had an impact on the interview.

The Vancouver school of doing phenomenology framework highlights the importance of verifying the co-researchers' 'stories' with them and this may be achieved through further interviews or dialogues with them (Halldórsdóttir, 2000). Therefore, all of the co-researchers were asked whether they would be happy to be interviewed a second time. While all agreed, when the time came for this seventeen consented to being interviewed a second time. Those who decided not to be interviewed a second time were not asked about their reasons for this. However, five did volunteer this information e.g. one woman was tending to a very unwell relative and four felt that they had no more to say. The sixth co-researcher decided against having a second interview without giving a reason but sounded well and chatty while she was telling me this in a telephone conversation.

4.5 Data Analysis

As previously discussed in chapter 3, steps 4 to 11 relate to data analysis. For clarity the steps are identified but the reader is directed to chapter 3 for a description of these steps.

Step 4: I listened attentively to the interview tapes and read the transcripts in their totality several times so that I could get a "feel" for the co-researchers' experiences of ageing and health related issues. As recommended, I did not make any notes during this time rather I concentrated on reading and listening so that I could be open to what was being said and in a sense live with the data. In addition, I reviewed my field notes and reflections on the interviews before any tentative coding began.

Nvivo 10 was used to manage and organise data analysis[6]. Initially I imported all the transcripts in to an Nvivo file (an internal sources file) and set up 23 source files which comprised the 23 transcribed first interviews entitled 'first interviews' (**Appendix 11**) as well as a 'case node classification set' which included demographic data about the co-researchers (**Appendix 12).**

Step 5: Themes from key statements were identified using what is termed 'open coding' in Nvivo. Initially all the themes were coded as 'free nodes' (Nvivo). Each theme was described by giving it a name and a definition or rule for inclusion. This was done for each individual interview. **Appendices 13 and 14** respectively provide examples of coding of themes for 'Kelley' with a description of one of these themes, i.e. 'adapting'. I also wrote individual notes (referred to as memos in Nvivo) about the themes (**Appendix 15: memo/note example**). These helped me to document my thoughts regarding each (initially tentative) theme.

Step 6: In order to develop individual case constructions the initial themes coded in step 5 (discussed above) were grouped and coded into broader main themes. **Appendix 16** illustrates this phase of coding using Nvivo and includes both main themes (Nvivo's parent nodes) and subthemes (Nvivo's child nodes) for "Agnes".

Using the main themes I devised individual models for conceptual mapping of the phenomenon as each co-researcher had experienced it. This resulted in a total of 23 models which represented the individual case constructions for each co-researcher. An example, Kelley's model is included in **Appendix 17**.

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[6]Data management within this study incorporated using the software analysis package, Nvivo 10, as well as maintaining and utilising word and excel documents. Reference is made to Nvivo throughout this description of the data analysis and includes a description of how it was used when analysing the data within the philosophical context of the Vancouver School of doing Phenomenology.

Step 7 Verification of the individual case constructions was achieved through second interviews. The majority (16) of co-researchers indicated that they wanted their interview transcript, these were posted to them. Within a couple of days, I contacted the co-researchers to arrange a meeting. Seventeen agreed to a second interview, of these 17 co-researchers, 13 had been given their first interview (dialogue) transcript; four had not wanted a transcript.

Dialogue during the second interview focused initially on the interview transcript verification with amendments as appropriate and moved to a review of my interpretation of their experiences. The aim was to ascertain if co-researchers recognised their experience within this interpretation. Therefore, some of the questions posed sought clarification or further exploration of points discussed in the first interview. The transcripts of the 17 second interviews were imported into an Nvivo internal source file entitled 'second interviews' (**Appendix 18**). I subsequently amended the initial case constructions to incorporate new data and removed aspects that the co-researchers felt on reflection they did not want included. In addition, some points were clarified and these clarifications were included. I analysed the second interviews and amalgamated certain themes (nodes) with those already in existence and developed new themes (nodes) as appropriate.

Step 8: Meta-synthesis required examining the themes of all the co-researchers' individual case constructions and synthesising these. This resulted in the creation of a new Nvivo case node file entitled 'in case cross-case analysis' of which there are four main themes (nodes) reflecting the main findings: *1) Being in control: Balancing needs and supports; 2) Navigating a changing world; 3) Being connected and involved and 4) Trying to stay well* (**Appendix 19**). Each of these themes (case nodes) has a number of sub-themes (descendant nodes).

Appendix 20 provides an example of some of the sub-themes of one of the main findings namely "Being in Control: Balancing Needs and Supports". Arising from the four main findings, there were 271 sub-themes (descendent nodes). One of the ways in which Nvivo supports deep data analysis is the facility to run relevant queries (Bazeley, 2009) which permits in-depth examination of the data. Therefore, I ran a number of matrix coding queries which helped to interrogate the data to see whether there were any relationships between the themes (case nodes) and demographic data and between the themes themselves (**Appendix 21 provides an example of a query**).

A matrix coding query creates a collection or matrix of nodes which helps in the validation process as it enables the researcher to determine whether the tentative findings are supported with the data (Bergin, 2011). This process illustrated the relationships between the themes (case nodes) of the main findings and demonstrated that health and ageing are very interlinked and it would be difficult if not impossible to separate the influence or impact of one on the other. Ultimately the meaning of the co-researchers' experiences reflects the interwoven nature of ageing and health issues.

Step 9: I returned to the data and paid close attention to the key statements being made. I had to do this with an open mind and be careful of not superficially reading and listening to the tapes merely to confirm the findings. This was challenging but being mindful and aware of the potential for premature closure helped me be alert to the possibility of other/different key statements.

However, this process confirmed the key statements already identified. I had rigorously reviewed and interrogated all of the themes, sub-themes and their sub-themes during step 8, meta-synthesis. Therefore, when I compared the essential structure with the data during this step, differences and merging of themes had been previously identified and addressed.

Steps 10 and 11: I spent considerable time thinking and actively reflecting on the findings in order to identify an overarching theme. I was very open to developing this theme and anxious not to prematurely decide on a statement that reflected some but not all of the meaning of the experience.

Before committing to one overarching theme, it was important to establish if I was on the 'right track' and I needed to see whether the co-researchers could recognise their experience from my findings. I gave the findings to some of the co-researchers to see if they recognised their own experiences within these. I had asked the co-researchers during the second interview whether I could talk to them about the findings when I had finished the analysis. Nine agreed that I could send them a short summary. Therefore, I sent them an executive summary of the findings with a covering letter requesting feedback on this either via a short feedback form or through a telephone conversation or both (**Appendices 22** and **23** respectively). Five of the co-researchers agreed to take a telephone call from me as well as sending me their feedback forms.

I discussed the findings with them to determine whether I was clear on the meaning of their experience and whether I had captured the meaning of their experiences. While Roisin agreed with the summary, she reiterated that her visual impairment rather than the ageing process caused her the most distress. Both Siobhán and Michelle felt they could relate to the findings particularly how being healthy was crucial and that getting old can be frightening as they feared losing personal control over their lives. Similarly Aoife considered that the summary covered the importance of staying healthy, being involved and having financial independence; all of which were important aspects of her experience. Agnes felt that while the summary reflected her experience she tried not to think too much about getting older rather she focused on the positive aspects of life.

It was difficult to find an overarching theme that fitted exactly with each co-researcher's experiences. Consideration was given to the emphasis on being healthy, being independent, being involved and adapting to change. All of these aspects were important and I needed to consider how these could be captured while recognising that the final analysis of the experiences is a composite view and should be broadly reflective of all the co-researchers' experiences. Eventually, I decided on an overarching statement which I believe reflected the meaning of older women's experiences of ageing and health related issues namely "Retaining autonomy within a process of adaptation and continued engagement". This statement captured the interwoven nature of the co-researchers' experiences i.e. how ageing and health issues are inextricably linked. It is important to highlight that there are connections and relationships between each of the main findings and that together all of these findings comprise the overarching meaning of the phenomenon.

Step 12 The findings must ensure the co-researchers' stories of their experiences are heard. Therefore, the findings of this study were written as a multi-voiced text (Halldórsdóttir, 2000). The voices of the co-researchers through their quotes and contributions are reflected in the findings chapter.

4.6 Trustworthiness and Rigour of the Study

This section discusses the trustworthiness of this study and the efforts made to ensure rigour. These are discussed under the following headings: dependability/auditability/consistency; transferability /fittingness/ applicability; credibility/truth value; confirmability/ neutrality and reflexivity (Lincoln and Guba, 1985; Sandelowski, 1986; Halldórsdóttir, 2000; Magnusdottir, 2005; de Witt and Ploeg, 2006; Blondal and Halldórsdóttir, 2009; Moule and Goodman, 2009).

4.6.1 Dependability/Auditability/Consistency

This section describes the decisions made to ensure the dependability/auditability /consistency of this study. I have kept detailed records of my recruitment process, access, sampling, data collection (including interview transcripts) and data analysis (initial, amended and final themes; conceptual models of individual case constructions and the meta-synthesis of all the case constructions). I used hand written notes, word documents and Nvivo10 data management software to assist in the organisation of the data within the data analysis. All of these processes contribute to the auditability of the study.

Furthermore, I have kept a reflective journal describing and analysing my thoughts regarding the interviews and this speaks to the consistency of my approach. For example, immediately following each interview I described the interview process and identified my initial thoughts and impressions about what the co-researchers were saying about their experiences. To illustrate, after I interviewed Siobhán, my initial impressions were of a woman experiencing ageing and associated health issues as a time of slowing down but wanting to remain engaged in life and also as a time of increased health worries.

I was aware that these were my first impressions and so I did not want to prematurely accept these as being Siobhán's experiences. Through listening to the interview audio-tape and reading the transcripts several times, I analysed Siobhán's interviews. One overarching theme namely '*Adjusting, Managing, Engaging and Relating'* represented my interpretation of Siobhán's experiences and included five (5) themes (tree/parent nodes) and 14 subthemes (free/child nodes) I wrote notes (memos) for all of the themes (nodes) which helped clarify my analysis and identification of the themes. I followed the same pattern for analysis of all of the co-researchers' interviews.

4.6.2 Transferability/Fittingness/Applicability

Through my description of both the research process and the presentation of the findings, readers of this research will be able to make an assessment or determination as to the applicability of this study's findings to their own field of interest or situation.

Within this study I have discussed in detail the research design and how I applied it. I have comprehensively presented the findings (chapter 5) taking care to ensure that the experiences of the co-researchers are represented. An important aspect of the Vancouver school of doing phenomenology in the presentation of findings is 'hearing' the co-researchers' voices. To this end I have included as appropriate direct quotes to illustrate the meaning of their experiences of ageing and health related issues.

4.6.3 Credibility/Truth Value

The iterative process of data collection and analysis used in this study is congruent with the Vancouver School of doing phenomenology and enhanced credibility. The co-researchers were engaged with at numerous stages during data collection and analysis so they had the opportunity to verify that the findings represented their experience of ageing and health related issues. These opportunities included: being offered a copy of the first interview transcript to verify that they were happy with what they originally said; being invited to participate in a second interview (dialogue) to discuss and elaborate on the initial findings as presented by me (17 participated); and lastly nine co-researchers were sent a copy of a summary of the draft findings, five of whom provided feedback via the telephone.

Integral to establishing credibility is how assured readers are that the research is a true reflection of the co-researchers' experiences (Moule and Goodman, 2009). The process of re-engaging with co-researchers within the Vancouver school of doing phenomenology gives confidence that the study has credibility.

4.6.4 Confirmability/Neutrality

According to Koch and Harrington (1998) confirmability is ensured when issues of credibility, transferability and dependability have been addressed. These have been discussed above. In essence, assessment of confirmability determines whether the findings are grounded in the data (Lincoln and Guba, 1985).

Following the steps within the Vancouver school of doing phenomenology enabled me to be sure that I had not inferred findings which were not in the data. Furthermore, being reflexive (discussed next) demonstrates how I managed my assumptions and pre-conceptions in order not to misinterpret the data.

4.6.5 Reflexivity

Keeping a reflective diary was crucial to helping me engage in the reflexive process. When I thought about and reflected on my experiences, I realised that there were many influences. These included my knowledge of older women through: personal relationships; my experiences of nursing older women in the past; my theoretical knowledge of ageing and older women and how some of my assumptions are shaped by national and international societal and cultural influences. My view of how older women experience ageing and health related issues was multi-layered.

Essentially I felt that many older women living in Ireland were an almost forgotten part of society whose work and sacrifices had been taken for granted. I was not convinced that they were really considered by the state or society. I also felt that for them there was a sense of 'aloneness' in how they might experience ageing, partly because of their less than visible status but also because many may be widowed/single, have less family support and reduced financial support.

When I commenced this research study I knew that I had to be alert to not looking for data which confirmed my assumptions but rather to be open to what the co-researchers were saying. While some of my assumptions were correct e.g. many were widowed, others were not so clear cut. For example, I thought many of the co-researchers were likely to be religious and had not expected the number who questioned the traditional view of religion and God. It made me realise that ageing can be a time for questioning the meaning of life and the life lived.

Prior to undertaking any of the interviews, I took time to be 'silent'. This helped focus my mind and free it up from everyday concerns. This enabled me to 'hear' the co-researchers and be open to seeing the world from their viewpoint. For example, following my interviews with Rosy, I realised that the influence of societal views on the co-researchers' own expectations of ageing could militate against seeking treatment. Rosy had been experiencing back pain but attributed it to the ageing process. It was only when she had an acute episode did she seek medical advice, the consequence of which resulted in immediate surgery.

This led me to reflect on how individuals adopt wider societal attitudes and beliefs about ageing and how this can adversely impact on their expectations of ageing, whereby ageing is identified as a time to expect aches and pains. This caused me to wonder whether there is an expectation that one will have health problems because one is ageing as opposed to there being a health problem. This incident influenced my interpretation and development of the finding on 'trying to stay well'.

The cyclic process of: silence, reflection, identification, selection, interpretation, construction and verification (Diagram 3.3) which Halldórsdóttir (2000) recommends entering into at each of the 12 steps of the research process enabled me to think critically, reflectively and analytically about each stage of the research.

An example of how my reflections influenced the development of the finding on 'navigating a changing world' was how a number of the co-researchers spoke about the way they had to adapt to their environment as well as adapting their environment.

I realised that for many co-researchers their physical worlds were shrinking and their 'lived space' was becoming more confined. For example, Aisling took less exercise outside her home as she was afraid of falling on uneven and cracked surface when walking on the footpath. Eleanor no longer used her upstairs as she was unable to navigate the stairs, while others modified their houses with downstairs bathrooms, special beds, fitted handrails and security alert systems. So this lead me to think about how older women balance safety with risk taking e.g. does trying to stay safe prevent them for doing what they want to do and in a way make them feel fearful and overly cautious?

However, in tandem with 'navigating a changing world', within the narratives of virtually all of the co-researchers was the concept of independence. The strength of feeling about this was striking. This led me to consider how being independent and being in control of one's own affairs is a crucial aspect of being an adult. It made me realise that even when one is physically incapacitated or physically more dependent, the desire to be autonomous is an innate and fundamental aspect of what it is to be a person. I wondered then do whether older women are really seen or heard as the person they are rather than the person we think they are within the context of all our layers of judgements, values and typecasting.

While following the steps of the Vancouver school of doing phenomenology and being conscious of ensuring trustworthiness and rigour are important aspects of the research process, all research needs to adhere to ethical standards. The next section addresses the application of ethical considerations for this study.

4.7 Application of Ethical Considerations

It is important that research is conducted ethically not least for the co-researchers but also for me as the researcher, for the third level institution in which I am enrolled as a student and for the body of knowledge to which this research will contribute. The ethical considerations for this study have were discussed previously in chapter 3 (3.7.6).This section describes how these ethical considerations were addressed and applied during this study and addresses core aspects of ethical research including ethical approval; informed process consent; confidentiality and anonymity; fair sample selection; data protection and favourable risk-benefit ratio, underpinned by principles of respect and justice.

4.7.1 Ethical Approval

The research design was approved by the National University of Ireland Galway's Research and Ethics Committee who made an independent assessment as to the overall design from an ethical perspective (**Appendix 9**). Its value was explained in the ethics application. It was flagged that this was an important study as there is little published research reflecting the voice of older women in Ireland and so their specific perspective is largely absent from the current discussion on age and ageing in Ireland.

4.7. 2 Informed Process Consent

A fundamental aspect of the Vancouver school of doing phenomenology involves interviewing co-researchers more than once. This is subject to their agreement to this iterative process. Therefore, process informed consent was required. Written and oral information about the study was provided. The co-researchers were provided with the opportunity to ask questions at any time (before, during or after the dialogue(s) (interview(s)). Specifically all of the women who indicated an interest in the study were provided with an information pack about the study.

They then completed an expression of interest form and sent this to me (SAE was enclosed in the information pack). The co-researchers were afforded a minimum of one week to further consider their decision to participate. By allowing at least a week to elapse, they had time to further consider their decision to participate in this study. Thereafter, arrangements were made to meet at a time, day and place convenient to the co-researchers. Prior to the commencement of the interview, information about the study was provided again and any of their questions were answered, they were also encouraged to ask any further questions at any time.

In this way, at each meeting co-researchers were reminded of the nature of the research and their decision to continue to engage was sought. It can be the case that the co-researchers' interpretation of what the researcher is asking may not fully reflect what the researcher meant. Therefore, in this study, every effort was made to keep the co-researchers informed at all stages of the research process and to check that they understood both these processes and the research aims and objectives

They were also assured of the voluntary nature of this study and made aware that they could withdraw at any time from the study and that if they chose to do this, their decision would be respected and no explanation would be required (none did). Co-researchers were then asked to sign a consent form agreeing to participate in the study **(Appendix 8)**. It is worth noting that not all of the co-researchers decided to be interviewed a second time which indicates that they did not feel obliged and were comfortable in deciding not to participate in a second interview.

A key aspect of process consent is that the co-researchers have the right to withdraw parts or all of the interview data. Two of the co-researchers upon reading the transcript of their first interview asked for some of the information to be removed which was duly done. I went through the

transcript, line by line with them and they reported being satisfied with this. It is worth pointing out that this information had not been directly related to the research specific questions and was more part of general conversation.

4.7.3 Confidentiality and Anonymity

It is acknowledged that the co-researchers could have been concerned about confidentiality and anonymity but I explained that I would not use their real names (pseudonyms were used to protect their identities) or any information that would identify them. The tape recordings were given code numbers. Electronic files were stored on password protected computers and hard copies were stored in my office**.** Access to these anonymized files was limited to me and through me to my research supervisor and on occasion to an Nvivo support expert. The names of the co-researchers were stored separately to the interview transcripts. Care was taken to ensure that biographical data would not identify the co-researchers i.e. very distinctive personal information which could have identified the person was not included in the findings. The interviews were held at times and locations decided by the co-researchers.

4.7. 4 Fair Sample Selection

Fair sample selection includes the inclusion and exclusion criteria as well as the recruitment process which have been described previously. The use of multiple sites helped facilitate fair selection as this provided the opportunity for a large number of potential co-researchers to be informed of the study. Information about the study was initially provided through posters and/or via gatekeepers. Potential co-researchers were free to judge whether they wanted to hear more about the study by contacting me rather than I initiating contact.

4.7.5 Data Protection

The research process was informed by data protection laws (Data Protection Commissioner, 2014). There are number of responsibilities associated with data protection and these have been discussed in section 3.7.6. As the data controller for the study I fulfilled the legal responsibilities in the following ways. The data was collected for the purposes of this research study only. In accordance with the terms of approval by the National University of Ireland Galway Research and Ethics Committee for this research study, the information will be retained for five years. Following this all electronic information will be deleted and hard copy information will be shredded.

As part of this research design all co-researchers whose interviews were audio-recorded (22) were offered a verbatim transcript of their first interview, 17 accepted this offer. All were entitled to request and be provided with copies of their second interviews and/or any personal information being stored for the purposes of the research study. To date none have requested this. Issues in relation to informed consent, anonymity and confidentiality have been described in sections 4.7.2 and 4.7.3.

4.7.6 Favourable Risk-Benefit Ratio

There were no direct benefits for the co-researchers but they have contributed to the body of knowledge on this topic. While it was not anticipated that the interviews would cause any kind of risk to the co-researchers' well-being or safety, I recognised that by discussing their experiences, unanticipated concerns or worries could have been voiced by them. It was also acknowledged that by talking about a negative experience a co-researcher could have become distressed. As a registered nurse I have experience and skills in being able to communicate effectively with people who are upset. Therefore, in the first instance, I was confident of being able to listen and assist the co-researchers.

However, I was aware that co-researchers might have needed more support than I could have provided, so I decided that advice would be provided about the support systems in place (e.g. GP and the wider Health Services Executive services etc.) if needed, however, in this study it was not.

As previously discussed in chapter 3, there can be similarities between research interviews and therapeutic relationships (Hewitt, 2007). In relation to this study, the interviews were not meant to be therapeutic in the sense of a nurse-patient relationship but in order to engage fully with the co-researchers the development of a positive relationship between the co-researchers and myself was crucial to the research process. Whether the co-researchers found the process therapeutic (or not) was not something they discussed but all were happy to be interviewed by me at least once and the majority twice. While a number of the co-researchers had on occasion some less than favourable experiences of the health care services, in the main they were not distressed when talking about their experiences, rather disappointed or annoyed or angry.

There was one exception, one co-researcher recounted her recent hospitalisation and described how poor communication made her feel uncared for which she found upsetting. I listened to her account and her sense-making of this. Another co-researcher said she told me more about her experiences than she had ever told anyone but of course, it is acknowledged that I was asking her about these specifically. I felt it was therapeutic for these co-researchers to recount their stories, highlighting the fact that there can be unforeseen benefits as well as risks to participating in this research. For the majority of the co-researchers (17) the research process was not a ‘once off’ interview and so this could have led to some of the co-researchers becoming a little used to meeting me.

As discussed in chapter 3, there was the possibility that co-researchers could feel loss upon completion of the study (Hewitt, 2007) and I was mindful of this. At each stage of the process from the first interview to the final telephone conversation, I explained what I was doing and why, and that I was open to any questions at any time during the research process.

All the co-researchers were given my mobile telephone number as well as my email and postal addresses. During our final conversations I explained that we had concluded this phase of the research and that we would not be having any further meetings. I thanked them and expressed my appreciation for their participation both orally and in written correspondence. This section has reported on the measures employed to ensure this study was conducted ethically. In summary, it has addressed core aspects of ethical research including ethical approval; informed process consent; confidentiality and anonymity; fair sample selection; data protection and favourable risk-benefit ratio, underpinned by principles of respect and justice.

4.8 Chapter Conclusion

This chapter has demonstrated the application of the Vancouver school of doing phenomenology for this study. It has illustrated how the sample selection and recruitment processes reflected the heterogeneity of older Irish women living in the mid-west region of Ireland. The importance of preparation for data collection is highlighted in the discussion of the pilot study and its evaluation.

The data collection via individual interviews (dialogues) was guided by the importance of the collaborative nature of research within the Vancouver school of doing phenomenology. The steps of the Vancouver school of doing phenomenology provided a framework for the data collection and

analysis with the centrality of the co-researchers' 'voice' being emphasised. Furthermore, issues of trustworthiness and rigour, and application of ethical considerations for this study are discussed in detail. The next chapter, chapter 5 presents the findings of this study detailing Irish older women's experiences of ageing and health related issues.

Chapter 5

Findings

5.1 Introduction

This chapter presents the study findings. The first section presents the essential meaning of older Irish women's experiences of ageing and health related issues, which was found to be 'retaining autonomy within a process of adaptation and continued engagement'. Four themes were found to comprise the essential or overarching meaning of this experience and these are presented in detail. The themes are: 'Being in control: Balancing needs and supports'; 'Navigating a changing world'; 'Being connected and involved' and 'Trying to stay well'. Key interpretive phenomenological concepts (i.e. being–in-the-world, being-in-the–world-with-others, lived body, lived time, lived space and relationality) are identified and expanded upon, both within the overarching theme which reflects the essential meaning of the experience and within the interpretation of the four themes from which the essential meaning was determined.

5.2 The essential meaning of the co-researchers' experience of ageing and health related issues

'Retaining autonomy within a process of adaptation and continued engagement' describes the essential meaning of the co-researchers' experience of ageing and their health related issues. It captures the meaning of the experience in so far as there was a strong desire by the co-researchers to retain autonomy and continue to be the mistresses of their own destinies i.e. to continue to be the decision-maker regarding their own lives. While they wanted and were determined to have this control, they felt they needed to adapt to ageing and their changing health status so they could continue to engage with life.

The co-researchers' experiences of ageing and related health issues were influenced by not only physical factors although this was acknowledged as being very important, but were also influenced by social, psychological, political and economic factors which impacted on their decision-making and ability to retain autonomy, adapt and remain engaged. Older women's reality of 'being-in-the-world' and 'being-with-others' is impacted upon by a confluence of individual elements peculiar to each woman (their life world existentials) with the wider elements of the world in which each co-researcher exists at this current time.

Four key themes ('Being in control: Balancing needs and support'; 'Navigating a changing world'; 'Being connected and involved' and 'Trying to stay well') were identified and represent the women's perceptions and experiences of what the ageing experience and related health issues involved. It is clear from the analysis that age, ageing and health are very much interlinked, reflecting the interconnectedness of the impact of ageing and health/health problems on each other. It would be very difficult to try to separate the experience of ageing from health issues and the management of ill health. The idea that one has an impact on the other can be seen in the interconnections between the key themes and encompassed in the overarching or essential meaning of the experience (Figure: 5.1).

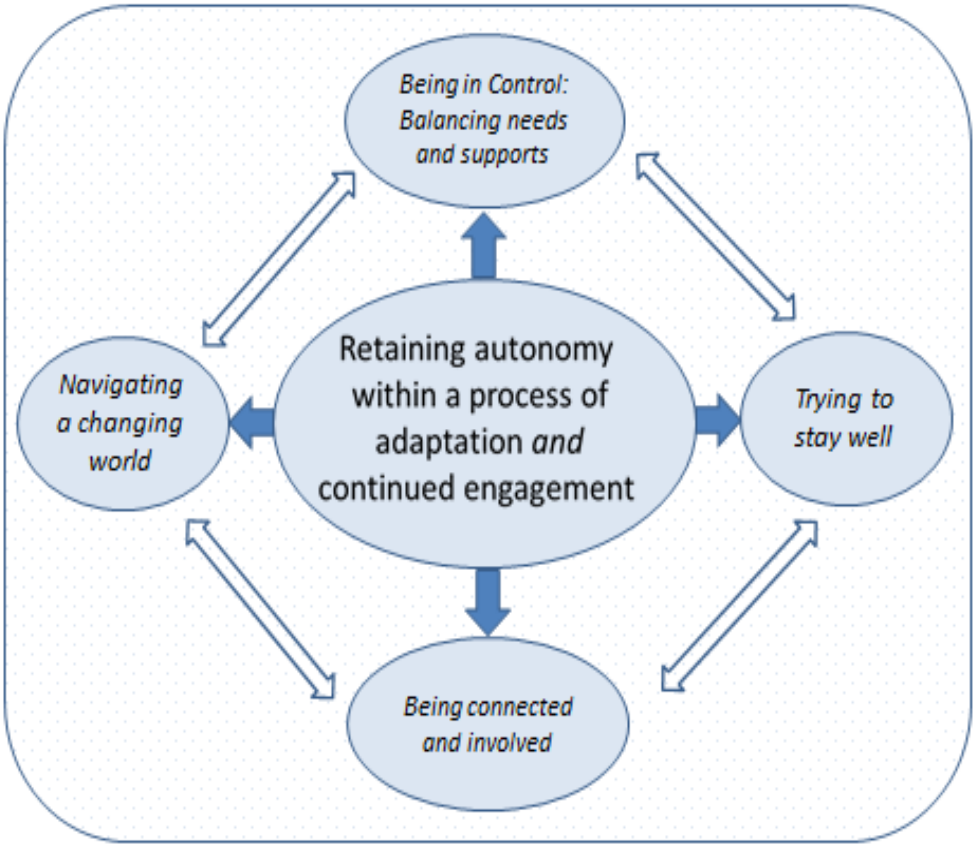

Figure 5:1 Irish older women's experiences of ageing and health related issues: Retaining autonomy within a process of adaptation and continued engagement

An overview of each of the four themes is provided to illustrate their interconnectedness and how together they are captured within the essential meaning of older women's experiences of ageing and health related issues in Ireland (Table 5.1).

The theme of 'Being in Control: Balancing Needs and Supports' reflects the women's experiences of being independent and in control. These experiences were determined not only by the desire to remain autonomous but also by retaining autonomy through personal actions, abilities and external influences (positive and negative) on well-being. However, remaining independent and in control, must be taken within the context of second theme 'Navigating a changing world'. Maintaining independence and control was not without its challenges as the women needed to do this through adapting to living with the more negative aspects of ageing as well as adjusting to the reality of slowing down and adapting to a changing world.

The third theme, 'Being Connected and Involved' reflects the co-researchers' experiences of maintaining relationships through making the effort to engage and stay engaged with life. Staying connected and involved was identified as being crucial to the health and wellbeing of the women as they aged. The fourth and final theme 'Trying to stay well' captured the women's beliefs of what being healthy is and what they actually did to remain healthy in the context of their personal perspectives on ageing, health and ill health.

The four themes taken together demonstrate how the older women worked to retain personal autonomy and independence. They clearly recognised that they have had to make adjustments and expected to make more, so as to adapt their lifestyles to their ageing, health needs and desire to stay well. However, they wanted to continue to make these decisions for themselves. An important aspect of their experiences in retaining autonomy was the desire and determination to remain engaged with life through personal relationships with family, friends, health care professionals, the wider community and for many, with God. The support and strength derived from these relationships augmented their efforts to retain autonomy.

The table below represents the essential meaning of the older women's experiences of ageing and health related issues in Ireland. The four main themes are identified along with the sub-themes of each of these.

Essential Meaning of Older Women's Experiences	**Retaining autonomy within a process of adaptation and continued engagement**			
Main Themes	Being in control: Balancing needs and supports	Navigating a changing world	Being connected and involved	Trying to stay well
Sub-themes	*Having control and being independent* *External influences on wellbeing*	*Living with the negatives* *Slowing down* *Adapting to a changing world*	*Maintaining relationships* *Making the effort to engage and stay engaged*	*Being healthy* *Staying healthy*

Table 5-1 Themes and subthemes of "Retaining autonomy within a process of adaptation and continued engagement"

Each main theme and their subthemes are described in detail in the succeeding sections. Common to all four themes is the interconnectedness of the women's life world existentials. For clarity, these are explicated under each theme and this interpretation is provided in section 5.7 Phenomenological conceptualization of the findings.

5.3 Theme 1: Being in Control: Balancing Needs and Support

Being independent and having control is determined not only by the desire to remain autonomous but also by retaining autonomy through personal actions, abilities and external influences (positive and negative) on well-being. In ways the experience of being in control can be likened to a balancing act between needs and supports. There are two sub-themes to this theme: 1) *Having control and being independent and 2) External influences on wellbeing.* These are explored in this section using examples from the co-researchers to illustrate the meaning of their experiences of 'Being in Control: Balancing Needs and Support'.

5.3.1 Sub-theme: Having control and being independent

The importance to the co-researchers of *Having control and being independent* is evident in how much they valued their independence, their fierce determination to be independent and to retain the right to choose what they wanted to do and how they wanted to live their lives. The extent to which co-researchers valued and expressed their independence was demonstrated in a number of ways such as being self-reliant, making one's own decisions and being able to come and go as they pleased without recourse to or being answerable to anyone else.

> *"I'm as headstrong as a mule…Whatever I want to do; I'll do it, no matter what they'll say… So I am independent that way." (Agnes)*

For Suzanne having a car and being able to drive was crucial to her sense of being independent and she very much valued the freedom that her car afforded her. Having a car enabled her to go on a journey or run an errand whenever she wanted without having to consult or rely on anybody else. Her car symbolised freedom and independence to her, it meant she could go where she wanted and is reflected in the following.

> *"Some days if I feel really out of it I can get into my car and drive to XXX and walk the beach … the freedom to get into that car and go where I want without accounting to x, y or z [is important] …."(Suzanne)*

Co-researchers' individual personalities and personal preferences were important considerations in the context of having control and being independent. This is reflected in the level of engagement that co-researchers chose. While many of the co-researchers felt it was important to 'get out and about' and to participate in various clubs and organisations, a number are described as being *home-loving but not reclusive*.

This reflects the heterogeneity and diversity of the cohort. While all co-researchers valued living in their own homes, some were very happy spending time alone in their homes and tended not to socialise that much. This was by choice rather than lack of opportunity; they preferred their own company or the company of family or smaller circles of friends to that of larger or more organised gatherings such as day centres or social clubs. However, others (e.g. family or friends) though well intentioned did not always accept this decision and repeatedly advised or encouraged club membership.

There is a fine line between actively encouraging and not accepting what someone wants and is perhaps reflective of a paternalistic attitude to older people within society. For example, Winifred liked being at home. She was not interested in joining the local day care centre or other organisations but indicated this decision was not fully accepted.

> *"I'm not that interested …. … They have the ICA and all those things but I'm not in any of them. No I don't go to that [Day Centre] either although everyone is telling me you should be going to it ... But I'm very much a home bird anyway… I don't mind being on my own… I can do what I like when I like." (Winifred)*

Aligned with valuing independence is staying in control which was an important aspect of the co-researchers' experience of ageing. They identified various ways in which they remained in control of their lives. A mind-set of wanting and being autonomous underpinned their actions and is reflective of the value they placed on independence. Being independent and self-sufficient were valued and admired attributes, and the desire to be independent influenced how they made decisions. They recognised that being independent (for them) meant being responsible for one's own actions and living with the consequences of these actions.

> *"I always had to make up my own mind and suffer the consequences… make your decisions and if they were stupid decisions, so what and if they were good, excellent." (Noirín)*

Being and staying independent was a sentiment which resonated with all co-researchers. Staying in control was assisted by being organised and pro-active, these were highly valued and key to being able to manage and direct one's life and maintain independence. The co-researchers believed that the onus was on them to stay independent and that they would not and could not expect others to do things for them. Retaining this ownership and responsibility was an important part of staying in control and independent, the alternative was to cede control and hand responsibility over to others.

> *"If you don't do it, well nobody is going to say come on … 'let's get going'. They won't do that, you have to do it for yourself."(Úna)*

The subject of allowances and benefits available to co-researchers is discussed in more detail in the next sub-theme *External influences on well-being.* However, it is worth pointing out that 'money matters' i.e. fiscal considerations and the management of personal finances were identified by the co-researchers as being crucial to staying in control and being independent. Being financially independent was an important aspect of overall independence.

> *"My name always went on the [house] deeds… the children's allowance was paid to me …I felt it was my right. When I was working I had my own money. I always had my 'running away' money… that would be a very strong point with me, having my independence and being able to do what I wanted to do." (Noirín)*

Part of being independent was balancing risk taking and safety. Many of the co-researchers were quite determined and pushed themselves mentally or physically to continue to do what they wanted or felt was the right thing to do even in the face of incapacity and increasing health problems. For example, Michelle was determined in spite of ill health to make the effort to go and visit a sick sibling who lived overseas.

> *"I can still make myself do what I want to do … no matter how I felt, I'd be off like. There would be nothing I think would keep me back from going, that's how I feel."(Michelle)*

Similarly Rebecca (who is wheelchair bound) was very determined to maintain her independence and used aids such as her scooter to enable her to get out and about by herself. Risk taking was a 'trade off' for Rebecca, sometimes what she chose to do was not the safest thing for her physical wellbeing but it was more important to her to be involved in what was happening in her locality. The alternative was staying at home or waiting for someone to take her and thus being dependent on others and subject to their availability.

> *"I went even up to the horse fair…I know 'twas stupid and all that but I went up anyway…well horses and everything …'twas dangerous." (Rebecca)*

However, wanting to stay in control and be autonomous was tempered by an acknowledgement that there were factors which can erode independence. In general co-researchers were concerned about the erosion of their independence as they aged. Not respecting one's independence was identified as being problematic as exemplified by Rebecca, who disliked it when people did not respect her choice to be independent. She described her annoyance at her treatment at a local social event.

> *"What they do is take away my wheelchair from me … I can't go to the toilet at all .[They] put it [wheelchair]over in a corner… out of the way, so if I want to go the toilet then two of them will have to give me a hand to get me into the toilet which is stupid. I said it to them … they said 'you'll be alright'. That's why I stopped going up there." (Rebecca)*

These experiences were in sharp contrast to those at events organised by the MS Society as Rebecca explained

> *"I go now with the MS Society, I can go to the toilet and everything on my own."(Rebecca)*

At a more general level, co-researchers feared that their personal autonomy could be taken from them by others as they aged. This related particularly to others making a decision to place them in a nursing home whether they wanted it or not. They were afraid that others had the power to make unilateral decisions about their lives and they (the co-researchers) had little or no power to challenge this. For example, Rosy's family wanted her to go to a nursing home but she was not receptive to this.

> *"They'd like me to go into a nursing home…. a nursing home, jeepers. My daughter said 'I'll pay for everything'. She picked out different ones, those communal places…. I left her talk away but… but I've no notion of going there…" (Rosy)*

However, Rosy was concerned that she may not have a choice and the decision would be made for her even as she tried to postpone what she believed as the inevitable.

> *"They might put me into a nursing home. I wouldn't fancy going into a nursing home…. and they want to put me into a fancy place. 'We'll look at someplace, we'll have the spring' I said and 'we'll get a few months out of it and then we can sell it [house] before the winter maybe'." (Rosy)*

In contrast to the above idea of control being taken from them, other co-researchers acknowledged that as they aged they may not be able to live independently. In this way age and ill health were seen as eroding their independence. They were concerned that they may need residential nursing home care in the future and this was not something that any of the women wanted.

The concept of losing their independence and being dependent on others, not having the freedom to come and go as they pleased, to have others care for them and make decisions for them was anathema and something to be avoided if possible. An indication of the level of antipathy towards moving into a nursing home is illustrated by Jane who implied she might consider suicide. However, even though the notion of going to a nursing home was a hypothetical question for her at this time in her life, her sentiments reflect her strong feelings about what a nursing home means to her.

It is likened in a way to jail, a place with no freedom and highlights the perception that nursing homes are a place of dependence. While other co-researchers' reactions were not as extreme as Jane's, needing to go to a nursing home seemed to be the ultimate erosion of independence for the co-researchers.

> *"Wait till the time comes. I might knock myself off… You know I feel a nursing home is like... lock her in there, throw away the key."(Jane)*

However, co-researchers recognised that their independence was modified in so far as they had to tailor their activities in response to their abilities. Therefore, they made choices and compromises regarding what they wanted to do, accepted help on their terms and acknowledged that they had increased dependency albeit this differed across the cohort.

However, even for those who were quite physically dependent, personal control was still maintained in their situations through negotiation and partnered decision making with family and so decisions regarding care and help were primarily led by the co-researchers themselves.

However, initially for many co-researchers needing to ask for help indicated to them that they were no longer able to cope and stay in control. Being reluctant to ask for help seemed to stem from the fact that to do so would indicate that they had failed. Éilis spoke about her personal experience of caring for her deceased husband and how she gradually came to recognise that she needed to accept help to care for him. Initially she expected that she should be able to manage by herself.

> *"I couldn't go out and leave him but I did get help after I gave in to it which I was a bit reluctant. Independence, Its terrible…Foolish… I thought I should be able to do it you see." (Éilis)*

Many co-researchers recognised that ageing was a continuum and that while many were independent, there were now some new levels of dependency in their lives. This change in independence was not something the co-researchers liked or wanted but many believed that they needed to accept this change and adapt accordingly to retain independence. For example, Éilis eventually accepted this and did now ask for and accept assistance when she needed it.

> *"Well at the beginning I didn't like it but I just have to make up my mind well that's how it is… in all honesty what can you do? No I would rather to be more independent." (Éilis)*

However, others felt that as one aged and as one's health deteriorated that independence was difficult to maintain. In such situations, some co-researchers engaged in partnered decision making. For example, Saorcha was unable to live independently and her situation reflected the need for joint decision making. She made decisions with her family regarding living arrangements and activities. With assistance from them and the home help, she lived three days in her own home and the other days of the week in the homes of her family. Saorcha would prefer to live in her own home all the time but recognised that compromises needed to be made and she accepted the arrangement as the best option.

> *"I'd prefer to be in my own house if I was able to get on there but sure when I'm not." (Saorcha)*

This arrangement while not ideal did try to accommodate Saorcha's wish to spend at least some days in her own home. Within the concept of 'modified independence' it is acknowledged that family, neighbours and home helps play an important role in helping many of the co-researchers retain their independence.

Overall being independent is a central theme in the co-researchers' experiences, being able to determine and decide how they wanted to maintain their independence was important. The concept of choice and the facilitation of choice was a crucial aspect of their experiences.

5.3.2 Sub-theme: External influences on wellbeing

Co-researchers' desire to be independent and in control was determined to some degree by external influences such as financial factors including benefits, allowances and entitlements as well as safety and security measures. These factors had either negative or positive effects on their level of independence, control and ability to choose and ultimately impacted on their health and wellbeing as they age.

Financial security had a positive influence on being independent because it gave co-researchers freedom to make choices about how they lived. Social welfare benefits including: pension entitlements, home help, medical and GP cards, allowances for fuel, television licence, electricity and free travel were identified as making it easier to live independently. However removal and/or reductions in such support as well as new charges have had a negative impact.

Many had non-contributory pensions. Invariably not everyone was content with the amount but most were relatively satisfied with their pensions. While it covered basic living expenses it was acknowledged as being challenging if one wanted it to meet other expenses e.g. saving for Christmas or socialising. While those in receipt of the fuel allowance were grateful for it, they acknowledged that it did not actually cover all their heating costs.

Therefore, some supplemented it themselves or their family helped. The availability of Government grants in order to refurbish or adapt homes was also identified as being positive. While some co-researchers could supplement these grants privately, many had to accept that the grant did not cover all the work that they wanted done. For example, Rebecca converted a garage into a bedroom with en-suite bathroom but she supplemented her grant with her own money.

> *"I got a grant...I had €6,000 to pay out on my own." (Rebecca)*

While these benefits were welcome in so far as the co-researchers could make certain choices about how they lived their lives, the issue of supplementation highlights how disparity in income and means can impact on life choices. This is a reality regardless of age but impacts more on those who are older because they have fewer opportunities to augment their incomes and are less likely to be in paid employment. Being knowledgeable about what services and allowances were available was important, for example, Kelley knew who to contact for information on how to access housing grants and medical supports but not all co-researchers were as aware.

Being informed and having the capacity to know how to access information is something which impacts on one's ability to be in control and independent and those without this 'know how' can be at a disadvantage. All co-researchers were entitled to a free travel pass but their usage varied. Some used it extensively; others used it infrequently for particular or once off occasions. Others could not use it because of physical incapacity or because they were not on the bus/train route so unless they had a way to get to the bus/train stop it was of little use to them. However, those who did use it, found it useful. Ellen valued her free travel pass as it enabled her to be independent.

> *"This free travel is great for older people …I'd be very slow to justify paying the train fare to Dublin…So I wouldn't go…if I've the free travel I can go… Come and go as I please so." (Ellen)*

The provision of day care centre services also contributed to well-being. Many of the co-researchers found these beneficial in terms of company, interaction, fun and support.

> *"Best thing [that] ever happened… the staff are fantastic….you can have great crack with the staff and... there's a different crowd every day."(Aisling)*

Transport was provided to take people to the day centre and many availed of this. This service also provided 'peace of mind' as it was routine for the bus driver to check whether co-researchers were alright if he did not see them waiting for the bus. Co-researchers accessed public health services through GP or medical cards and these were identified as a positive factor in health maintenance. Some visited their doctors monthly, others less frequently. There was less interaction with other health care providers (e.g. public health nurses (PHN), occupational therapists or physiotherapists). The general view was that these health care professionals were available if one needed them but for a specific reason only. Based on assessment of need, the HSE provided equipment such as walking canes, walkers, wheelchairs, chairs and mattresses.

These practical supports enabled many of the co-researchers to continue to be independent. In the absence of regular PHN or other health care professional visits to older people, the onus was on the co-researcher to make a judgement on their health and decide whether they needed assistance. This could present a challenge in knowing when to make that call i.e. how compromised does one's health need to be before assistance is sought and how does one determine the need for assistance?

> *"Before now ….the nurse would call at least once a year….We haven't seen a nurse for years… I will talk to her in [health centre] if I want anything or talk to her on the phone ... she always says that she's very busy but if you really need me I will come."(Betty, Saorcha's carer relative)*

Some co-researchers had home helps and this service was very valued as a means of supporting independence because it helped facilitate many co-researchers to stay in their own homes. Typically they developed positive and in some cases close relationships with those providing the home help service as exemplified by Agnes.

> *"I have great help in her ... she's a marvellous little girl, she's more like a sister to me than my home help…She's a great girl." (Agnes)*

However benefit provision was affected by the cutbacks. The negative impact of the recession and severe cutbacks on supports as well as increased living costs were acknowledged by co-researchers. There have been increased costs in goods and services and new levies e.g. the universal social charge, property and water taxes, septic tank levy and removal of the telephone allowance.

Certain cutbacks had particular implications for the co-researchers such as increased prescription charges, increased threshold for over 70s medical card eligibility and reductions in home help hours, household benefits (e.g. electricity, gas, fuel allowance) and housing adaptation grants. Furthermore, reductions in overall health care spend and health care provision had some negative impact with regard to increased hospital waiting lists and PHN visits.

Some co-researchers invested in private insurance and believed this was necessary if one wanted to stay healthy and have early access to treatment and care. This approach is not unreasonable within the context of the current economic climate with long waiting lists for consultation appointments and for treatment through the public system. In an effort to reduce prescription costs the Government has advocated the prescription of generic rather than branded medication to public patients.

Not all co-researchers were convinced that these drugs were of the same quality and were sceptical as to why they were being prescribed. This highlights the need for people to be confident and trusting of the motivation and services of health care providers and points to the need for appropriate health education when introducing new or different services.

> *"They're changing them anyway while you're on the medical card …they're trying you out with...[generic ones]… I would have to find out why they're cheaper." (Michelle)*

The co-researchers were very concerned and even angry about whether their benefits would be further reduced or removed in line with the current austerity measures. These fears had a negative impact on the co-researchers' sense of 'peace'. There was further anger regarding the perceived inequities and inequalities in how they and the general public were treated in comparison to others within society.

Some believed that those in position of power and privilege were not subject to the same level of scrutiny nor had they suffered the same level of wage/ pension reduction as the general public. Noirín explained that older people had paid their dues and should not have to pay for the excesses of the Celtic tiger.

> *"I'm sick and tired of paying for everything… we are the people who brought the country as far as it did up to that Celtic tiger. We are the people who paid our taxes ... in order to bring the country up to the standard that it was… I find it very annoying." (Noirín)*

Further to the monetary aspects of external influences on wellbeing were the external influences on 'feeling and being safe'. Co-researchers identified feeling and being safe and secure as an important aspect of ageing well which positively impacted on their sense of wellbeing and overall health. Some feared for their physical safety in so far as they might fall but also feared having their homes broken into.

Many took measures to prevent falling and also planned how to contact someone in the event of falling. Preventative measures included being careful, having railings fitted and using walking canes or walkers. Some of the co-researchers kept their telephones close by and used these to contact family/friends if they needed help. A number had monitored personal alarm systems. For example, Michelle had previously fallen and was not found for two days, this has made her quite fearful and she has since acquired a person alarm pendant.

> *"I fell a couple of times in the apartment... I was there for two days... they had to break in the door.... I was just cold as ice … I'm always frightened after what happened me that time ...I was frightened it [would] happen to me again ...but thanks be to God I'm lucky now... I never fall, I'm very careful. I have my panic button." (Michelle)*

Not all of the co-respondents had alarm pendants and those that had did not always wear them. Siobhán did not have one and felt that pride prevented people wearing them suggesting that accepting that one needed an alarm could have an adverse impact on one's sense of independence.

Some co-researchers chose not to wear their pendants but rather kept them in one place. This may be from convenience but could also reflect ambivalent feelings such as wanting to have the alarm close by but not wanting to wear it. Wearing it could be seen as a diminution of independence.

> *"I have the alarm bell …I have it below on the head of the bed [laughs]."(Agnes)*

Conversely it could be argued that having and wearing a pendant is a symbol of taking control and being practical as it may be of use if one falls or becomes ill. Therefore, rather than a sign of increased dependency it could be construed as an aid to maintaining independence.

> *"Oh I'm very careful, I always have that [pendant] around my neck or in my pocket… and beside me at night in the bed… for safety."(Éilis)*

While being frightened of falling was a very real concern, many of the co-researchers were also concerned about their personal security particularly within their homes. Sometimes this fear was heightened by hearing of crimes on older people on the media. Therefore, having a personal monitoring alarm system had a dual purpose in so far as being useful if one fell but also if one's house was broken into.

Some of the co-researchers had fitted light sensors and alarms in their houses. In addition, many relied on vigilant neighbours who keep an 'eye on their houses' and who called in regularly or could be called upon. However it is acknowledged that in the countryside especially, there are not as many neighbours around as in previous years reflecting societal changes e.g. people commute to cities and towns for work, more women work outside the home and increasingly people farm alone.

Of concern was a lack of visible Garda[7] presence (in both rural and urban areas) and this added to their sense of insecurity in so far as they thought a more visible presence could act as a deterrent. Kelley bemoaned the lack of Gardaí visits to people in the community and had not had a visit in over two years.

> *"I never see a Guard, there is supposed to be a community Guard at least come around once a month, they don't." (Kelley)*

For two of the co-researchers, fears about 'break ins' had been realised as they had been victims of crime. Their homes had been burgled and robbed. This left these co-researchers more fearful and adversely impacted on how secure and safe they felt in their own homes. This sense of insecurity was compounded by the fact that both lived alone. Since being burgled Eleanor was especially fearful and this had adversely affected her sense of feeling safe within her own home.

> *"I'd love someone to be here at night… I don't go to bed until one or two o'clock in the morning… I'm still afraid to go to bed early in case anyone breaks in the back door. Even when I'm inside in bed I'm looking round the room and making sure that there's no one around."(Eleanor)*

Kelley was still living with the effects of being burgled and worried about the perpetrator's imminent release as he lived in the neighbourhood

> *"He's in prison; he'll be out any day. Oh I dread him. I dread him … they do be that high on drugs you don't know what they're going to do… It is an anxious time." (Kelley)*

[7] Garda refers to a member of the Police force. Police officers are commonly known as guards

Reflective of the heterogeneity of the cohort and in recognition of the co-researchers' individual experiences, it is important to point out that a small number of them were disillusioned with the justice system. Furthermore at least two had been victims of crime and their views may have been influenced by these personal experiences. Overall, external influences on wellbeing include financial factors such as benefits, allowances and services. In addition, co-researchers identified feeling and being safe as impacting on their sense of wellbeing.

In summary the theme of 'Being in Control: Balancing Needs and Supports' captures the co-researchers' experiences of remaining independent by retaining personal autonomy through being determined, proactive and utilising available supports. Remaining in control of one's life is affected by both internal (e.g. personal attributes, physical and mental wellbeing) and external influences (e.g. factors affecting health maintenance as well as feeling and being safe).

5.4 Theme 2: Navigating a Changing World

The need to live in and navigate a changing world was evident in all the co-researchers' experiences. Three subthemes were identified: *Living with the negatives; Slowing down* and *Adapting to a changing world*.

5.4.1 Sub theme: Living with the Negatives

For many of the co-researchers, age and ageing had negative connotations, believing it could and did adversely impact upon their health. The co-researchers clearly identified that they were living with the negative aspects of ageing and that their health concerns were linked to this. In particular there was a resignation that ageing is part of life rather than something that they particularly looked forward to. For a number of the co-researchers certain worries and fears had been realised while for others they were concerned about these occurring in the future.

A key aspect of living with the negatives of ageing is the concept of 'going forward but not liking it'. This encapsulates the co-researchers' reluctant acceptance of ageing within the context of not liking the process or of looking forward to it. Ageing, health and ill-health are interlinked, many had health problems associated with or exacerbated by ageing and they were concerned about not being a burden on their families as they aged. Growing older was a difficult phase of life for many of the co-researchers as they felt sad about what they were losing or could no longer do.

> *"I don't want to get old. I hate the thought of getting old. I'm old... I'd love to be young. I would always look at fashions ....and say 'oh wouldn't I love that now. I'd love something like that' ... but you can never have a thing like that again."(Michelle)*

The sense that time may be running out influenced how co-researchers planned for their futures. Many of the co-researchers agreed that while they made provisions for their future (e.g. pension, savings, health care needs) they did not make very long term plans as such.

> *"I wouldn't be making plans for a year ahead… no way… first of all you'd wonder ... would we be able to afford it, would we be both well enough to go."(Noirín)*

However, all co-researchers were in agreement that when the time came for them to die they hoped it would be quick. Many were concerned about having debilitating conditions, fearing that they would be incapacitated and need extensive help and care. This worried them as none of them wanted to have to go to a nursing home or be a burden on their families. Many had personal experiences of caring for their own relatives and did not want their families to have this responsibility either in providing the care or having the financial burden of paying for care e.g. nursing home fees. These sentiments speak to how the co-researchers wanted to remain in control and independent in as far as possible.

> *"I just wonder how I'd face that … I wouldn't like to be lingering on ...and everyone tending to me. I'd hate that… because I was always kind of very independent."(Winifred)*

Tied in with losing one's independence and having to ask for help were co-researchers' feelings of not being valued or not even thought about because one is older, reflecting their sense of there being general negative or even ageist societal attitudes toward ageing and older women.

> *"Nobody takes any notice of me now, they couldn't care less you know when you're over sixty, you're heading for the grave… it's disgraceful, nobody kind of bothers."(Avril)*

This perception of not being treated as an equal adversely impacted on how this cohort felt they were viewed and treated. It is further exemplified by the belief by some co-researchers that age limits for health screening places older people at a disadvantage at best or at worst are discriminated against.

> *"I think from sixty five onwards we're dumped… you're over sixty five, forget about us but that's not right… they should bring in something that's specifically for older people, say sixty five to eighty … it would prevent people having to go into nursing homes…I get annoyed when I see up to sixty five, everything stops at sixty five."(Noirín)*

A further aspect of living with the negatives of ageing was the concept of 'living in a shrinking world'. The co-researchers' lives invariably changed as they grew older e.g. retirement, less household duties, less responsibilities and increased bereavements (e.g. spouse/partner, family, friends). These changes contributed to a contracting social world. Furthermore, within the space of a generation there have been significant societal changes and expectations regarding with whom older people should live.

These have been influenced by the role of women in the home, life expectancy and families living larger distances from each other. Living as an extended family with several generations in the same house had been the norm for many co-researchers when they were children and younger adults. Indeed many had cared for their own parents and/or parents-in-law. It is unlikely that any of the co-researchers could have foreseen a situation where they would either be living alone or with an elderly spouse when they themselves were old.

For many, living in this new world was exemplified by experiences of loneliness, feeling invisible and feeling frightened. For example, Rosy lived alone with little immediate family living nearby. Even though she did visit her family regularly and kept in contact, she felt very lonely.

> *"They [children] ring regularly…they're very good, [they send] cards and presents ... but 'tis very lonely."(Rosy)*

Some of the co-researchers admitted that they were not good social mixers and were often reliant on family for companionship. When circumstances changed e.g. bereavement/family living far away, this had a negative impact and they often felt lonely. For example, Avril was lonely but also reserved and so found it difficult to socialise in contrast to her deceased husband, who had been outgoing. She had depended on him both for company and to guide her through social situations.

> *"Loneliness is the worst...I'm a bit of a loner like ... I say good morning to my neighbours and good night ... Jxxx[husband]was always out with the garden and he'd be chatting and everyone that would pass would know him but... I withdraw a bit more."(Avril)*

A number of the co-researchers had become more fearful and 'scared' as they aged. Not surprisingly for some, their fears were exacerbated upon the deaths of their spouses as they were now living alone. Living alone may certainly contribute to feeling lonely but not all of those living alone felt lonely and conversely some who were not living alone felt lonely at times. For example, those who had retired from work outside the home missed the company of work colleagues and the routine of employment.

A final aspect of 'living with the negatives' were the challenges for healthy ageing. In particular co-researchers worried about the impact of ageing upon their health, as well as the impact of ill health on ageing and how these could adversely affect their personal autonomy and independence. Some co-researchers found that they became aware of their ageing when their health began to decline. The effects of ill health negatively impacted on their ability to do things they could previously do, either they could no longer do certain things or else it took them much longer. Ageing for them was very much linked with their declining health.

It seems that a point came for them when they realised that they had to adapt to the demands of their bodies. They responded with acceptance and/or anger. Having to ask for help was very difficult for many of the co-researchers and heightened their fears about losing their independence. For example, Aisling explained that having arthritis made her realise that she was ageing which made her angry because she could no longer independently do what she wanted to do.

> *"I could be all day in a perpetual state of anger … all my life I was helping somebody ... now I have to humble myself and ask for help. From being useful to being useless."(Aisling)*

Siobhán agreed that it was hard to accept that she could no longer do the things she used to be able to do but believed it was important to accept this.

> *"You have to accept it even though you hate having to accept it. You have to give in and say well I can't do it, and that's it … It's an awful thing to have to say... we don't want to admit it but you'd have to admit it." (Siobhán)*

In addition, to adapting to current health problems, co-researchers feared serious illness. In particular, they identified three specific illnesses: stroke, cancer and dementia. The major concern was the loss of autonomy and dependency associated with these illnesses. Co-researchers reported insider experiences of the devastating impact of these illnesses because they knew someone or had cared for a relative with these illnesses. For example, Aoife described her fears about losing cognitive capacity and personal autonomy should she develop dementia.

> *"The big fear of Alzheimer's ….a big worry…I would hate that ... so God forbid...Keep that away... my sister-in-law died with it. It was awful. It was sad to see her. I would have a fear of that now. I would be hoping that wouldn't happen… because it's a terror not knowing what's going on." (Aoife)*

To summarise co-researchers recounted how they were living with the more negative aspects of ageing. Their experiences included striving to manage the challenges to healthy ageing as well as accepting and adapting to ageing and health related problems within the context of a 'shrinking' world. Concerns about personal safety, security and financial were also identified as negative factors associated with ageing and ill health. These issues have been discussed previously in 4.3.2. Sub-theme: *External influences on wellbeing*.

5.4.2 Sub-theme: Slowing down

For many of the co-researchers 'slowing down' describes when they first realised that they were getting old and were not as physically able as before. They identified 'slowing down' as a time of increased dependency and loss with an exacerbation of their health problems. However, on a more positive note, a number of the co-researchers did see ageing and 'slowing down' as a time of opportunity where one can pursue personal interests.

For many of the co-researchers, ageing was seen as part of life's natural order in so far as there is a 'time for everything' in life. Some felt they had reached the older stage of their lives while others felt that they were not quite there yet and that they were only at the beginning of the older age continuum. However, acceptance of ageing as a natural part of life was identified as being important.

> *"No one wants to grow old. You try to keep young I suppose as long as you can… But then you just gradually... you get there and accept it and it's grand... I suppose that's just nature". (Aoife)*

Interestingly there seemed to be an 'age' that many of the co-researchers pinpointed as the time when they felt old and realised they were ageing and this varied for different people.

> *"I find the eighties has slowed me down a lot…I wasn't bad in the seventies but now everything is a kind of a hardship really to do anything. I'd be saying to myself 'is it lazy I'm getting?' but it isn't, no I'm just not able. And I get so tired after anything I do." (Winifred)*

> *"I do see a relationship between ageing and my health and I am aware that my body is not at all as obliging at seventy five as it was at seventy."(Niamh)*

Important contributors to the co-researchers' experiences of 'slowing down' were diminishing health and abilities. For many, ageing (interlinked with health problems) happened gradually.

> *"It [ageing] creeps up and all of a sudden it's there. You don't feel it creeping up and then all of a sudden you're not able to do things that you should be doing ... or you put things off doing them."(Siobhán)*

As the co-researchers got older, they became aware of having less energy and less ability to recover quickly from physical exertions; they reported having less energy reserves to draw on overall. They adapted to this by pacing themselves and taking rests. For some it did affect their ability to continue to engage in hobbies, reading and socialising. Some co-researchers with multiple morbidities identified certain health problems as being more difficult to deal with than others. For example, Roisin had survived several types of cancer but it was her increasing visual impairment which she found most challenging. The effects of this impairment were wide ranging and seriously impacted on her ability to be independent as it affected shopping, walking, tending to household duties, socialising, reading and watching television to mention a few.

> *"The cancer was bad but I think the sight [is] the worst thing of all. It's a very hard thing to accept… I can't see television, I can't read and I can't write. I can't go out for a walk on my own because I wouldn't see what was on the path."(Roisin)*

This highlights the far reaching effects of certain chronic conditions, and it is acknowledged that other co-researchers had their own particular examples e.g. diabetes, cardiac and mobility problems etc.

The notion that 'everything is down to old age' was something that many of the co-researchers experienced. This refers to them attributing decreasing abilities and medical problems to being old and their ageing bodies. They believed that as they aged, their health would be compromised and so they had lower expectations about their health.

> *"I am seventy three; I can't expect to be walking at the pace I used to walk."(Noirín)*

> *"I got my two knees done. Not great now, I suppose my age probably holds 'em back a bit."(Winifred)*

However, sometimes new problems or an exacerbation of existing problems were not recognised as such by the co-researchers and consequently they sometimes did not seek medical advice. In addition, there were cases when these problems were attributed to the ageing process by health care professionals.

> *"We both go to the doctor and tell them the tale and the doctors listen and you can see they're thinking you know he's such and such an age, what does he want?" (Jane's partner Joe)*

However, this approach was not without its problems. For example, Rosy had back problems and felt that this was very much associated with her age. However, her problems were such that she needed urgent surgery. This highlights that not all problems can or should be attributed to general decline and there may well be an underlying pathology or problem in the older patient that needs investigation and treatment.

It is acknowledged that other co-researchers did not think about ageing as such and just accepted what they could or could not do. For example, Sinead acknowledged that she did not think about ageing much and was more focused on living in the present rather than thinking or worrying too much about the future.

> *"I just go along with the present. I'd rather not think... I just wouldn't think about it. And I suppose if you're busy you don't have time to think."(Sinead)*

Some of the co-researchers did not believe that they had reached old age yet, suggesting that there are incremental stages to becoming older. This may also be a reflection of their perceptions of old age. If old age is identified as a time of incapacity, dependency and ill health, then those who do not fit this profile would not see themselves as being old. Individual beliefs and attitudes about what it means to be old are influenced by and can be reflective of wider societal views. For example, Sinead did not go to the day care centre as she believed it was for older people with particular needs.

> *"I'm not in that category yet" (Sinead)*

Overall, it is acknowledged that during this phase of the co-researchers' lives, growth and decline were juxtaposed in so far as their health and abilities were declining but there were also opportunities for personal development. Many of the co-researchers experienced this period of their lives as a time of having less responsibilities and more freedom to relax and pursue their personal interests. These included undertaking courses or developing new hobbies (e.g. computers, literature, art and sewing). They also had more time to attend social clubs, day centres, associations and organisations. The concept of personal development in conjunction with the process of ageing and development of health problems is captured by Niamh.

> *"It means what I think Shakespeare summed up in the seven ages of man... 'and so from hour to hour I am aware of rotting and rotting and from hour to hour I am ripening and ripening and thereby hangs a tale'. That's what I have to deal with, the awareness of my nearer closeness to decline and simultaneously my intellectual growth at a pace that appears to me internally to be faster than it ever has been in my life"(Niamh)*

Some co-researchers believed that old age was a time to 'hand over' responsibilities to the younger generation. This reflects the idea that at particular stages in life there are associated rites of passage and tasks to be accomplished.

> *"I think the younger people should be more involved [in a community]. When you get to a certain age I really think you should leave that to the younger people as such… because definitely you're not going to be able to do things."(Aoife)*

In addition, to changes in health and abilities, the experience of 'slowing down' was also a period of contemplation for many of the co-researchers. It enabled them to reflect on their beliefs about life, mortality and God. Most of the co-researchers had a strong belief in God, and faith was part of their everyday lives. It was not something they questioned or thought about as such as it was interwoven into the fabric of their lives.

> *"I have a [religious] belief that gets more important as I get older… it is a dimension that... keeps order and balance and gives hope."(Niamh)*

In contrast other co-researchers had begun to question their beliefs in God and religion. It was a time of uncertainty as their beliefs and views about God had changed over the years. This was exemplified by Michelle who hoped there was something there after death.

> *"There must be something there, there must be something for good and there must be something for bad… normally as we get older I think myself we get more religious. That wouldn't be unusual whereas I find as I'm getting older… I'm going the other way you know."(Michelle)*

During this period of reflection a number of the co-researchers became aware of their own mortality and some believed that they had a 'limited time left'. Some were quite sanguine about death and dying.

> *"I mightn't see next Christmas. When you're old you don't expect...I'm ready to go. I don't care now if I die in the morning… I wouldn't care. I'm prepared. I have my mind made up that I have to go and I haven't long more to go, you know you can't expect to live forever."(Eleanor)*

However, others chose not to think about it very much and left it in the hands of God. While more were less sure and did not think it was something they were ready for yet.

> *"I'm not prepared for it… are any of us prepared for it?" (Michelle)*

> *"I don't think I'm ready yet." (Sinead)*

In conclusion 'Slowing down' captures both the negative and positive aspects of ageing experience and its related health issues. In a way, it seems to be a dichotomous entity as it can be likened to both a period of decline and growth.

5.4.3 Sub- theme: Adapting to a Changing World

The third sub-theme of the experience of 'Navigating a changing world' is *adapting to a changing world*. Co-researchers recounted how they experienced a changing world with different societal values, extensive technological developments, as well as intergenerational differences. They felt they needed to adapt to and make changes to their environments in response to their age and health related needs and so in a sense their world was also changed because of how they now perceived it. Adapting to a different world after loss and bereavement was also highlighted and was an experience common to all.

Many of the co-researchers believed they were experiencing a changing world in the sense of: taking retirement, having less home duties while simultaneously having (for some) to take up the role of unofficial carer for their husbands. Retirement (from paid and unpaid work) was recognised as a major change in many of the co-researchers' worlds. The status accorded the co-researchers through their role was important. This is not surprising as people generally have an investment in being employed, as it helps define their personal perception of self-worth through both having a job and the role associated with that job. Furthermore, the camaraderie and social interaction of working was beneficial to the co-researchers in addition, to the sense of purpose that employment afforded them. For example, Suzanne's life had changed very much since retirement (from teaching) and this is was something that she was still adjusting to several years later.

> *"I've lost my jizz. Tis retirement…I retired in June and I woke in September. I remember the morning well, 'I have nothing to get up for, what am I getting up for, sure my life was useless. What have I to get up for, sure I'm no use to anyone now'. So that was a tough year, a very tough year". (Suzanne)*

In addition, to retirement, many co-researchers took up new unanticipated roles of being unofficial carers for their husbands. The carer role impacted on their lives. For example, both Roisin and Sinead felt responsible and concerned for their husbands both of whom have dementia. The change in their husbands' cognitive abilities had negatively impacted on both co-researchers' lives, particularly stressful were their safety concerns for their husbands. Being a carer within the context of ageing, increased health problems and decreased functioning was challenging.

> *"[I] went in the room and he wasn't there. So I rang around the families... and then I found him ... he was gone to a music session... But I didn't know where he was... I was just afraid". (Sinead)*

> *"…very very much [a worry]... he fell several times last year. He has fallen a lot. He's gone from knowing where anything [everything] is... he wanted to know where the tea was the other day. I'm always shouting to know where he is ... if he goes down the back [of the house". (Roisin)*

All of the co-researchers have had to adapt to societal and technological changes. A number of generational differences in societal values and practices were highlighted. Some of these practices were accepted by the co-researchers (e.g. co-habitation before marriage) while others were more difficult to accept (e.g. child rearing practices, secularisation and church attendance). There have been enormous changes in religious practices, in particular less regular attendance at mass. For some of the co-researchers this had impacted on their own attendances.

> *"Up to a couple of years ago, I went every Sunday to mass… [now] there's no one going. There isn't twenty in the church down below. It's a change in the religion... all the young people don't go to mass… there is about twenty elderly going."(Kelley)*

Many co-researchers preferred socialising with people of their own age as they felt they were more at ease within this company. They were in the main with like-minded people and so there was a comfort in this familiarity.

> *"An easiness now rather than being stressed or wondering... we have a cup of tea...and we have a chat and we play the Bingo...well tis just the camaraderie."(Aoife)*

This is not surprising as groups generally share a common purpose with agreed norms, and similar interests, values and beliefs. However, many co-researchers did socialise with other generations but this was primarily through their relationships with family. For some co-researchers there were reduced opportunities for intergenerational living because of where they live and socialised. In particular a number of the housing estates within the urban areas were ageing and were inhabited predominately by older people therefore; there were limited opportunities for intergenerational interaction.

> *"The parish is getting old now so whereas before you had Communions, births and Communions and then Confirmations ... then after years 'twas weddings and now unfortunately, not our gang yet, but one of these days, 'tis all funerals that are coming in. It's sad; it's a sign of the age of the parish."(Siobhán)*

The co-researchers recounted how they adapted to the changing world in which they now lived. Adaptations were made in response to their psychological and physical changes. A number of the co-researchers experienced forgetfulness and some used a list as an aide memoire. Others had balance problems and many used a walking stick to help steady themselves and to mobilise.

Others recounted how they needed to adapt their lives to their medical problems, for example, Éilis explained how she coped with having urinary continence problems, recognising that she had to get up several times during the night as well as planning her trips around knowing where public toilets were.

> *"I have to be careful and if I go in anywhere with my daughter I'm always saying where is the toilet?"(Éilis)*

Some changes in the co-researchers' physical appearance were directly related to ageing e.g. wrinkles, greying hair, body shape and posture and/or underlying medical conditions. Co-researchers described how they found these changes psychologically difficult to deal with as they were a stark and obvious reminder of their ageing and health problems.

> *"And each month that goes along, you're getting frailer and you're getting thinner… you're going smaller… because your pants are getting big. Your legs are getting smaller and the shoes are getting big….at times... sometimes I just sit down and cry you know."(Kelley)*

> *"My feet swell up and I can't get my shoes on."(Jane)*

While these bodily changes influenced their choice of clothes and footwear, co-researchers also recounted how they had modified and adapted their own home environment in response to their own changing abilities and needs. They included personal alarms, walking sticks and frames, wheelchairs, hand rails, visual impairment aids, bathroom and bedroom modifications. The decision to use this aids and make these modifications was sometimes difficult as it reinforced for many of the co-researchers that they needed to adapt to the changes wrought by age and health related problems.

It forcibly brought home to them that they were no longer as able as they had been. However, they conceded that these modifications were necessary and were ultimately satisfied as conversely the changes enabled them to be more autonomous.

> *"Sure I had to adapt. The first thing that was done was the dining room was halved and I have a bedroom and bathroom. So I'm very happy ... now that I can walk in across there and I haven't to go upstairs. I missed it first and I used to say to the tradesman… 'you can do what you like with it but I'll never sleep in it, I'll have to go up to my own bed' but …it was after that then I had to go into hospital, and when I came back from hospital I was glad to have it." (Agnes)*

As a result of these bodily changes, co-researchers reported needing to give themselves more time to do things and to pace themselves.

> *"Every day you have to adapt to something new you know when you're getting on, something silly now like you know you'd have to leave maybe a bit early. You have to just allow yourself extra time, that's what it is. You can't just stand up and run and do things anymore". (Siobhán)*

Co-researchers recounted their experiences of negotiating and adapting to the world beyond their home and many found this environment, mentally and physically, hard to navigate. For example, many feared falling because of wet leaves on the footpath or because of uneven surfaces. Others worried about the level of road traffic when walking or driving. For others carrying their shopping was tiring. Therefore, many made decisions on where they would go and what exercise they would take, based on their assessment of their ability to walk/drive safely, the level of difficulty of the activity and the availability of public transport.

While these factors impacted on their freedom to choose what they wanted to do, by making a risk assessment the co-researchers were exercising their right to make independent decisions and retain personal autonomy and control by making independent decisions. A final aspect for the co-researchers' adaptation to their changing world was coping with loss. Co-researchers experienced loss of: abilities, the life that they had lived and deaths of loved ones. However, while sad, many co-researchers responded in a fairly pragmatic way through adaptation.

> *"…growing old means not being able to do what you used to do and your hair going grey… not as mobile as when you're young and not being able to do the things in the house that you'd love to do [however,] you grow into it or it grows into you…you have to, you just automatically adapt into it." (Jane)*

However, this acceptance did not preclude the co-researchers from taking actions to maximise their health in the face of these changes. These are discussed in detail in the section 5.6.: 'Trying to stay well'. Naturally as the co-researchers were older, they had experienced bereavement following the deaths of friends and family. They explained that they had reconciled themselves to these losses in different ways e.g. drew on religious faith and/or rationalised that they (deceased) were better off. While this helped them to adapt to their changed lives, they still missed their loved ones.

> *"My husband died of cancer… and he was so sick and so miserable 'twas nearly a relief… to see God taking him. The poor man he was suffering so much but xxxx [son died suddenly] … that was what took a lot out of me. Thanks be to God I have recovered… and I say maybe he [son] was better off." (Agnes)*

The sub-theme *Adapting to a changing world* describes the co-researchers' experiences in relation to living in a changing world of new and different roles, adapting and adjusting to different societal and generational values and mores. Furthermore the co-researchers' experiences of adapting to physical and psychological changes including bereavement and loss were addressed.

In summary this theme has explored the co-researchers' experiences of 'Navigating a changing world'. For co-researchers, ageing and the challenges of healthy ageing represented a diminution of independence by not being able to do what they wanted to do. Growing old was not something they wished for but they believed that it was important to accept the situation. The co-researchers also identified that they were living in a shrinking world in so far as their worlds were contracting due to decreased abilities, increased health problems and having a decreased social circle. However in tandem with living with these negative aspects of ageing were increased freedoms and fewer responsibilities.

This enabled them to pursue personal interests. It was acknowledged that part of navigating a changing world was being able to adapt to changing roles, changing societal values as well as physical and psychological changes associated with health, ill health and the ageing process.

5.5 Theme 3: Being Connected and Involved

This theme captures the importance of relationships and engagement in life and illustrates their impact on co-researchers' health and well-being. There are two sub-themes to this theme, *Maintaining relationships* and *Making the effort to engage and stay engaged.*

5.5.1 Maintaining relationships

A recurring theme highlighted by the co-researchers was the importance of having and maintaining relationships. Different types of relationships were outlined and all co-researchers experienced one or more of these. Many relationships were with family members such as siblings and spouses/partners but quite often they were with children and grandchildren reflecting the age profile of the co-researchers. Having good neighbours was identified as being important as a source of support e.g. having someone to call on if needed. It was highlighted that it was important to have someone to contact in case of illness or an emergency, be that a friend, family member or neighbour. Relationships with God were very important to many of co-researchers albeit for some it was not the God or religion that they were brought up to believe in.

Of central importance to many co-researchers were their relationships with their immediate family. Many stayed involved with family through family gatherings and celebrations and for some, babysitting and childcare. These activities kept them involved in everyday family life and provided opportunities to stay connected. A minority of the co-researchers had husbands or partners and they highlighted the companionship and support afforded by these relationships. Jane and Joe her partner described the support that they gave one another but also identified their concerns if either one was left alone.

> *"We support each other but if one of us wasn't here ...but while we're together things are okay. We can manage. We can do what we want more or less but if one of us wasn't here…. (the other would find it hard to cope)."(Joe)*

> *"That's the thing, what would happen if one of us goes. That's going to be a big thing for everybody when their partner goes." (Jane)*

Siobhán described the companionship that she and her husband share.

> *"We feel quite comfortable ... we're very happy I suppose that's the main thing. We're grand actually we're very at ease... we're two of a kind."(Siobhán)*

However at least two co-respondents reported that their relationship with their husbands had changed in recent years and increasingly, they were taking on a carer role (this has been explored in the theme 'Navigating a changing world'). However, reflecting the age profile of this cohort, for many their immediate family were their children, grandchildren, nieces or nephews. In general, these were positive relationships. Activities with family included visiting, socialising, going on holiday together and child minding.

A number of the co-researchers had family living with them, for example, Joan's son lived with her and since becoming unemployed he did all the house work. It is worth pointing out that there was reciprocity within many of the relationships whereby the co-researchers helped with child care but also with advice and support. Therefore, there were benefits for both parties within these relationships.

> *"I'm friendly with all my neighbours. My family always come to me, they're all friendly. They always come to me when they have problems, why me I don't know. They always did and they will."(Jane)*

Similarly, Úna provided child care for her grandchildren and also daily lunch for two of her sons but felt that these arrangements benefited herself, her children and grandchildren. She was able to develop a relationship with her grandchildren while helping her daughter with child-minding. Choosing to cook for her sons encouraged her to eat a balanced diet which she might otherwise have foregone.

> *"I've two of them [sons] coming to me for their dinner every day…if they weren't coming you know I don't think I'd bother... and that's the danger then you see you can't allow that to happen whereas if they're coming, well you can't hand them up a cup of soup so you'll have to get your potatoes on and your meat on and your whatever and of course, the bit of baking, Sure they're spoilt rotten."(Úna)*

Relationships were not confined to family and the co-researchers recounted those they had with friends and neighbours. Many of the co-researchers had close friends and enjoyed meeting and socialising with them and for some holidaying with them. However, relationships needed to be worked at in order to be maintained. Aisling believed that it was important to keep in contact with friends as one aged especially in view of increased mortality. In a way this connection provides a link with the past and to shared experiences.

> *"It's important to keep in touch. …because you're getting old you feel that most of your friends are dying anyway… so the few that's left it's nice to keep in touch with them." (Aisling)*

However, relationships could also develop as one aged and these happened primarily through social clubs and community groups. Interestingly, Jane counted her home help and physiotherapist as well as her neighbours as friends, highlighting that close relationships that can be built between people, their health care professionals and neighbours. This is not very surprising as these are the people she most regularly met. Most co-researchers had positive relationships with their neighbours and felt that they could call on them if they needed.

Furthermore, some had arrangements with them to be taken to the shops to run errands on particular days. There was a mutual benefit to these relationships as the co-researchers often 'keep an eye' on their neighbour's house if they were on holidays and away from home and vice versa. Many of the co-researchers were involved in community groups including senior citizens clubs, sports, religious and cultural organisations and these were a medium through which the co-researchers could and did develop relationships and stay connected with their local communities. Being connected helped maintain an interest outside of the home emphasising the importance of social interaction for emotional wellbeing. For example, Agnes described how she stayed involved with local women through membership of the Irish Country Women's association.

> *"I've no car but one of the ICA women comes here for me… and some other one would bring me home. Once a month yeah and then we have a night out."(Agnes)*

Similarly, Úna was a member of two choirs and her local senior citizens' club. Being a member of these groups facilitated social interaction and provided a forum for engagement with people who shared her interests. She explained her involvement with her local senior citizens' club.

> *"It's great now .... we have this every Tuesday night and we have a little Christmas do then and we have a day out in the summer... they're a nice group."(Úna)*

An important aspect of staying connected was maintaining one's specific interests. There were a number of different ways in which the co-researchers did this such as attending sporting events, reading, being part of a choir, engaging in further education, following political and topical events through television, radio and newspaper. Developing personal interests facilitated involvement and being genuinely interested in the area or topic helped sustain these connections as they were based on common interests. Noirín described how her interests have facilitated making and sustaining connections.

> *"I'm involved in the xxx [local museum] and in the xxxxx Archaeological Society. So they'd have days out going here and there and I go on those. They're nice trips."(Noirín)*

Similarly Éilis explained how cultivating an interest in sport helped her become involved with other people, illustrating the importance of being able to involve one's self in social conversations.

> *"My husband, God rest him, was terrible for the sports, it used drive me nuts but strangely since he passed away I'm inclined to listen a little bit more just to know when I hear people talking that I'll say 'oh that's right they won or they lost'. " (Éilis)*

Maintaining relationships however was not confined to people. The presence of God and religion in their lives was crucially important to many of the co-researchers and helped sustain them. The nature of this relationship varied and for some their relationship with God had changed over the years, influenced in part by personal reflection and by scandals which have rocked the Roman Catholic Church.

However faith and religion were very important for the emotional wellbeing of many co-researchers. Attendance at mass and other religious events and for some, devotion to particular saints was part of the fabric of their everyday lives. Involvement in church activities and religious organisations was also important for a minority of the co-researchers e.g. choir, church committee, liturgical committee, apostolic organisation. Some did not physically attend church because of disability or mobility problems, but listened on the radio or watched on television.

Having God and religion in their lives sustained many of the co-researchers and helped them within their everyday lives. Aisling explained that she needed God in her life.

> *"I need my religion. I need something to hold onto … I need God. I need Him on my side [laughs]…He made me, He'll put up with me. I need God … to get up in the morning."*(Aisling)

Sinead explained the importance of religious faith in in her life.

> *"I think if you haven't faith you have no purpose to life… it gives you strength and it overrides the disappointments."(Sinead)*

For many, attending religious services, gave them renewed energy and vigour as well as peace of mind. Agnes described how energised she felt after going to weekly mass.

> *"I'd be so much better when I'd come back. So much livelier and looking forward more to life than I'd be if I were sitting down here and couldn't go."(Agnes)*

Rebecca who is wheelchair bound explained the importance of priest 'house call' visits.

> *"He [the priest] calls once a month [he] gives Holy Communion, hears my confessions and things. Oh it is [important.]."(Rebecca)*

A number of the co-researchers were upset about recent church scandals such as child sex abuse and Magdalene laundries. However, they rationalised that these practices were not reflective of all religious people nor was it representative of church teachings. For example, Úna described herself as being religious but found recent scandals disillusioning.

> *"I've been very disillusioned with all the goings on. I have to be honest with you now I have really and truly. I was very, very disappointed... Now we have the Magdalene thing coming out you know. God I think it was dreadful." (Úna)*

However, other co-researchers' views and practices have changed over the years and these changes were not necessarily because of the church scandals rather more the result of a long process of reflection. For example, Noirín had been raised as a Roman Catholic but no longer identified herself as a member of this religion.

> *"I'm not religious at all….I was a Catholic but I'm not anymore. I lead a good life but I don't go to church or anything. I wouldn't be into religion." (Noirín)*

For a number of the co-researchers, they had reached a point in their lives where their responsibilities were significantly decreased and there was an acceptance that they were ageing. Therefore, the attitude seemed to be that in the bigger scheme of life there was no point in worrying as such. Ellen stated she only worried about things she could change but did not worry about things she cannot do anything about. Aligned in a way, many co-researchers believed it was important to think positively as they aged and experienced difficulties. Positive thinking was practised by many of the co-researchers and helped them put their worries and concerns into perspective. Positive thinking was enhanced by their relationships with people who were themselves positive. Úna explained that being a positive thinker helped her to remain optimistic and active.

> *"It's positive thinking. That's what you have to have … you need someone to be light-hearted and good-humoured and good-natured and it does help, it does help whereas if they're down, kind of down in themselves ... and moping. What do be wrong with them for God's sake? It drains you whereas I say come on lads let's go, let's go for a walk, let's get out of here, it'll lift you, you know within reason like." (Úna)*

Eleanor strongly believed in positive thinking and in its power to help her keep well and neatly summed up her philosophy on life.

> *"Positive thinking is everything and faith in God."(Eleanor)*

However, it is acknowledged that not everyone will be or can be a positive thinker and various factors need to be considered such as personal circumstances and overall health and wellbeing.

In summary this sub-theme reflects the co-researchers' experiences of maintaining relationships with friends, families, the wider community and with God. Developing and maintaining these relationships helped the co-researchers to feel emotionally connected and included. While there were undoubted benefits for the co-researchers' wellbeing, it is acknowledged that there were reciprocal benefits for family, friends and neighbours.

5.5.2 Sub-theme: Making the effort to engage and stay engaged

This sub-theme describes the co-researchers' experiences of *Making the effort to engage and stay engaged* by exploring the co-researches' reasons for staying engaged, discussing the efforts and ways in which they engaged, and examining the benefits of engagement for them.

Staying engaged was identified as important in ageing well and maintaining well-being. There were different reasons for wanting to stay engaged including: coping with loneliness; wanting to avoid getting into the habit of staying home all the time; wanting to experience new activities; wanting to remain positive and/or active; and having family responsibilities which necessitated being engaged. Loneliness is something that a number of the co-researchers (particularly those who lived alone and/or were bereaved) have experienced and which negatively impacted on their sense of well-being. For example, Kelley (a widow of several years and who lived alone) described her experience of loneliness.

> *"... your family can't be here with you, which you'd love, because they have their own families … they do their best for me but it's once the darkness comes you're all alone…..You're all alone. Nights there now the phone wouldn't even ring. Lonesome, very lonesome and sometimes all you want to do is sit down there and cry. You get into fits of depression… when you lose your husband you lose everybody. He's a part of your life and I was forty five years married to him. We had our ups and downs but I think loneliness is the worst of all." (Kelley)*

Kelley further explained that even though her family is supportive, she believed that they do not or cannot appreciate how lonely she felt. She believed they expected her to 'pull herself out of it' and she explained "*that's easier said, it is easier said than done".* Co-researchers combated loneliness by making the effort to get out and socialise through joining social clubs (e.g. senior citizens clubs, bingo etc.) as well as entertaining themselves by watching television or engaging in hobbies. Co-researchers also believed that an essential part of making the effort to engage and stay engaged involved 'not getting into a rut'. This involved being active, having past-times and interests, making the effort to get involved, paying attention to one's physical appearance, and engaging in positive thinking. Éilis explained the importance of not 'getting into a rut' having seen the negative effects of this for her husband when he disengaged from the world when ill.

> *"I was determined I was going to get out... because you could get into that rut… I was determined because I had seen it with my husband. He gave up and he didn't want to go out anywhere and was sitting there and just looking, gazing at the television. I said 'no I have to get out'. " (Éilis)*

In addition, some co-researchers had specific responsibilities in their capacity as a carer for their spouse or an adult child with special needs. This meant engaging with services and social groups for their relative's sake. They also had concerns for the future and worried who would take on the carer role if they were no longer able. Hilary explained that while her son attended day services he needed ongoing support.

> *"One of my sons is in xxxx [day services] he's not a resident there. He goes in at eight in the morning and he's home at half four quarter to five. But he wouldn't be able to look after himself."(Hilary)*

Avril also worried about her son with special needs but highlighted their loving relationship.

> *"He goes there [day care services] from nine until half three but he can't go out on his own. He has no concept of money… he'd get lost you know if he went out on his own so ...otherwise then he's fine and very kind and loving do you know. Oh I do, I'd be lost without him."(Avril)*

The co-researchers engaged in personal development, with society and their communities in a variety of ways including maintaining relationships with family, friends and neighbours (described previously) and through staying active; having hobbies and interests, and being interested in current affairs. Hobbies and interests were varied and included knitting, reading, further education, listening to music, television, radio, bingo, cooking, painting, travel, playing cards, walking, participating in local social and community groups and clubs (e.g. sports supporters clubs; day care centres, senior citizens' clubs, choirs, church activities).

The co-researchers explained how they benefited from this engagement. For example, Agnes spoke about how she enjoyed attending her local day care centre.

> *"I love it, the company. The company and the meals… And you sit there and you can have a Jacuzzi, you can have your hair done, you can have your feet done. Oh you'd have a great old time …somebody might come in, to do exercises with you."(Agnes)*

Saorcha believed getting out and meeting people lifted her spirits.

> *"Oh you feel much better. I feel much better. I forget all my ailments when I'm out."(Saorcha)*

Niamh explained that she loved learning and attending further education classes.

> *"I have loads of books that I love and enjoy… but I love being in class. I didn't discover it until recently that I like being a student… I like being in school. That's what I like to do in life. It's great … I think there's something so fantastic about learning... it's like being in love….You just can't pretend it's not happening."(Niamh)*

Sinead spoke about how she enjoyed working part time.

> *"It's lovely to be out with the people like…You like meeting them and having a chat… I'm glad to have that work to do."(Sinead)*

Many of the co-researchers were interested in news and current affairs and felt that this kept them informed as to what was happening in the wider world around them. Most read a daily newspaper as well as listening to news items on the television and radio. In addition, a number of the co-researchers worked part-time, fund raised, one volunteered by working in a local charity shop, and some donated their knitwear for local causes. However, the co-researchers explained that sometimes it was hard to make the effort to become and stay engaged and that they needed to push themselves but admitted that the benefit (sense of achievement) they derived made the effort worthwhile. Siobhán explained why she pushes herself and makes the effort to engage in activities.

> *"I think you have to keep pushing… be determined. You have to make the effort … sometimes [its] not easy to do that. It's all a state of mind really … and if you're feeling any way down…[its] very hard, you have to give an extra effort then to try and get going because you're inclined to stay in. If things are aren't going your way and you feel like God I won't bother today I think I'll stay in and just watch television ….[but from making the effort]] I feel I've achieved something I think it's great, that gives you a bit of a boost." (Siobhán)*

Éilis also spoke about the benefits of going out even if it is an effort to get ready.

> *"I go out [to the pub] on a Friday night too, [with friends]. Sometimes I don't want to, I feel I wish I wasn't going out but it makes you get ready… no it's a push but you do it." (Éilis)*

Being mindful of one's personal appearance and making the effort to be presentable was something that many of the co-researchers identified as being important for self- image, feeling confident and engaged.

> *"I like the style and it's nice to be interested in it…I'd spend money on [my hair]... getting a shampoo and blow-dry and get it cut and that kind of thing. That's as far as I would go you know. I get the odd manicure and pedicure then going into the summer. It would be very important to get my toenails painted and stuff like that …it does make you look better and feel better."(Noirín)*

> *"I get my hair done ….I get it done coloured ... I get my nails done. I like to keep myself as nice as I possibly can… I like to be very tidy and I was always that way, always, and I won't let my hair go grey for no one."(Eleanor)*

Éilis felt that it was very important that you keep yourself tidy and presentable and making this effort was a step in enabling her to stay involved.

> *"…[you can] get lazy, you can get into that rut you don't want to ... you don't want to be bothered… to tidy up…You know at least it makes you tidy yourself a bit and be clean." (Éilis)*

Making the effort to engage and stay engaged was an important part of the co-researchers' experiences of staying connected and involved. While it was acknowledged as being an effort at times, it was considered important to stay engaged with society as well as engaging in personal development. However, it is worth remembering that regardless of whether the co-researchers were outgoing or not, all felt it important to make the effort to engage and stay engaged albeit in different ways and according to their own inclinations.

In summary this theme: 'Being connected and involved' reflects the co-researchers' experiences of maintaining relationships and making the effort to engage and stay engaged. Staying connected and involved is identified as being is a crucial to the health and wellbeing of the women as they age. By making the effort to engage and stay engaged the co-researchers were able to connect, maintain and develop their relationships which helped to combat loneliness, boredom and isolation.

5.6 Theme No 4: Trying to Stay Well

This fourth and final theme, 'Trying to stay well' specifically outlines the co-researchers' understanding of what being healthy is and what they do or try to do to stay healthy. It is very much about what they believe about health and wellness and what they feel they should do and what they actually do about staying healthy and well. This theme has two sub-themes *Being healthy* and *Staying healthy.*

5.6.1 Sub-theme: Being healthy

Unsurprisingly all co-researchers agreed that being healthy was important to them and that it was the foundation to enabling them to live their lives fully.

> *"[being healthy] it means a lot to me ...it is important ... [if] you haven't your health you've nothing…you could have a million dollars in the bank and 'tis no good to you if can't go out and enjoy it or whatever so that's it. It's very important." (Ellen)*

However, the co-researchers had no one definition of what being healthy means, illustrating that the meaning of *being healthy* is difficult to articulate in a single definition. This lack of uniformity is indicative of the different interpretations and meanings people in general ascribe to *being healthy*. It is reflective of the different perspectives (e.g. medical, societal, lay etc.) which have influenced how these women view and define being healthy. Being healthy may be viewed as a continuum from being completely mentally and physically fit to being healthy within an individual context of the ageing process, increased dependency and presence of underlying chronic and/or acute ill health. The co-researchers defined being healthy in a variety of different ways and in different combinations including: being mentally and physically well; being able to do things for one's self; being active; having a positive body image and having a healthy weight.

Winifred described what being healthy meant to her.

> *"I'd say being able to get around and being able to enjoy your food and things like that."(Winifred)*

Being able to do things for one's self was identified as being synonymous with being healthy as exemplified by Hilary.

> *"Being able to do things myself .... Like when I had the weight now I couldn't clean the windows or... now I can clean the windows." (Hilary)*

Keeping mentally active was also identified as being an important element of *Being healthy*, Jane explained how this might be achieved

> *"I think very important that they [older people] use the brain... I watch Countdown; we watch every quiz show... the harder the better." (Jane)*

Furthermore, being mentally well was identified as essential to being healthy. This included having someone to talk to. For some co-researchers this was being able to go out and socialise, for others it was having it was having a core group of close friends or one particular confidant.

> *"I think it's nice when you have a good friend that you can rely on… But I think if I didn't have that maybe... I mightn't feel so confident in myself but I've never had to feel like that so I don't know. I think it's a big thing not to have it."(Ellen)*

For many of the co-researchers being healthy encompassed both physical and mental health. Siobhán explained that she took a walk every day, which helped her mentally and physically.

> *"I have to go out walking. I'd go mad if I didn't get my walk. " (Siobhán)*

Part of being physically healthy for many of the co-researchers included having a healthy weight. They described their experience of trying to achieve and maintain a healthy weight. This included monitoring their diets, taking physical exercise and some have enrolled in weight control programmes. Hilary recounted her efforts to lose weight and spoke about how this has enhanced her body image reflecting the positive relationship between physical and mental health.

> *"I'm trying to lose weight ... I was sixteen stone, I'm gone down to twelve now [with] Weight Watchers, well there was nothing fitting me and I was getting tormented with myself … I was taking a size twenty eight, now I'm gone to size eighteen, I mean I'm still a bit heavy but...I'm delighted now myself do you know."(Hilary)*

Further to defining and articulating what being healthy meant to them, the co-researchers identified personal factors which influenced their view of what being and staying healthy is. They felt that positive thinking and specific personality traits such as not worrying and wanting to adopt a healthy life style enabled them to be healthy (specific health maintenance and health care preventions actions are described in the next sub-theme on *Staying healthy*).

In summary the sub-theme *Being healthy* illustrates the challenge in defining what it means to be healthy. As illustrated, different co-researchers placed emphasis on different areas e.g. weight, activity, mental health. This perhaps is not surprising as all were defining health from within their frame of reference i.e. looking at being healthy within the context of current health problems and current abilities. For some they defined being healthy from an aspirational perspective e.g. to achieve a healthy weight or become more active. Others focused on continuing to engage in activities that they made them feel healthy e.g. keep walking as it made them feel mentally well. Regardless of the different emphases they placed on different areas, what is clear is the concept that being healthy is feeling physically and mentally well within the context of their own individual situations.

5.6.2 Sub-theme: Staying healthy

This sub-theme focuses on co-researchers' experiences and views on what they do and should do to stay healthy. All had health problems and managed these within the context of the challenges of the condition and the bio-psycho-social effects of ageing.

Many of the co-researchers believed it was important to engage in preventative health care to prevent deterioration of existing problems and to avoid new illnesses or conditions. They used the following strategies: Being active; Eating well and Being proactive and Following advice. In general, they tried to follow these but prioritised some over others and did not always strictly follow advice. This is not surprising and is reflective of all people regardless of age. This is influenced by individual health beliefs as to the level of importance of certain practices to overall wellbeing; belief in the efficacy and/or effectiveness of certain actions; motivation and personal belief in what they feel they can/cannot achieve.

Being both mentally and physically active was seen as important and many of the co-researchers tried to do this albeit in varying degrees and within the limits of their capabilities. Activities included reading, learning skills (e.g. computer), doing crosswords and puzzles. Regardless of underlying health difficulties, all co-researchers were determined to keep as mentally active as possible reflecting a determination to retain capacity and remain in control for as long as possible. For example, Saorcha who was quite frail and physically dependent acknowledged that her memory was failing but tried to keep active through reading, playing bingo and actively tried to memorise names and events.

> *"... my memory is going… I try to keep it. I try to hold on to it as well as I can. I memorise things you know, the names of my great-grandchildren."(Saorcha)*

Physical activity was also identified as an important preventive measure and primarily included walking for most co-researchers or seated exercises for those with mobility problems. Having a well-balanced healthy diet and healthy weight was something that many of the co-researchers tried to achieve. Jane reflected the views of many as she described the value of food traceability, additive free nutritious food and tried to eat well.

> *"I'm very conscious of food, proper food to eat ... I hate them [additives] because they're not good for you. Additives just to make them taste good and you never know in all those sauces, they've been using horse meat haven't they? I like fresh meat. I like free [range] eggs... food to me is very important, what you have and where it comes from."(Jane)*

Being proactive by following advice and taking preventive action was important in avoiding the development of problems or the deterioration of existing ones. The concept of personal responsibility and taking control for one's health status was reflected in the need to be proactive.

> *"My attitude [would be]... let's get out and see what we can do about it … get it sorted. I wouldn't be one to sit around and say 'oh gosh that pain is still there you know'… I wouldn't do that… And I wouldn't have much time for anyone who'd do that."(Noirín)*

Many co-researchers tried to pre-empt the development of problems by having regular GP check-ups. Being prepared for these visits was useful as Niamh explained,

> *"I have to go to get my meds once a month [For the blood pressure]. I have ...learned … to make a list before I go to the doctor's office if I have any problems…and to put it out on the desk when I go in so he's aware as well as my reminder that I'm not just there for a small talk and a script."(Niamh)*

Typically co-researchers sought advice from their GP, day care centres, pharmacist and health centres depending on what the problem was. However, most of the co-researchers' initial point of contact with the health care services was through their GPs. They were then referred as necessary to other service providers for surgical or medical consultations; physiotherapy, public health nurse services.

Maintenance of medical conditions included regular check-ups to test blood pressure, blood sugar levels, blood tests for therapeutic drug levels e.g. warfarin levels and so on. Many of the co-researchers were on medication for various conditions in particular anti-hypertensives, anti-coagulants, diabetic medication, analgesia, anti-inflammatory medication, inhalers, cardiac drugs, bone strengthening medication and cholesterol lowering medication.

Less commonly, a number were prescribed anti-depressants, sleeping tablets and steroids. It was important to co-researchers to try to ensure that these chronic conditions were contained and did not deteriorate. For example, Úna who had osteoporosis had undergone a course of injections to promote bone strength.

> *"...[osteoporosis]in my back you know so I had to go on injections… so I'm on them now gone into my second year now and there's about another six months."(Úna)*

In addition, to existing chronic health problems, co-researchers developed new health problems which could be an exacerbation of an existing problem or a new one e.g. chest infection, leg ulcer and so on. However, not all co-researchers were able or wanted to adhere to their medical advice when managing their health problems or were able to see a connection between existing health problems and the development of new one.

For example, Joan whose diabetes has worsened was diligent in attending her doctor, the diabetic clinic and taking prescribed medication but found it very difficult to adhere to a diabetic diet. She also had poor eyesight and recently had a number of falls but attributed these to uneven cracked footpaths. This certainly contributed but there could also have been a link with her failing eyesight which may also have been related to her diabetes. Similarly, Kelley had several medical problems one of which was insomnia but her doctor had reduced her sleeping pill from one pill to a half of a pill.

However, she did not believe this was satisfactory for her needs and recounted how she managed this.

> *"I take a sleeping tablet which Dr xxxx told me to cut down to half. If I cut it down to half I'd be up at three o'clock in morning I wouldn't get back to sleep... I used to be on thirty sleeping tablets a month, now he's was cutting me down to fifteen but then if I have the bottle of wine I won't touch a sleeping tablet….I'm [down]to one a night but with the tablets I'm on Dr xxx won't give you one a night. Fifteen tablets should do you for the month, by halving them….. you see the way I look at it, I have a drink on a Friday night, on the Saturday, I have one on a Monday night, that saves two sleeping tablets. That's the way I work it out …an exchange [laughs.]."(Kelley)*

This example highlights the challenges arising from what the co-researchers believed they needed and what the GP thought was an appropriate course of action or treatment for them. There are many reasons why people in general do not or cannot always follow treatment regimens or who have unhealthy lifestyles, e.g. personal health beliefs, knowledge and understanding of health care and socio-economic reasons. However, having a good relationship with health care professionals in particular with the GP was identified as important in health care maintenance.

Core aspects of a positive relationship included trust, respect, humour, confidence, time, feeling attended to, feeling at ease and valued. In addition, to the quality of the interpersonal relationship, it was important that health care professionals were familiar with their patients' medical histories. Siobhán spoke warmly about her relationship with her GP and Practice Nurse,

> *"I can say things to Dr xxxx, and he'll tell me stories that he's heard and it puts you at ease…. he listens which is a very important thing …I can [have a conversation] and I know him ... [the practice nurse] will give you medicine that she knows that you need ….she can prescribe things …. she knows your history backwards because she has been with you for such a long time ... and she's young and she's jolly."(Siobhán)*

Suzanne spoke about her confidence in her surgeon's abilities. This was facilitated very much by his communication and interpersonal skills, highlighting the importance of an effective patient-health care professional relationship.

> *"I went up to see him [surgeon]. I nearly fell in love with him, well I mean he was gentle to me…He was nice to me. He treated me as a person… You know and he was very, very nice so I was impressed with him and I'm going ahead with it [the operation]."(Suzanne)*

Jane explained the need for trust between a patient and her doctor

> *"Everybody ...should trust in their GP and rely on them when they want, I rely on xxxx [her GP]. She's only very young but she's the best because she puts herself out for everybody…She treats everybody the same .So she won't give you only what she thinks you need… She'll spend half an hour. She doesn't rush patients."(Jane)*

However, not all were satisfied with the level of information, referrals or care provided by health care professionals. These difficulties affected their confidence in the advice and treatment they received. Michelle explained that she had asked her doctor for a referral letter but did not receive one which made her feel angry and ignored.

> *"I'm kind of vexed with him that... he never went to the trouble of doing it for me when I asked him and he said he would ... and that way I'm mad with him."(Michelle)*

She also spoke of an incident when she was hospitalised and sought information about her medications. She felt her concerns were not given adequate consideration and she was treated rudely and left feeling upset.

> *"I remember one morning saying to one of the nurses in the hospital. I said 'would you ever tell me what they're [medication] for because ... if I don't know what they're for I don't think I'll take them' and she said 'you have to take your medication'. I said 'but sure I don't know what they're for', well she said 'the doctor ordered them, it wasn't I gave you them', maybe she wasn't in good form ... but those little things always got me."(Michelle)*

Staying healthy refers not only to preventative health measures and medical treatments but also to the co-researchers' experiences of managing the effects or symptoms of the problem(s). Certain problems had far reaching effects on the lives of the co-researchers and could restrict their ability to be physically independent.

There were various consequences to ill health (e.g. pain, anxiety, discomfort, breathlessness, decreased mobility, sensory impairment etc.) and the co-researchers managed these in a variety of ways such as living with the symptoms; identifying and knowing triggers which exacerbate the symptoms and dealing with these proactively as well as managing symptoms by using distraction techniques; aides, resting, having help and assistance etc.

The co-researchers were often pragmatic in their approach, accepting that they needed to alter their lifestyle in some way. By taking ownership of this, they retained control over what was happening to them. For example, Úna had tinnitus and she explained how she managed this problem using distraction techniques and living with it rather than letting it curtail what she wanted to.

> *"…you just kind of have to live with it, put up with it and get on with it …so you try to manage round it basically. When it's quiet and I'm on my own [and] at night ...my own doctor said leave the radio on which I do but then if you drop off that's inclined to wake you then as well so you don't know what to... but if you're listening for it it'll come into your head you know… but you tend to put it behind and get on with things you know."(Úna)*

Living with the effects of a chronic condition was something that Jane also has to do. She had a fall several years ago and despite several spinal operations remained in chronic pain. This together with her other medical conditions have affected her ability to mobilise and be physically independent.

> *"Well I have a help, I pay a help to come in … I couldn't do my housework in a million years ... if Joe [her partner] isn't there I have to stay in bed until he gets back." (Jane)*

While heavily reliant on her partner and her home help to manage physical aspects of care and housekeeping, she retained control over what she wanted to do and made her own decisions. It is acknowledged that she and her partner decided together on the 'logistics' of Jane going out and about. Without his support, it would be much more challenging for her to carry out her wishes, highlighting the importance of a supportive relationship in such a situation. In contrast, Michelle lived alone and had osteoporosis and knee problems which adversely impacted on her mobility and ability to do heavy housework. She managed the consequences of this by employing a home help to assist with heavy housework.

> *"I do have a home help that I pay myself ... for doing the bed and hoovering… [as] some days you won't be able, you're not that good and some days. When I wake up I find that I'm so sore and my back is so sore… I have trouble getting out of the bed but once I'm out there on the floor it's just like I do my best. I thank the Lord I'm out." (Michelle)*

The consequences of sensory impairment such as visual problems and hearing loss were managed through the use of hearing aids, spectacles and specific visual aids.

Both Roisin and Winifred had macular degeneration, and for Roisin in particular her visual impairment was so severe than she could see virtually nothing. This impairment was very restricting and she was dependent on others to guide her when she was out and about. There can be unexpected consequences to these impairments. For example, Siobhán has an impaired field of vision in one eye following a stroke and as a result had a blind spot which caused her to bump into people and objects which she found embarrassing. Furthermore, she was unable to drive and so was dependent on public transport and family and friends to drive her to where she wanted to go. Such dependency can impact negatively on one's sense of control and independence.

Chronic illness can of course, include mental health problems including depression and anxiety. For example, Suzanne suffered from anxiety but managed this in a number of ways. One of which was recognising and avoiding in so far as possible stressful situations and if in such situations she practiced breathing exercises. She also recognised that sometimes she needed to 'get away" and have time to herself. Being self-aware and knowledgeable about one's own health can facilitate informed decision making and help maintain personal control.

> *"If I'm het up he'd [her counsellor instruct her to] 'centre, come on, two feet on the floor now'. I do [breathing exercises]at home...[having personal space was] important, it's necessary for sanity. I just try and go away and do my own thing and just put my energy into looking after myself. I put a shield around myself to preserve myself … I just protect myself and I'm very good at that."(Suzanne)*

While the concept of having to adapt to ageing and limitations associated with ill health has been discussed previously particularly in 5.4.3 Sub-theme *Adapting to a changing world*, it is worth highlighting these adaptations to illustrate their importance in managing the consequences of ill health.

The co-researchers identified a range of supports that helped them to adapt and maintain their health. These included family, home-help services, health care professionals, as well as allowances and benefits. The co-researchers' adaptations included: realising what they could do and maximising this within the bounds/limits of the incapacity e.g. give themselves more time to do things, continue to walk and take exercise but perhaps not at the same intensity as previously; taking care and being more mindful of one's environment so that they did not fall; using walking sticks, walkers or wheelchairs, having personal alarms; adapting one's home environment to maximise independence e.g. having wall rails, grabbers, downstairs bedrooms and bathrooms.

While some of the adaptations within one's home require extensive modifications, others require simple changes. Co-researchers' experiences of staying healthy encompassed a number of key areas including preventative health care, maintain one's health in the presence of existing problems but also dealing with new problems.

There were consequences of ill health which the co-researchers managed. Important areas that influenced staying healthy included adaptation, having support and being able to access services. Finally the nature of the health care professional-co-researcher interpersonal relationships did impact either negatively or positively on the co-researchers' trust and confidence in health care personnel and services health.

The theme 'trying to stay well' reflects the co-researchers' personal interpretations and views of what being healthy means to them. All agreed that mental and physical wellbeing equated with being healthy, but unsurprisingly all viewed being healthy from their personal perspective and within the context of their experience of the ageing process and their own health problems.

They tried to stay healthy by being proactive and using preventative measures to avoid ill health or prevent exacerbation of current health problems. They also tried to maintain health through adaptation, using supports as necessary and seeking health care advice and treatment as necessary.

5.7 Phenomenological Conceptualisation of the Findings

Interpretation and conceptualisation of the meaning of the findings from a phenomenological perspective is important in understanding these women's experience of ageing and health related issues. While all four themes are interconnected and give rise to the overarching meaning, it is useful to our understanding of the meaning of the experience to interpret the findings from the perspectives of lived time, lived space, lived body, lived human relation, 'being-in-the-world' and 'being-in-the-world-with-others'.

The concept of **lived time (temporality)** was ever present in the women's experience and this is reflected in the juxtaposition of growth and decline within the experience. There was at once a sense of having time to pursue all the things that were put on hold doing the 'business of living' when younger. Personal time had been limited due to various demands such as raising children, looking after the home, caring for older relatives and working outside the home. There was now a sense of excitement in being able to pursue personal interests. The women saw this time in their lives as 'their time'; a time for personal growth and fulfilment. This time afforded them opportunities to both rekindle old interests and hobbies and to develop new pastimes, skills and/or pursue further education. Furthermore, they had more time to socialise with friends and family.

However, alongside this was the view that time was running out. Paradoxically, they felt that although they now had the time to devote to personal interests, there were time limitations and a sense of time having caught up with them. It was hard for some to know how to fill this extra time because they had limited energy and so were limited by their ageing bodies. Longevity and thus time had an impact on the body. Ageing and co-morbidities affected the women's ability to do what they wanted.

On one level they had much more time but the circle of available time was decreasing and limited by the increased length of time it took to do things. The available time was now taken up with the 'business' of getting washed and dressed, and attending to household chores, all of which now took longer to do. There was sense of their bodies not being able to 'keep up'. For many, there seemed to be a time in their lives, almost like a tipping point, where they found it hard to accommodate ageing and health related changes in their efforts to continue to do as they had always done. The most stark example of time 'running out' was how the women did not make long term plans about going to places or attending events as they felt they were inexorably moving to the end of their lives and that death was drawing nearer.

The women's world views and thus experiences were also influenced by societal changes which had occurred over time. What was certain and constant when they were younger was no longer the case. There have been enormous changes within Irish society over the last forty years or so especially in relation to the role of women, lifestyles, parenting, increased separation of church and state, all of which had an impact on the women's sense of who and what their role is in the world and thus their experiences as they aged.

Integral to the meaning of the women's experience is the lifeworld existential of **lived space (spatiality).** Lived space refers to their homes; the environment outside their home; places where they socialise and for a minority where they work (paid or volunteer).

Home was particularly important within the women's experience. Home was typically identified as their domain in so far as they were the principal homemaker; responsible for the day to day running of the household, raising children for many but also where they had cared for members of their extended family. In this way home was a deeply personal and significant space for them and their sense of identity as capable independent women. As they aged, their relationship with their home had changed as evidenced by the need for modifications to accommodate the effects of ageing and co-morbidities. These included fitting of hand rails, moving bedrooms downstairs and installing extra security lighting and alarms (house and personal). To a greater or lesser extent depending on individual circumstances, the home was no longer seen as the safe place it once was, rather it was a place which needed to be risk and accident proofed (increased to decrease the risk of falls) and made safe. Therefore the effects of ageing and health problems were clearly visible in the changes they have to make impacting on their sense of self and the meaning of their experience.

From the perspective of the wider environment outside the home, the women's lived experience reflected how they had to accommodate changes wrought by the effects of ageing and co-morbidities. They needed to be careful not have an accident and so were vigilant in assessing risks such as the state of footpaths, having adequate street lighting and being aware of road traffic.

Furthermore, the space or places to which older women could go to (be that into town, meet people to socialise or holiday) were influenced by whether they had a car or means of transport. Many found it difficult to either use or access public transport and so were often dependent on others to help and/or take them places. Having a car or being able to use public transport was a way of getting to places but was also an important space in its own right, as it represented freedom for the women to go places wherever and whenever they wanted. Ultimately within the women's experience, there was a sense both within the home and the wider environment of a shrinking world. For many the space in which they now lived and socialised had shrunk as a consequence of ageing and health related problems.

Central to the women's experience is the lifeworld existential of the **Lived body** (corporeality) encompassing all elements of the body: cognitive, affective and physical. Each of these elements was interconnected with and had an impact on the others. The process of ageing and concomitant co-morbidities had a significant effect on the women's bodies. This was evident in the visible signs of ageing, physiological changes, pain, decreased energy levels and reduced abilities but also in how they perceived themselves and how they managed these changes.

The women now found themselves encased in a body which needed much more attention and maintenance. These changes needed to be accommodated but how this was done was influenced in no small way by the mind-set of the women. Many believed it was important to be proactive in staying as healthy as possible. This enabled them to offset some of the effects of ageing and co-morbidities, and get the best out of life. Being proactive required them to attend to their health needs (seek treatment, take medication, eat well, and exercise) and their reduced abilities by modifying their lived space (discussed previously), by having home helps and by using aids (e.g. canes, hearing aids, glasses, wheelchairs). In a sense these aids became an extension of their bodies and older women adjusted sometimes reluctantly to the new reality of these now being essential to their changed bodies.

Although the women were pragmatic and understood at a cognitive level that with age comes bodily change, there was a feeling of having been left down by their failing body. Their physical body had now to be tended and minded. This new reality, while unwelcome, had to be accepted and adapted to. This altered body image was difficult to accept and their visible appearance forcibly made them realise that they had changed at least outwardly and belied how they felt underneath. There was some tension between how they perceived themselves as independent, autonomous women with what their new aged bodies represented to them, their families and to the wider community. The effect that ageing and being old has on immediate and wider relationships is addressed in the next section (Lived human relation).

The women's life world existential of **Lived Human Relation** (relationality) is crucial in understanding their experience as intrapersonal and interpersonal relationships had an important and complex impact on their sense of self.

For many women, their personal relationship with God was very important to them. For them, God and religion helped them make sense of their world as they aged, it provided support, comfort and meaning to their lives. This relationship was part of who they were and how they lived their lives. However for others, the process of ageing and life experiences had led them to question and for some change their previously held beliefs about religion and God. This was unsettling for some and left them uncertain about what would happen when they died.

Relationships with family and friends were important to all, albeit the nature of these relationships were deeply personal and influenced by shared life experiences. In the main, these relationships were positive and sources of comfort and joy. However for others, interpersonal dynamics were more complex and at times challenging. Loss, bereavement and grief were something all experienced and reflective of the time in their lives, was becoming increasingly common. The relationships with those who had died or who had moved overseas remained important in terms of remembering shared histories and in terms of adjustment and reconciliation to the loss.

All of the women wanted to retain control and autonomy over their lives but this was not always straight forward. Well-meaning paternalism from family at times challenged the women's autonomy. Negotiation and for some partnered shared decision making helped the women retain their autonomy. Relationships with health and social care professionals were important in how the women remained in control. These ranged from support, advice and treatment in order to stay healthy and well, to practical assistance such as that provided by home help.

Women's relationships with their wider community varied from being very engaged to limited. This was in the main more reflective of the women's personalities rather than from a lack of opportunity to engage. But it does highlight that being engaged, be that through clubs, organisations, further education, was important to many of the women. However, there was a sense that society as a whole did not value or hold older people particularly older women in esteem. Many felt invisible and marginalised, for example by age limited screening, cuts in supports, increased taxes and fees, and longer waiting list for medical care. However, they also held the contrary view that supports, benefits and pensions were available to them. These opposing views indicate the importance for society of not only supporting and valuing older women but being seen to value them.

While the four lifeworld existentials have been presented separately, it is crucial to understanding the meaning of the women's experiences to accept that they are parts of the whole experience with each influencing the other. Ultimately, all are interconnected and give rise to the women's experience of **Being-in-the-world** and **Being-in-the-world-with-others.** The way older women experienced being-in-the-world and being-with-others was through relating with others through their body (affective, cognitive and physical) within a particular space and during a particular time. The coming together of all of these elements led to understanding the essential meaning of the experience, 'retaining autonomy through a process of adaptation and continued engagement'.

5.8 Chapter Conclusion

This chapter presented the findings of the study. The essential meaning of older women's experience of ageing and health related issues is 'retaining autonomy through a process of adaptation and continued engagement'. This overarching theme captures the co-researchers' determination to remain independent and in control of their lives as they age.

In addition, it reflects the co-researchers' recognition and acceptance that they need to adapt to the ageing process and their changing health needs within the context of remaining engaged in life. Remaining engaged reflects the co-researchers' desire and belief in the importance of remaining engaged with life, through relationships with some or all of the following: God, family, friends, health services providers, all of which impact on their health status and ultimately their ageing experience. The co-researchers' experience is captured within four main themes: 'Being in control: balancing needs and support'; 'Navigating a changing world'; 'Being connected and involved' and 'Trying to stay well'.

These themes demonstrate that personal autonomy, being adaptable, being connected and involved, being informed and proactive are important interconnected factors in how the co-researchers experience ageing and health related issues. It is clear that older women's health, ill health and health related issues are inextricably linked to their ageing experience. It is important that neither is looked at in isolation. It is acknowledged that the level of governmental, social and familial support influence older women's choices, self-determination, engagement and their health care management. There are a number of areas for discussion arising from this presentation of the findings of this study and include: autonomy, adaptation and engagement and the older women. These are discussed in the next chapter. In addition, recommendations will be made so as to inform health promotion strategies, policy making and service delivery for older women living in the community.

Chapter 6

Discussion

6.1 Introduction

This chapter discusses the findings in relation to the literature. While there are similarities between these findings and other studies on ageing and health, this study's offers a unique insight into the lives of a cohort of older women living in the mid-west region of Ireland, specifically their views and experiences of health, ill health and health needs within the context of their ageing experience.

The essential meaning of their experiences was found to be 'retaining autonomy within a process of adaptation and continued engagement'. This overarching theme was derived from the four themes or main findings identified within the data: 'Being in control: balancing needs and supports'; 'Navigating a changing world'; 'Being connected and involved' and 'Trying to stay well'. The findings demonstrate the interconnectedness of ageing, health and gender within older women's experiences.

Inherent in this phenomenological research is how older women's experiences were situated in the life-world existential themes of lived time (temporality), lived space (spatiality), lived body (corporeality) and lived human relation (relationality) and ultimately how older women experiences of being-in-the-world (dasein) and being-in-the-world-with-others (mitsein) (concepts previously discussed in 3.4.2.1, 3.4.2.3 , 3.5 and 5.7) are contextualised within the socio-political-cultural and economic environment of Ireland.

The concept of **lived time** is interwoven across the findings and is reflected in how time was paradoxically both slowing down and speeding up. Co-researchers' experiences reflected a sense that time was running out for them and there was sense of urgency about this for some co-researchers while for others a sense of peace. Conversely there was more time to pursue activities and interests and to spend time with others because co-researchers were no longer confined by schedules and timetables.

Lived space as a concept was experienced in a variety of ways both within their internal and external environments. The lived space of home was changed as co-researchers either modified their homes or modified what they did within their existing home environment to accommodate their changing needs and abilities. For many co-researchers their experience of their external lived space was changed and environmental factors such as traffic, modes of transport, terrain, distances, had to be assessed and negotiated from a different perspective to accommodate the effects of ageing.

Lived body was fundamental to co-researchers' experience and in a way the meaning of their experience is embedded and embodied within their changed and different body. For example, the physical effects of their ageing together with the pathophysiological effects of related health problems impacted on the co-researchers' sense of self vis-à-vis their body image, their adjustment to changed abilities, how others viewed them and the influence of socio-politico-cultural and financial factors on how the co-researchers perceived this changed version of themselves. The co-researchers were challenged to live within and through their changed body.

The fourth existential theme, **lived human relation**, speaks to the relational changes older women experienced with family, friends, neighbours, community and society in general. Shifting dynamics within these relationships changed the nature of these relationships as the co-researchers aged. Internalised individual and societal views of ageing and older women influenced how older women perceived themselves and how others viewed them. None of these life world existentials can be viewed in isolation and all affect the other, ultimately being captured in the meaning of the women's experiences i.e. 'being-in-the-world' and 'being-with-others', essentially 'retaining autonomy through a process of adaptation and continued engagement'.

Three key concepts have been identified as essential to the meaning of the older women's experiences: 'retaining autonomy within a process of adaptation and continued engagement'. These concepts of autonomy, adaptation and continued engagement are inextricably linked within the experiences of this group of older women. The framework for this chapter is centred on these three themes.

The section on autonomy discusses the importance co-researchers placed on 'being in control' through balancing needs and supports in order to retain autonomy which was of critical importance to them. Co-researchers' appraisal and adaptation to changes associated with ageing and health is discussed in the section on adaptation. The impact of personal beliefs on actions as well as the types of actions taken is also explored. The final section 'continued engagement' discusses the co-researchers' desire and efforts to remain engaged and connected with life though their relationships with God, family, friends and society as well as through maintaining and developing personal interests. Finally the chapter examines the effectiveness of existing support structures and makes suggestions for future supports.

6.2 Autonomy

There are different conceptualisations of autonomy (Aveyard,2000; Mars *et al*,2008; Hillcoat-Nallétamby,2014).Theories of autonomy are broadly classified as negative autonomy (non-interference of one's actions) or positive autonomy ("actively shaping one's life and identifying fundamental values") (Mars *et al,* 2008: 336). Negative autonomy refers to being autonomous by having non-interference of one's actions i.e. people are not restricted by being actively prevented from doing something and includes anti-discrimination policy (Mars *et al,* 2008). Positive autonomy takes a more universal approach and refers to "increasing people's opportunities to arrange their lives" through both anti-discrimination policy and universalizing disability policy (Mars *et al,* 2008:337).

Essentially autonomy can be defined as having free will, being independent and having the right to self-determination (Welford *et al*, 2010; Underman-Boggs, 2011). However, this does not preclude an individual accepting support while still remaining autonomous (Berthelsen *et al*, 2014). Deci and Ryan (2012) argue that one can be autonomously dependent (chose to rely or depend on others) or one can be autonomously independent (chose not to rely or depend on others). Integral to the concept of autonomy is being in control of one's own life (McCormack, 2001a; Welford *et al,* 2010; Deci and Ryan, 2012).

The importance of having and retaining control was highly valued by the co-researchers. This study found that being autonomous and retaining autonomy can be positively or adversely affected by a number of factors including: having choice and a sense of personal control; societal attitudes and views; lobby groups and Government policies and strategies as well as the types of health and social services available to older women. These points are discussed in the following sections: 1) Making choices and taking personal control, 2) Impact of societal views and 3) Health care needs and provision.

6.2.1 Making Choices and Taking Personal Control

Central to being autonomous is the concept of choice. Being able to choose what they wanted to do and how they wanted to live was key to the co-researchers' experiences. Seminal research by Langer and Rodin (1976:192) on the effects of choice and personal responsibility for older people indicated that "choice is ... a crucial variable in enhancing an induced sense of control". Gerontological research has identified personal control as a key concept in the ageing experience and supports "the need for personal control as we age" (Mallers *et al*, 2013:67). Similar to the study findings, Byles *et al* (2014) and Wiles *et al* (2013) identified that both older women and men want choice in where and how they live, having this choice enhanced their sense of independence and autonomy.

This current study found in line with the findings of Quéniart and Charpentier (2012) and Terrill and Gullifer (2010) that concepts of choice, personal control and independence are interlinked, in so far as older women in these studies wanted the freedom to choose and the ability to do what was important and meaningful to them. Common to all co-researchers was their determination to retain personal control and autonomy.

Their sense of being in control and remaining independent required them to balance their needs and supports in an effort to stay well as they aged. This was done by being proactive, for example, leading a healthy lifestyle, seeking professional advice and care as well as prudent financial management. It is acknowledged that the co-researchers also retained autonomy and exercised choice in other aspects of their personal, financial and social lives such as managing their houses, taking part in social events and having a car. Merighi *et al* (2013) report similar findings, participants in their study placed importance on maintaining autonomy in daily domestic

routines and attending to personal self-care needs. Similar to the present study, being financially secure was highlighted by Hedberg *et al* (2009) as important to maintaining independence, indicating not surprisingly that having insufficient funds makes older women feel less in control of their own affairs.

In the present study co-researchers' beliefs about having personal control influenced their efforts to remain autonomous. Being independent, self-sufficient, self-reliant and having control over their lives were valued attributes and for many were values embedded from childhood. However, there was a 'downside' to these strongly held beliefs as many felt it was a sign that they were becoming dependent if they asked for support and as a consequence their personal control would be diminished. Consequently the co-researchers' sense of self as being independent autonomous people was negatively impacted on by the thoughts of having to depend or rely on others for support or help.

The co-researchers were worried about being a burden on their families which is similar to previously reported research findings (McLaughlin *et al*, 2011; Lowe and McBride-Henry, 2012). Indeed many resisted asking for help until a particular event occurred e.g. a fall or an exacerbation of an underlying health condition. Lowe and McBride-Henry (2012:22) emphasise in their study on older women how needing help with personal care was seen as the "beginning of becoming dependent" and something to be avoided if possible. Not wanting to be a burden, doing something useful or being able to reciprocate for any assistance provided were identified by McLaughlin *et al* (2011) and Bell & Menec (2015) as enhancing older women's sense of autonomy. Similarly, Crawford-Shearer *et al* (2009)

report that the fear of becoming a burden was ever present for older women in their study and in an effort to remain independent, these women felt it was important to stay healthy. Wanting to stay healthy and making the effort to ensure this was also strongly emphasised by co-researchers in the present study.

While a number recognised that they may not currently or in the future be fully independent in the sense that they needed or will need support to manage their activities of living, they were adamant about wanting to remain in control of their lives even in the face of needing such support. However this did not preclude asking for help as some co-researchers sought assistance or changed their perspective about asking for help, rationalising that they were choosing to make these decisions. Therefore, they were in control of the type and level of support accepted. Accepting support helped them to maintain their independence. This pragmatism is also highlighted in the literature (Giddings *et al*, 2007; Mars *et al*, 2008; Foster and Neville, 2010; Song and Kong, 2015) whereby accepting help on one's own terms was seen as way of maintaining personal control and independence.

Co-researchers in the current study accepted help on their terms, for example, help with shopping, getting lifts to an event or appointment and/or household duties but had reservations about asking for or accepting help if their core independence seemed threatened as they worried that they would no longer be seen as being able to cope. This finding suggests it is how older women interpret help that is important. Research highlights that different types of support have different meanings attached, these influence how older women and men perceive and accept support (Foster and Neville, 2010; Song and Kong, 2015; Allen and Wiles, 2013). For example, in Allen and Wiles' (2013) study support offered in response to particular situations was acceptable e.g. illness or where there was the capacity for reciprocity between the giver and receiver of support.

However, in the current study and similar to research on older women's experiences (Roberto *et al,* 2005; Hedberg *et al,* 2009) support was not welcomed when co-researchers felt they did not need support or help or when they felt it negatively impacted on their independence (for example, home renovations, being encouraged to move to a nursing home). How help and support is perceived is important and determines whether it is seen as enabling independence or fostering dependence (Wiles *et al,* 2012).

A common finding across the literature and found in this study too, is that personal choice on whether to ask for and accept help (or not is) an integral aspect of what it means to be independent. Some co-researchers believed that asking for and receiving help meant that they were no longer capable and required others to manage their lives. At times fears about ceding control and handing over responsibility to others influenced their decision not to ask for help. Wanting ownership over one's own affairs is reflected in research findings (Hedberg *et al*, 2009; Queniart and Charpentier, 2012) which reported that older women were adamant that they did not want others making decisions for them.

Findings from the current study and from the literature suggest that there is a general reluctance to accept the decision making abilities of older women, reflecting the view that they need to be guided to make decisions or more worryingly that they cannot be trusted to make these decisions (Nelson, 2005; Roberto *et al,* 2005). It is of concern that some co-researchers in this present study feared that their personal control could be subverted because they were old and this view resonates with the notion that older people may be seen as lacking capacity to make decisions, are powerless and incompetent (Nelson, 2005). This is supported by Crawford Shearer *et al's* (2009: 157) findings in which older women complained that their children disregarded and "usurped" their decision making role, resulting in them feeling their views were not considered and that their decision making abilities were diminished.

Therefore, an understanding and an acceptance that older women have the right to make their own decisions is essential. This right needs to be maintained and upheld within the context of older women retaining their autonomy. Regard for their right to self-determination must be underpinned by respect. These rights are adversely affected by ageism at worst or by paternalism at best and suggests that some non-old people believe they have the right to make decisions about and for older people by virtue of the fact that these people are old (Nelson, 2005; Roberto *et al,* 2005; Jönson, 2012). It is important that older women are supported to make their own decisions and feel confident that these will be respected.

Non-Governmental groups such as Age Action Ireland, Older People's Empowerment Network (OPEN), The National Centre for the Protection of Older People (NCPOP), Active Retirement Ireland and Third Age (this includes SAGE, a support and advocacy service for older people) advocate for the rights of older people.

Typically older people are invited to participate in related fora and councils through local authorities. However, with the exception of active retirement groups, none of the co-researchers within the current study were involved in any of these organisations. It is important that these organisations find ways to publicise invitations and/or garner interest in participation so as to reflect the views of a wide range of older women. Unfortunately a casualty of the economic recession was the demise of the Older Women's Network organisation which had specifically campaigned on issues facing older women living in Ireland, including income, adult/child dependency, education, health, transportation, social participation, public representation and independence (Older Women's Network, 2011). Organisations which have a specific older woman focus such as this one can be useful in articulating and representing older women's specific needs, views and concerns. It is recommended that existing organisations

devise ways in which older women's specific views and opinions can be heard and considered at both local and national level. However, older women must be aware of these organisations and what they do in the first instance and therefore, it is recommended that information about these be made available through health and day centres, GP practices and social clubs.

A number of the co-researchers described how they retained their autonomy in the face of increased physical dependency and frailty through partnered decision-making, illustrating how accepting help can enhance independence. Typically discussion and negotiation occurred with family members, for example, three co-researchers required assistance to remain living in their own homes. This approach was individualised to the needs and wishes of the co-researchers involved and speaks to the importance of retaining autonomy for these co-researchers through joint decision-making. It is recommended that a similar approach be adopted by health and social care professionals.

For example, Hicks *et al* (2012) argue that more attention needs to be paid to the individual needs of the older person and advocate for a participatory approach to designing social supports through engaged dialogue between older people and health care professionals. In a similar way, McCormack (2001b) has championed the need for negotiation to maintain older people's autonomy. Although his observations were made in reference to residential care, it is argued that negotiation is also important in non-residential health care provision. This negotiation needs to be based on understanding the individual's values and through this the person's autonomy can be facilitated and maintained (McCormack, 2001a). Negotiation is an important consideration for all older people but it is particularly significant for older women as they typically live longer, are

more likely to have chronic conditions and more likely to live alone, become increasingly frail and therefore will need specific supports to be tailored to their particular needs.

All the co-researchers wanted to remain living in their own homes and for some support is or may be required for them to do so. Therefore, as highlighted by the National Women's Council of Ireland (2014:15) it is important to "address the different social and health-care needs of older women ... who require care support to enable them to live in their own homes". National collaborative initiatives such as the 'older people remaining at home' (OPRAH)[8] project (currently being piloted and evaluated) will further provide insight into the needs and support that older people require to continue to live at home (Age Friendly Ireland,2015).

While such initiatives are welcomed, the level of commitment by the Government to support older women living in the community needs to be questioned within the context of the non-statutory entitlement of community care services. Connolly (2015) argues that as a consequence of this, social care in the community is fragmented and in contrast residential care as a statutory entitlement has been prioritised over community care services. This may result in older women being offered and provided with residential care in the absence of adequate community care services.

Thus there are challenges in how older women are facilitated and empowered to make their own choices. What needs to be considered from an Irish context is how personal control is currently supported and facilitated for older women because "when control is enhanced, individuals experience positive outcomes..." (Mallers *et al,* 2013: 69).

[8] The OPRAH project is a collaboration of the older person, local voluntary organisations, public and health services and centres on identification of specific needs of the older person, developing an individualised plan and providing support based on this plan (Age Friendly Ireland, 2015)

6.2.2 Impact of Societal Views

Co-researchers' experiences demonstrate how societal views impacted on their autonomy. Previously discussed anti-ageism initiatives and legislation by Government and national organisations highlight that ageism is a cause for concern in Ireland (2.4.2, 2.4.3). It is suggested that similar to international research, negative perceptions about ageing and ageism can have negative consequences for older women in Ireland. Holstein (2015: 63) highlights that as a result of negative perceptions of old age and ageing, older women have "internalised ageism [and it is] normalized and naturalized in …society".

It is argued that the co-researchers had also internalised ageism, both by the way they perceived themselves and how they perceived societal attitudes as being negative towards older women. At the extreme these negative perceptions can contribute to ageism. Beliefs regarding the capacity/incapacity of older women to make decisions are influenced by wider societal values and attitudes about older women which in turn can be internalised by older women themselves (Stevernik *et al,* 2001; Westerhof and Tulle, 2007; Day and Hitchings, 2011; Marques *et al*, 2015).

Perceptions that those who are older are less capable can adversely affect older women's sense of control. For example, one of the co-researchers described a social event where contrary to her wishes her wheelchair was taken away and stored for the duration of the event. However, her experiences at multiple sclerosis (MS) society events were different. There it was accepted that she wanted to attend to her own personal needs and is reflective of the MS mission statement '*To enable and empower people affected by Multiple Sclerosis to live the life of their choice to their fullest potential' (Multiple Sclerosis, no date)*. The contrast in approaches highlights different underlying attitudes towards older people with a physical incapacity although it is accepted that those within the MS society may be committed to an ethos of enablement regardless of the age of the person.

However, this example illustrates how the concept of 'doing for' rather than 'doing with' (enabling) older people reflects a paternalistic approach towards older people (Jönson, 2012, Holstein, 2015). In contrast, organisations which are attuned to the desires and needs of people with disabilities both collaborate with and empower them (National Disability Authority, 2011) (NDA). Ageist attitudes can negatively impact on older women's sense of personal worth, control and autonomy and can adversely affect the number and types of choices available to them (Nelson, 2005; Hurd Clarke *et al,* 2008; Older Women's Network, 2011). Ultimately ageism can result in age discrimination which results in older people being devalued and disempowered (HSE, 2009).

Therefore, those employed or working as volunteers in organisations and clubs attended by older women with disabilities and/or impairments need to be aware of and responsive to what older women actually want and how they want to live. There are aspects of the social model of disability care which could be adopted and applied to older women living in the community. These include the promotion of independent living, equity and the provision of independent advocacy and personal assistance according to the needs of the individual (NDA, 2002).

In an effort to combat ageism, Holstein (2015) exhorts older women to develop autonomy competence, a skill set which would enable older women to live in a way which preserves their integrity and not feel forced into trying to make their body conform to the socially decreed image of the ideal youthful woman (Holstein, 2015). While any such suggestions are worth considering, more in-depth exploration of this concept is required to determine if such an initiative could be developed in Ireland. The feasibility and efficacy of such a programme as well as interest (from older women and service providers) would need to be determined from an Irish perspective. However, regardless of how internalised ageism is combated, what is important is the need to explore ways in which internalised ageism can be ameliorated.

Nationally, efforts are being made to demonstrate that longevity and ageing is something to be celebrated and not feared. Government initiatives aim to facilitate older people to live in their own homes where possible or if not, to be supported in suitable residential care (HSE National Service Plan 2015; DOH, 2013a). Government actions include the enactment of anti-ageist legislation through the equal status Act (Irish Statue Book, 2000), the promotion of anti-ageism, the National Positive Ageing Strategy and the 'Age Friendly Cities and Counties' programme. With specific reference to supporting independence and autonomy, the National Positive Ageing strategy (DOH, 2013a:3) has committed to making Ireland "a society in which the equality, independence, participation, care, self-fulfilment and dignity of older people are pursued at all times".

Similarly the Age Friendly Cities and Counties programme (2015) emphasise the role of the older person in the development of age friendly communities, affirming their right to have a say in the type of community they live in. Age friendly communities are expected to be supportive of the needs of older people through having access to health care, having a safe and secure environment as well as affording older people the opportunity to be fully involved in community life (Age Friendly Cities and Counties Programme, 2015).

While all of these initiatives are welcome, they have a generic approach to older people with little in the way of specifically addressing gender differences and needs. It is argued that while all older people may value retaining autonomy, consideration on how best to support older women to do this must be taken in context of older women's bio-psycho-social, cultural and economic needs and resources.

Unfortunately there is some dissonance between these laudable espoused Governmental and non-Governmental beliefs on ageing and older people, and how older women are supported or not as they age. In view of an ageing female population in Ireland the emotive language used to describe the changing demographics (e.g. 'ageing time bomb') and older hospitalised people being referred to as 'bed blockers' (delayed discharge due to lack of suitable non-acute care facilities) has particular significance for older women.

Terms such as these can negatively impact on older women's sense of well-being and feeling of being valued and respected (Oliver, 2008). Holstein (2015:70) argues that older women are both 'hypervisible and invisible' in so far as they are clearly identifiable by their physical appearance but once seen become invisible through being ignored and marginalised. Quéniart and Charpentier (2012) highlight that older women are subject to both ageist and sexist societal attitudes, leading to older women being discriminated against in a myriad of ways including pension entitlements and health and social care services. Being treated in a disrespectful way is humiliating (Holstein, 2015) and detrimental to one's sense of self (Quéniart and Charpentier, 2012) as a worthwhile autonomous being.

According to Holstein (2015) such treatment is evidence of unequal power structures between young and older populations and is reflective of an ageist society. As previously discussed (in 2.2.3 and 2.3.3) older women are particularly vulnerable to ageism. Jönson, (2012) argues that non-old people are essentially ageist and discriminate against their future older selves by believing that they will be different and will expect more than present older people. Using this perceived difference as a basis, they believe present older people have fewer needs than they [non-old] will have in the future and thus justify current treatment of older people as being acceptable but ironically would not accept such treatment for themselves (Jönson, 2012).

Further evidence of the somewhat contradictory approach in older person policy in Ireland is the variation in the support afforded to older people and in particular older women. As previously discussed there are various allowances and benefits available which enable older people remain independent. However, a number of these have been removed and/or reduced (e.g. in home help hours, telephone allowance, fuel allowance and medical cards) and in addition, new charges have been introduced (e.g. household tax, water charges, prescription charges, universal social charge) which can have particular significance for older women with fixed incomes and who historically have less means than their male counterparts (differences in pension entitlements in particular have been highlighted in 2.4.3). These changes adversely impacted on the co-researchers' lives and limited their choices regarding disposable income, household budgets, participation in social events, home renovations and private health insurance.

6.2.3 Health Care Needs and Provision

Wanting to retain autonomy was also evident in how the co-researchers managed their health needs as they aged. However, findings from both the current study and from other research highlight that older women do not identify ill health as such but rather view it to be a consequence of the ageing process (Nelson, 2005; Kim, 2009; NCPOP, 2009; Roberto and McCann, 2011; Hurst *et al,* 2013; Song and Kong, 2015).

Some co-researchers did not seek treatment as they believed their problems were age related rather than health related. Having an expectation that one will have ill health in older age is also reflected in the literature. Foster and Neville (2010) and Hurst *et al* (2013) found that older

women believed their ill health was part of the normal ageing process, influenced in no small way by a poor perception of old age and having low expectations of health in older age. Similarly Roberto and McCann (2011:95) state that "*preconceived expectations about ageing including ageist stereotypes and personal beliefs influence how [older people]…evaluate their health in later life*". It is argued that this belief can negatively impact on older women's sense of control or autonomy in so far as their expectations about their health were low. Similarly, Lorenz (2010) described that older women felt they had to endure the consequences of ill health as they aged without complaint.

Of course, there were times when the co-researchers did seek advice and treatment from healthcare professionals in managing their health care needs. Many described having positive relationships with health care providers, especially their GP with whom they had the most contact. The calibre of the interpersonal relationship between older women and health care professionals is important in facilitating choice and enabling older women to make their own decisions about health care (Lowe and McBride-Henry, 2012). Lee Smith *et al* (2013) also highlight the importance of physician support in helping older women manage their chronic health conditions. Therefore, health care professionals have an important role in helping older women retain autonomy in health care management as they age.

There was also evidence of less satisfactory relationships and it was found that some health care professionals were reluctant to explain issues and facilitate requests for follow ups. This finding is supported by the work of other researchers (Tannenbaum *et al,* 2003; Hickey *et al,* 2005; Tannenbaum *et al,* 2005, Lee Smith *et al*, 2013) which has demonstrated that less attention is paid to older women's psychological health than to their physical needs. Within the current study there was also a perception that some health care professionals did not take seriously their complaints of ill health because they (co-researchers) were older.

Merighi *et al* (2013) also found that older women felt their complaints of ill health were not taken seriously and were attributed to old age. Furthermore, Merighi *et al* (2013) like the present study found that information about courses of treatment were not always explained to older women. Not being fully informed about treatment and health care management can adversely impact on older women's autonomy and decision-making. According to Holstein (2015:72) doctors may attribute "treatable conditions on age and not offer treatments they would offer a younger person". Holstein (2015) has also argued that generally in medical consultations older people are given less respect, less patience and less information when compared with younger patients. NCPOP (2009) suggests that this perspective can result in older people being disrespected and discriminated against.

It is suggested that this approach, on the part of some health care professionals, may reflect a lack of knowledge and understanding about the health needs of older people in general and more specifically older women. As previously discussed (2.4.2) there are gender differences in the presentation of medical conditions and there is a bias towards understanding these conditions from a male perspective (Annandale, 2009). Subsequently women are discriminated against because of their different clinical presentation (Katz, 2008; National Women's Council of Ireland 2014). Sharpe (1995) has argued that older women's subjective experience of illness has been neglected and that stereotyping can have adverse consequences for older women's health. Similarly, Kosiak *et al* (2006) argues there is a lack of knowledge by both research and clinical staff about the particular needs of older people and advocates for the development of ageing specific quality measures and models of care.

The WHO (2015b:15) advocates for the inclusion of "geriatric and gerontological competencies in all health curriculums". It is acknowledged that the Irish national clinical programme for older people is currently devising models of care for older people and models have been developed for acute care and mental care services for older people (HSE, 2016b). In conjunction with HSE integrated care programme (HSE, 2016a) a proposed strategy for primary and community care services is to be developed. In Ireland there has been an acknowledgement of gender differences with proposals to develop gender sensitive policy, planning and service delivery within the HSE (HSE and the National Women's Council of Ireland, 2012), but the intersection of age, health and gender has not been highlighted.

There is inclusion of older person studies in health care professional curricula in Ireland. But in light of the findings of the present study and other research it is important to explore both health care professionals' attitudes towards older women as well as their specific knowledge of the health care needs of older women. Arising from the findings of this present study, it is suggested that if healthcare professionals provide a positive supportive role then older women may be empowered to retain their autonomy and exercise personal control.

Of central importance to retaining autonomy is the fundamental question of how much choice is actually available to older women in health care service provision. A number of co-researchers described not knowing where and how to access information about age and health related services. This finding is supported by the HSE Quality Improvement Division and Age Friendly Ireland (2015) which also reported a lack of information about services for older people. Being informed empowers people to make choices and have control over the management of their health care (Hurst *et al*, 2013).

However, notwithstanding the importance of information, Hicks *et al* (2012: 140) question the widely held view that older people are truly able to make informed decisions and ask whether they can really make autonomous choices within the context of "expertise and institutional concerns", suggesting that choices are limited as to what is offered and who gets to choose.

Co-researchers in the present study also voiced concerns over the lack of screening for certain conditions and felt this adversely impacted on how well they could monitor their health and also how this made them feel, essentially not feeling valued or worthy of consideration. The lack of choice in screening exemplifies how older women's desire to retain autonomy in their health care management can be limited depending on the options available. This is similar to Holstein's (2015:74) assertion that social service programmes offer "a narrow view of autonomy" in that choices can be limited to fairly meaningless "pre-existing options" and in essence do not consider how older people actually want to live.

Of concern is the evidence of ageism within the health care service and this can adversely affect both quality of care provided and access to certain treatments (NCPOP, 2009). For example, there are age limits for screening and according to NCPOP (2009:39) not offering older women breast screening is an example of "institutional ageism". However, it is acknowledged that there is a commitment in the programme for government (*Breast Check, National Screening Programme (no date)*) to extend this to include women aged 65-69 years but not for those older than this.

In conclusion this section has discussed the key concept of 'autonomy' in relation to the data and the literature, addressing the issues of *'making choices and taking personal control', 'impact of societal views'* and *'health care needs and provision'.* From a phenomenological perspective, older women's experiences of retaining autonomy is influenced by: their bodily abilities (cognitive and physiological); their relationships with family and wider society; where they live and how time is viewed through the lens of chronological ageing.

The data confirmed the importance of choice and taking personal control in maintaining independence and retaining autonomy. It has affirmed that older women have to balance their needs with available supports in order to do this. The data also illustrates older women's strong desire to have both the freedom and ability to choose to do what is meaningful to them. In tune with the literature (Terrill and Gullifer, 2010; Quéniart and Charpentier, 2012; Merighi *et al*, 2013), this study highlights how older women work to retain autonomy as illustrated by making proactive decisions about lifestyle, housing and health maintenance. Moreover, this study demonstrates how vehemently opposed co-researchers are to the thoughts of not being able to remain at home. They strongly opposed the idea of having to move to a nursing home in the future.

Furthermore, this study demonstrates how there can be an underlying anxiety and fear of ceding control and how the mere fact of being old can lead to personal control being subverted. While this has been previously flagged in the literature (Nelson, 2005; Crawford Shearer *et al*, 2009; Jönson, 2012) the data clearly shows that these co-researchers feared an erosion of their independence either by increased ill health or by a

diminution of personal control. They cherished their right to self-determination and resisted unwanted intervention by either family and/or health care professionals. Similar to the findings of others, the data shows that acceptance of help and support is nuanced and conditional on the type of help being offered (Roberts *et al*, 2005; Hedberg *et al*, 2009; Foster and Neville, 2010; Allen and Wiles, 2013; Song and Kong, 2015).

This study illustrates the importance of engaged dialogue and negotiation between older women and their families. Importantly, the concept of partnered decision-making identified within the data provides insights into how joint decision making can support older women to retain autonomy. It is suggested that health care professionals could assess the potential of this approach as a way of safeguarding older women's autonomy.

These findings have confirmed the impact of societal views on older women's autonomy in relation to factors which support personal control (e.g. national strategies and initiatives, positive relationships with health care professionals) and those which challenges it (e.g. paternal, negative and at times ageist attitudes, less than satisfactory relationships with health care professionals, and lack of gender specific considerations of the needs of older women in Governmental policies and strategies).

Furthermore, this data confirms what is currently known about the effect of positive and negative relationships with health and social care professionals on older women's experiences of ageing and health related issues (Tannenbaum *et al*, 2003; Hickey *et al*, 2005; Tannenbaum *et al*, 2005; Lee Smith *et al*, 2013; Merighi *et al*, 2013; Holstein, 2015) . In particular, the data shows that there are missed opportunities for health assessment and health promotion, in so far as there tends not to be a proactive approach to older women's health care needs. Specific to Irish policy, although some initiatives have been developed, there remains a gap

in national and local policies, strategies and application in how the gender specific needs of older women are addressed. Davidson *et al*, (2011:1039) argue for a "gendered perspective of ageing approach" to policy and strategies which encompass health care prevention and intervention, safe environments, education and appropriate housing specific to the needs of older women.

As early as the 1970s Langer and Rodin (1976:197) recommended that "mechanisms can and should be established for changing situational factors that reduce real or perceived responsibility in the elderly". Therefore, within the context of this present study, it is argued that empowerment of older women in managing their health concerns as they age can be facilitated by promoting and adopting non-ageist non-sexist attitudes, having a gendered ageing approach within policies and strategies to the health needs of older women and developing collaborative older women-health care professional relationships. Specifically, the following recommendations are offered to both support older women's proactive efforts in maintaining a healthy lifestyle and to value their contribution to society.

These include the: exploration of the attitudes and education needs of health care professionals in providing gender specific health care; provision of gender sensitive older person health promotion programmes; provision of easily accessible information on available support services; offering regular health check-ups; acknowledge and emphasise the concept of reciprocity whereby older women are recognised for being contributors as well as recipients within society; support for older women and their families in partnered decision-making and finally develop a climate which recognises and reassures older women that asking for help does not diminish one's independence rather it can support and enhance it.

6.3 Adaptation and the Older Woman

The co-researchers described how they adapted to the process of ageing and their inter-related health needs. Adaptation was an ongoing process for the co-researchers as they lived through the ageing continuum. There were periods of stability where equilibrium was achieved i.e. when their adaptation met the needs wrought by ageing and health related changes. Conversely there were periods when rebalancing was required and the co-researchers needed to readjust and readapt to new demands. These demands were either temporary (e.g. exacerbation of an underlying condition, short term illness or accident) or permanent (e.g. failing health and reduced abilities related to the bio-psycho-social changes associated with the ageing process). The process of adaptation was influenced by the co-researchers' feelings; perceived and actual capabilities; and their individual circumstances.

These aspects determined how they assessed or appraised their situation, and what actions were taken to respond, adapt and manage the situation. The different ways in which they viewed and appraised these changes impacted on how they adapted to living with them. This section discusses the findings in conjunction with the literature in relation to co-researchers' experiences of adapting to the concept of ageing and health; having a positive approach; adapting to bodily changes, loss and role as well as adapting to their 'lived space' (environment).

6.3.1 Adapting to the Concept of Ageing and Health

The co-researchers described how their worlds have changed as they have aged, specifically they discussed personal changes associated with ageing and health related issues. During this period of change and adaptation the co-researchers experienced a range of concomitant feelings and emotions including anger, feeling low, feeling sad, loneliness, worry, fear, frustration, annoyance, resignation, acceptance, reconciliation and freedom. Overall, the co-researchers were resigned to the effects of ageing and related health problems. Although there was general acceptance that they were ageing, for many ageing was not something they either looked forward to or wanted and they saw it primarily as being synonymous with loss and dependency.

In contrast, others saw it as time for self and self-development. Most described it as a mixture of both. The co-researchers' reactions were framed from within their individual experiences and how well they were and felt at a particular time. In a way this reflects a type of 'ebb and flow' of feeling positive or negative in response to feeling well or not at different times. For some of the co-researchers, being ill combined with the ageing process itself either compounded their existing negative feelings or gave rise to negative feelings.

Notwithstanding co-researchers' more negative views, most were pragmatic and were of the view that they needed to accept, adapt and accommodate these changes and problems and live their lives in the time left to them. Being able to accept these changes can help older women adapt and adjust to their new situation (Roberto *et al*, 2005; Lorenz, 2010; Lowe and McBride-Henry, 2012; Hurd Clarke and Bennett, 2013). Likewise older women in Lowe and McBride-Henry's study (2012) took a pragmatic approach to ageing and related problems. They accepted that they had

limitations but actively explored ways of coping with these through using aids, having help with housework and adjusting their activities in response to diminished energy levels and disabilities so that they could continue to be independent.

Being pragmatic and accepting the situation is typical of how women in the current study viewed growing older and having health problems. They felt it was important to appraise their situation and adjust accordingly. Certain situations e.g. acute illnesses and exacerbations of chronic conditions required temporary adjustments. Others e.g. chronic conditions and physiological changes associated with ageing required continued adaptation by the co-researchers to the incremental changes they experienced. Adaptation was a process of continually responding and readjusting to their changing abilities and needs. How the co-researchers felt and viewed their situation impacted on their specific adaptive processes.

6.3.2 Having a Positive Attitude

Research highlights the benefits of optimism and having a positive attitude for older women as they adapt to their new situation (Terrill and Gullifer, 2010; Merighi *et al,* 2013). Co-researchers in the present study indicated that developing and having a positive attitude was important in adapting to age, ageing and health related issues as this enabled them to accept and adjust in a proactive way to change.

This approach was similar to findings by Wurm and Benyamini (2014) who identified the concept of realistic optimism as important in being able to cope effectively, arguing that those older people who were optimistic but realistic i.e. prepared for 'physical losses' had lower symptoms of depression and were better able to maintain physical functioning.

McLaughlin *et al* (2011:25) also highlight how having an optimistic outlook enabled participants in their study to cope successfully with age related difficulties and revealed an attitude of 'making the best of it'. Similarly, Hurd Clarke and Bennett (2013:349) explain that older women in their study had "achieved a sense of acceptance" by believing that while chronic illnesses was unavoidable in older age, one had to develop a positive and optimistic attitude in order to cope and make the best of the situation. The findings of the current study demonstrate how having a positive attitude, accepting what can be done and not dwelling on what cannot be done was a key factor in helping the co-researchers adapt to growing old.

Interestingly, a number of women in the current study also advocated avoiding people who were negative, arguing that being in their company was unhelpful and energy sapping. It is argued that this action was self-protective for these co-researchers. These findings compare to research (Roberto *et al*, 2005; Levasseur *et al*, 2009; Hurd Clarke and Bennett, 2013) which found that older people in their studies disliked and at times actively distanced themselves from those they perceived as not being positive enough and who complained too much. Participants in these studies (Roberto *et al*, 2005: Hurd Clarke and Bennett, 2013) like the co-researchers, thought it better to focus on the positive aspects of one's life rather than on one's problems and ill health.

Having a positive attitude helped many co-researchers to 'carry on' and avail of opportunities afforded by having more time, less responsibilities and freedom to follow one's interests. This phase in their lives was seen as a time of opportunity and being able to do things that they previously did not have time for. For many of the co-researchers it was a case of 'carpe diem'. Others have reported that being older can be a time of personal growth, and opportunity to engage in activities that are meaningful to the individual (Rossen *et al*, 2008; Hedberg et al, 2009; Terrill and Gullifer, 2010; Quéniart and Charpentier, 2012). This suggests that having a positive

attitude to growing older enabled women to be open to new experiences and opportunities. A positive attitude enabled the co-researchers to adapt in a positive way to this phase in their lives.

In addition, to having a positive attitude, religious belief helped sustain many of the co-researchers. While not all were religious, many were and they drew on their faith and belief in God to help them adapt to ill health, loss and bereavement. They described the importance for them in putting their faith and trust in God to help them cope with and adapt to the challenges facing them. The positive effect of spirituality on older women's ability to cope and develop resilience is highlighted in the literature (Maddox, 1999; Roberts *et al*, 2005; Lamond *et al*, 2008; Lowe and McBride-Henry, 2012; Manning, 2012 and Krause and Hayward, 2014). Hedberg *et al* (2015) describe how belief in God engendered a feeling of safety in participants' lives which enabled them to cope with life's struggles and hardships. Spirituality can facilitate people to make sense of and cope with difficult situations (Lowe and McBride-Henry, 2012), health challenges and positively impact health (Roberts *et al*, 2005) and wellbeing (Manning, 2012). The findings of this present study are similar to those of TILDA, which demonstrated that the majority of older women in their study derived strength and comfort from religion (Timonen *et al,* 2011).

It is acknowledged that in the face of diminishing abilities and health related problems, older women may not feel particularly positive and may need the option of availing of support in identifying individual goals and opportunities. Health care professionals have a role in being a source of support by providing advice and information through individual health assessments and consultations. Furthermore, both Foster and Neville (2010) and Levasseur *et al* (2009) identified that health care professionals have a role in supporting this adaptation process through health promotion and it is recommended that a similar role would be of benefit to older women in Ireland.

6.3.3 Adapting to a Changing Body

Research has demonstrated that age related stereotyping can negatively influence older women's health promoting behaviours (Yeom,2013) and negatively impact on older people's health behaviours and lifestyles (Sánchez Palacios *et al* 2009). Sections 2.2.3 and 2.3.3.1 flagged the value society places on being young and how older women in particular are negatively viewed (Westerhof and Tulle, 2007; Maguire, 2008; Day and Hitchings, 2011; Chrisler *et al*, 2015; Holstein, 2015).

Of particular significance to the current study is the internalisation of negative views by many older women (Saucier, 2004; Hurd Clarke *et al*, 2008, 2009; Holstein, 2015). The co-researchers found bodily changes difficult to accept, in particular changing physical appearance and shape (e.g. wrinkles, greying hair, skin, posture, weight gain or loss, sight and hearing problems as well as conditions such as leg ulcers, arthritis, and osteoporosis). These obvious signs of ageing were unwelcome to many of the co-researchers and forcibly reminded them of their own age and that they were growing old. Negative body image and body dissatisfaction can adversely affect self-esteem and is not uncommon in older women (McCormick, 2008; Marshall *et al*, 2012; Hurd Clarke and Bennett, 2013; Chrisler *et al*, 2015).

Hurd Clarke & Bennett (2013) highlight how older women can be dismayed and embarrassed by their appearance and 'failing bodies'. Research has demonstrated that physical appearance of ageing can make older women feel unattractive and devalued which has negative consequences on their self-esteem (Hurd Clarke *et al*, 2008; McCormick, 2008). In particular McCormick (2008) highlights how societal and cultural attitudes devalue postmenopausal women's bodies; this she argues adversely affects self-esteem and increases the likelihood of depression and anxiety. In the same way, older women in Hurd Clarke *et al's (*2008) research reported that looking physically old made them feel old which adversely affected their self-esteem.

In this present study, women associated feeling and looking old with ageing and as such was viewed negatively by them. Ageing was more than a chronological number rather it encapsulated their body, abilities, experiences, views and overall sense of being and this was not welcomed by them. The negative connotations associated with the concept of being older are also reflected in research by Quéniart and Charpentier (2012:992) who found that "being an older woman is synonymous with slowing down, inactivity, boredom and isolation".

Co-researchers described wearing clothes and shoes which were comfortable rather than fashionable. In a way, this reinforced the concept that older women's appearances do not really matter within society or more worryingly that the physical signs of ageing need to be covered up (Hurd Clarke *et al*, 2009; Hurd Clarke and Bennett, 2013). Despite this, co-researchers felt it was important to make an effort to 'be presentable' illustrating how they adapted and responded to their changing appearance and were still interested in looking well.

Many of the co-researchers felt it was important for their self-esteem that they attend to their appearance and this involved (for some) dyeing their hair, wearing make-up and nail polish, being clean and tidy, watching their weight. Paulson and Willig (2008) found that wanting to look well was not confined to wanting to look younger, rather older women in their research enjoyed looking well and took pleasure in their clothes and appearance. In addition, to negative feelings engendered by age related bodily changes, many co-researchers experienced a sense of loss when confronted with decreased functional abilities. However, they felt they had to accept and adapt to these changes. Accepting that the past is gone and this current state is the new reality was also highlighted by Levasseur *et al* (2009) whereby participants in their study felt it was important to accept the loss

of their former selves and adjust to their decreased abilities. Being proactive was emphasised by the co-researchers in the current study as helping them adapt through taking personal responsibility and control in managing age and health related problems.

This included taking preventative and health maintenance steps such as having a healthy lifestyle including eating well, having regular medical check- ups and following health care advice. Foster and Neville (2010) also identify the importance of keeping healthy in older age through exercise and having a healthy diet. Kim (2009) highlighted that health promoting behaviour can positively influence physical and mental health and has argued for nurses to encourage older people to engage in health promoting activities. It is recommended that health care professionals in Ireland continue to develop their health promotion role by supporting the positive choices already being made by older women.

Aligned with taking preventative action was modifying personal behaviour to accommodate age and health related changes. The co-researchers identified ways in which they responded to their decreased functional abilities, decreased energy levels and adverse effects of underlying medical conditions.

The co-researchers outlined how they accommodated their changed body. Many used walking sticks or walking frames in an effort to adapt to balance and gait problems and used visual and hearing aids to accommodate impairments. They also described slowing down and taking more time to do things e.g. getting dressed, going places, getting jobs done. Similarly Lorenz (2010) and Nicholson *et al* (2013) described how older women needed to respond to their bodies and 'pace' themselves, to take rests and not take on too much at any one time otherwise they would be exhausted.

There are some similarities with Crawford Shearer *et al's* (2009:155) concept of 'listening to energy flow' whereby older women in their study monitored their energy levels and "adjusted their expectations and physical activities" according to how they were feeling.

Knowing one's own body and being able to interpret and respond to it enable older women evaluate their health status (Roberto and McCann, 2011; Sixsmith *et al*, 2014). Therefore, it is important to be aware of what is 'normal' for one's self and to be able to identify changes to that normal and if necessary seek advice. Having appropriate health information can facilitate older people to "make decisions about their health and maintenance" (Hurst *et al*, 2013:39). While it is acknowledged that health information is available via various sources (e.g. health care professionals, HSE health promotion unit, media) not all of the co-researchers in the present study were aware of this information or knew how to access it. The HSE Quality Improvement Division and Age Friendly Ireland (2015) also report that older people felt there was a lack of information about available health services. The challenge therefore, is how to help older women know what questions to ask as well as how to easily access information.

It is argued that this issue needs to be addressed by health service providers at both organisational and individual local level. Suggestions as to how this may be done include advertising available health services locally and nationally as well as developing effective and accessible health education and health promotion programmes specifically tailored to the needs of older women. Gender specific initiatives which identify the specific information and health management needs of older women could

help focus and maximise health service delivery to this cohort of people. In order to be responsive to women's particular needs, Horton and Ceschia (2015) argue that health care professionals must apply a gender perspective in their care provision. As previously discussed in 2.4.3 a framework for gender sensitive policy (HSE and National Women's Council of Ireland, 2012) has been developed in Ireland but currently there is no published evaluation of its implementation.

6.3.4 Adaptation and Lived Space

Older women's lived space or environment encompasses their home and the wider community. The co-researchers described how they had to adapt to their environment and adapt their environment to accommodate ageing and health related change. Adapting to changing abilities necessitated home modifications. Some co-researchers took active steps to adapt their homes to meet their changing needs such as installing stair lifts and assistive rails, modifying their bathroom and moving their bedroom downstairs. The extent of these renovations and modifications was reflective of the co-researchers' assessment and management of their level of need at this stage in their lives and within the context of their health status. It is important to highlight that adapting one's home can be difficult as it symbolises that one is becoming frail (Sixsmith *et al* 2014) and in need of some support. According to Sixsmith *et al* (2014: 8) "home is gendered space" and for older women it symbolises their central role in "maintaining an active social and family life".

Therefore, home modifications bring into sharp focus that the role and capabilities of the older woman are very changed from when she was younger and was, for example, a mother of young children, homemaker, partner or carer and the 'glue' which kept the family together. Within the current study, the modifications made to the older women's lived space of home symbolises their transition to older age or at least the beginning of this transition, whereby old age encapsulated a changed meaning of the

co-researchers' sense of self vis-à-vis abilities, appearance and self-concept.

In addition, many co-researchers highlighted how they wanted to feel safe and secure within their homes. Many fitted house alarms and sensor lights as well as having quick dial phone numbers to family and/or neighbours and having personal alarms. Many older people in Ireland fear for their safety and security, and worry about being victims of crime (An Garda Síochána, 2010). In an effort to assuage these fears and respond to the needs of older people, An Garda Síochána (2010) have developed a number of initiatives such as older people registers, community alert and neighbourhood watch schemes; bogus call initiative and involvement in the age friendly counties programme.

Notwithstanding these initiatives, co-researchers had mixed views and experiences about crime prevention and the visibility of community policing with some co-researchers believing that there was little police presence available. Not surprisingly those who had been the victims of crime (two had their houses burgled) were especially fearful of this happening again. This negatively impacted on their emotional health in so far as they were anxious and fearful. Thus a particular challenge for the police is to how to support and restore confidence in such cases.

The co-researchers' sense of ageing was impacted upon by their need to adapt their homes but also by their need to adapt to their wider environment. It is acknowledged that the concept of home is not limited to one's house but also to one's wider community and is commonly referred to as 'ageing in place' a concept which recognises the importance of continuing to live in one's home and community (Wiles *et al* 2011). Thus the co-researchers' relationships within the wider community are also of relevance to the meaning of their experiences. These relationships are discussed in 6.4 'continued engagement'.

Being proactive and taking preventative action was further reflected in the personal safety arrangements that the co-researchers made. A number were afraid of falling and worried about the immediate and long term consequences of this. Research has indicated how fear of falling adversely impacts on older people's activity levels, in particular walking (Roberts *et al*, 2005; Donoghue*,* 2014).Many of the co-researchers spoke about staying safe when out and about e.g. being mindful of traffic and being vigilant about the possibility of slipping on cracked footpaths or fallen leaves. Increased traffic and the absence of footpaths in rural communities as well as poor quality footpaths in more urban areas resulted in some co-researchers being afraid to walk on these roads which curtailed their ability to exercise.

Chaudhury *et al* (2012) report similar concerns; participants in their study identify how physical environment and traffic concerns impacted on their sense of safety and security. Factors such as the quality of footpath surfaces, absence of footpaths, traffic light timing and actual width of the road impacted on the level of physical activity these participants engaged in. Rantakokko *et al* (2014) have identified that an outside environment which hinders mobility increases older people's fear about going outdoors and is associated with poorer quality of life.

Such concerns warrant attention in planning age friendly environments. While it acknowledged that the Age Friendly Cities and Counties Programme (2015) is cognisant of the importance of addressing such environmental issues, this is a new initiative and it will take time and resources for plans to be implemented.

6.3.5 Adapting to Loss and Changed Role

Reflective of the heterogeneity of the cohort in the current study, co-researchers had different experiences of loss and changing roles as they aged. Some found loss of functional abilities, loss of loved ones and changed role hard to adjust to while others were more pragmatic. Some continued to work or volunteer, others took on new roles as carers, other continued in their carer roles, a number provided childcare for grandchildren while others retired from paid employment and more took a step back from house hold duties. However, there are common themes within the co-researchers' experiences.

Co-researchers had to adapt to the loss of loved ones through death, illness and relocation (of either the co-researcher or their families e.g. emigration). In tune with studies by McLaughlin *et al* (2011) and Hedberg *et al* (2009) many co-researchers felt sad and lonely following bereavement (primarily death of spouses but also family members and friends). Duarte-Silva *et al* (2012) also describe the negative emotional impact on older women of bereavement. Duarte-Silva *et al* (2012) report higher subjective wellbeing in those widowed for a longer period when compared to those more recently widowed. However, in contrast in the current study, some co-researchers reported still feeling very sad and lonely for years after the death of their husband and for some this changed life was difficult to adjust to.

While the focus of this study was not specifically on the effects of bereavement on wellbeing, the findings indicate that bereavement can have ongoing negative emotional effects. Typically in Ireland professional bereavement counselling is not routinely offered or provided unless in cases of traumatic death (e.g. suicide), however, there may be merit for some older women's emotional health that they are offered such services.

However, notwithstanding the significance of these losses, in the current study many co-researchers felt it was important to reconcile themselves to loss and learn to live with it. Being proactive in coping with loneliness and social isolation was identified as being important by the co-researchers. As this aspect of the findings is also very much related to the concept of continued engagement, it is discussed further in section 6.4 'Continued Engagement'.

In response to decreased functional abilities, the co-researchers no longer felt as independent and capable and this they reported adversely affected their sense of self. Furthermore, many in the current study worried about developing particular conditions (e.g. dementia, cancer and stroke) and were concerned about how they would manage if this happened. They disliked having to ask for and to accept help or the thoughts of having to do this in the future. They found it difficult to adapt to being on the receiving end of accepting support rather than being the one providing support. Research has indicated that this type of change can challenge older women's sense of self and traditional feminine values and traits of nurturance, caring, warmth, selflessness and being sensitive to others (Hurd Clarke and Bennett, 2013; Pudrovska, 2014). Furthermore, co-researchers found it difficult accept, adapt to and be reconciled with the dissonance between their beliefs about how one should be and what one is able to be and do.

Many co-researchers found the change in their role and status difficult to adjust to. In particular, retirement from paid employment and/or home duties was challenging for some to accept. It took time to get used to new routines, of having less responsibility, not meeting colleagues at work and

not having the same social standing as a younger person. Walsh and Harvey (2011) highlight that upon retirement older people can lose the social network associated with work which adversely affects their opportunities to engage socially with other. Regardless of the type of work, paid or unpaid that older people were previously employed in, Day and Hitchings (2011) argue that as a result of widespread age stigmatisation the mere fact of growing old can lower older people's social status.

This sentiment was reflected by some co-researchers who described themselves as "being dumped" and being someone that "nobody bothers about" once they had become older. These findings are similar to McLaughlin *et al's* (2011) findings where older women felt devalued and socially irrelevant as they aged. Essentially the co-researchers had mixed views about changes in their role once they became older and included having a sense of loss, trepidation and anticipation. This shift in role responsibilities was not always by choice but rather from necessity e.g. actual age (retirement age) and/or the impact of age and health related changes.

Nonetheless, many co-researchers felt that there was also a freedom to being older in so far as they had fewer responsibilities. There were new opportunities available to them such as having the time to pursue personal interests. Research indicates (Hedberg *et al,* 2009; Terrill and Gullifer, 2010; Quéniart and Charpentier, 2012) that older women felt that they had more time to themselves as they were no longer constrained by parenting, schedules or work.

However, even when the choice had been willingly made, adjustment was required. It is argued that older women may need support in adjusting to this change, loss or diminution of their role and capabilities. Although

general information on retirement is available from the Citizen Information Board website in Ireland, the challenge for Government and non-Governmental organisations is to determine how best to support older women during this transition period. It is recommended that state provision of retirement planning programmes incorporating three phases of pre-retirement planning, immediate retirement period and post-retirement period would be useful. Appropriate health promotion programmes which help prepare and support older women adjust and adapt to these role changes should also be included.

It is important to emphasise that quite a number of the co-researchers in the current study had a major role in providing family support. For some this included providing after school care for their grandchildren and providing meals. Some co-researchers continued to be responsible for informal care-giving for adult children with special needs or had to take on the role of care giver. Many had cared for their now deceased husbands while others were currently caring for their husbands. CSO (2012b) figures identified that almost 13% of older women in Ireland are active informal carers. McGee (2008) highlights that older women can be both care providers as well as health care recipients and this was also the case in the present study. Co-researchers who were informal family carers worried about who would take over this role if their current health status further deteriorated and/or they became incapacitated.

In particular, those caring for adult children worried about who would look after their children if they were not able or if they died despite assurances by family that their children would be cared for. In an Irish study, Crawley and Lynch (2012: 319) found that older women "felt obliged by society to remain as carers, even if they lacked the capacity to do care work".

While co-researchers in the present study did not specifically express such sentiments, they were concerned and worried about what would happen indicating that they did feel responsible for care provision. According to the Irish Older Women's Network (2011) the caregiver roles of older women is generally not recognised and many are unable to benefit from the carer's allowance. Crawley and Lynch (2012) and McGee *et al* (2008) emphasise the need at both public and policy level to recognise and support older Irish women in this role.

This has implications for Government policy and strategy development as well as health care service providers on how best to support and enable older women to continue in this role. Similar to Crawley and Lynch (2012) it is recommended from this study that older women not only be acknowledged for their valuable role but received tangible support from health service providers by way of practical assistance from health care professionals, education, training and respite care as well as increased financial support from the state.

In conclusion, this section, has discussed the key concept of **adaptation** in relation to the data and the literature by addressing the issues of *'adapting to the concept of ageing and health', 'having a positive attitude', 'adapting to a changing body', 'adaptation and lived space', 'adaptation to loss and changed role'.* From a phenomenological perspective, life world existentials are evident in the adaptation processes undertaken by older women, vis-à-vis their experiences of home, changing body, using their time and relationships with others.

Consistent with existing research findings (Roberto *et al*, 2005; Giddings *et al*, 2007; Mars *et al,* 2008; Foster and Neville, 2010; Lorenz, 2010; Lowe and McBride-Henry, 2012; Hurd Clarke and Bennett, 2013; Song and Kong, 2015) being pragmatic is important in helping older women adapt to growing older. The data illustrates that having a positive, realistic attitude,

facilitates acceptance and supports older women to respond proactively to ageing and health related changes, as well as taking opportunities for personal growth. This study gives a unique insight into how strongly this group felt and acted to remain as healthy as possible as evidenced by their proactive approach to this. Although it is recognised that the adaptation process is a continuum of incremental adjustment, this study illustrates how there can be temporary 'spikes' in the degree of adaptation required. For example, in response to episodes of temporary acute illness or exacerbations of chronic conditions, the co-researchers needed to adjust upwards their adaptation processes but once this acute incident has been resolved they returned to previous levels of adaptation.

The findings have confirmed older women's internalisation of negative views (Saucier, 2004; Westerhof and Tulle, 2007; Hurd Clarke *et al*, 2008, 2009; Maguire, 2008; McCormick, 2008; Day and Hitchings, 2011; Marshall *et al*, 2012; Hurd Clarke and Bennett, 2013; Chrisler *et al*, 2015; Holstein, 2015) about the ageing female body, highlighting the negative connotations associated with the visibly ageing body and its negative impact on older women's sense of self. It draws attention to the apparent contradiction of how older women are not seen as attractive, with the strong belief by the co-researchers that one should make the effort to look presentable and attend to their appearance. Furthermore, the data highlights how these older women in a general sense do not feel valued within Irish society.

This section, in tandem with the previous section on 'autonomy', emphasise how older women's desire to live at home is very strong. The efforts older women make to continue to do this is illustrated in how they both adapt to and adapt their homes. However these changes bring into sharp focus, the loss of abilities associated with ageing and health

management. In line with previous findings (Levasseur *et al*, 2009; Quéniart and Charpentier, 2012; Hurd Clarke and Bennett, 2013) the data indicates that loss of role; function and bereavement have a profound effect on older women. Less well recognised but identified in the data are the continuing long term effects of bereavement.

It is argued that integral to the concept of adaptation are identifying available supports which can enable older women to adapt to their individual ageing and health related changes. This section outlines the supports available to older Irish women that may assist this adaptation, so that they can remain independent, continue living in their own homes and manage their ageing and health related problems. Benefits and allowances as well as commitments by Government and the HSE to provide a range of home supports, develop community settings and age friendly cities and counties assist in this adaptation (these are discussed in detail in 2.4.2, 2.4.3 and 6.2.2.).

While these are welcomed, there are continued concerns about the level of provision of some of these services. With specific regard to women's health care needs, a commitment has been made to introduce gender specific health initiatives although there is little which specifically focuses on older women's needs (HSE and the National Women's Council of Ireland, 2012).

It is argued that more needs to be done to truly support older women to adapt and adjust to age and health related change. In this section a number of suggestions have been made. They include: 1) the need to support older women who are informal carers; 2) the provision of health information and development of health promotion programmes specifically tailored for older women which can facilitate adjustment to this new phase in their lives and enable them to manage their ageing and health needs; 3) continued and increased support to empower older women to live in their own homes and in their own community.

6.4 Continued Engagement

This section discusses the importance of continued engagement as co-researchers age and manage their health needs. The desire to remain engaged reflected the co-researchers' belief in the importance of continued engagement in life as one ages. They did this primarily through personal relationships (e.g. with family, friends, neighbours, wider community and God) and involvement in a variety of activities. Continued engagement was identified as being integral to their health and well-being as they aged. However, challenges for continued engagement exist, these and suggestions on how best to support older women to remain engaged are discussed. Specifically this section discusses the findings under the headings of 'Older Women's Relationships' and 'Older Women and Participation'.

6.4.1 Older Women's Relationships

As previously discussed (6.3.2) many co-researchers described how belief and faith in God helped them accept and adapt to their changing abilities and health needs as they aged. However, it is important to emphasise that their relationship with God encompassed more than this, rather it was an innate part of them and permeated many aspects of their daily lives. Therefore, this aspect of the discussion focuses on how these co-researchers' relationship with God impacted on their general sense of self as they aged. Teachings, rituals and practices associated with their religious beliefs provided many co-researchers with an order and code for living which they found reassuring.

They described feeling energised by attending religious services. Many derived satisfaction and peace of mind from their beliefs and from following religious observances. This finding is supported by other research, for example, there are similarities with those of Hedberg *et al* (2015) in that having a relationship with God gave purpose and meaning to older women's lives. Similarly Manning (2012:573) describes how for older women in her study "spirituality ... serves as a unique resource not only to make sense of their identity but to promote and enhance their wellbeing".

Unsurprisingly many co-researchers described the importance of maintaining personal relationships with family. They derived enjoyment and support from being involved in their families' lives. Furthermore, they had peace of mind in knowing that they had someone to call upon if needed. Humphrey (2008) identified the association between frequent contact with family and friends and a better health profile in older people, while according to Age Friendly Ireland (2015:14) "being part of a network of family, friends and community has a strong [positive] impact on health and wellbeing".

Family support also enabled a number of the co-researchers to live in their own homes and this has been discussed previously within the context of retaining autonomy through partnered decision making. Stephens *et al* (2015) emphasised the value that older people placed on engaging with family. Lowe and McBride Henry (2012: 22) have outlined how family support is essential in helping older people cope, stating "connectedness to significant others is crucial to our wellbeing". Research indicates that intergenerational family relationships are generally positive in Ireland with little evidence of intergenerational conflict (Walsh and Harvey, 2011; Scharf *et al*, 2013).

Crawley and Lynch's (2012) Irish research supports the current study's finding that older women felt valued by their family. The present study also provides evidence of reciprocity within older women-family relationships in that, older women and their families supported one another albeit in different ways. Many of the co-researchers provided their families with emotional and practical support. This finding is in line with McLaughlin *et al's* (2011) research where participants also provided care to family members and who in turn were emotionally and/or financially supported by them. This concept of reciprocity is likened to social exchange theory discussed in 2.2.2 whereby there are mutual benefits for both the older woman and her family.

However, there are some challenges for the maintenance of these positive older women-family relationships. As previously discussed in 6.2.1, a number of co-researchers were reluctant to ask for support in case it was construed that they were no longer capable. Furthermore, while happy to do so, some co-researchers cared for their husbands and/or adult children with special needs. Therefore, within the context of all parties ageing and having different needs, the dynamics of these relationships were changing.

Research by Flynn and Mulcahy (2013) and Rowbotham *et al* (2011) identify that carers in similar situations, experience a range of emotional problems including anxiety, loneliness, sadness, satisfactions, obligation and somatic complaints. The co-researchers in the current study particularly worried about and felt responsible for their husband/children while still enjoying their relationship with them. In addition and reflective of the heterogeneity of this research cohort, the families of a small minority of co-researchers lived some distance away or lived overseas. Thus, the nature of their relationships with family was different in so far as they kept in contact through letter writing, telephone and visiting for days or weeks depending on how far away family lived.

While family relationships were important, most co-researchers also described their positive relationships with friends, many of which were long standing. These differed from family relationships as these friendships were built on shared interests, beliefs and life experiences. There was a sense of belonging and being at ease within these friendships based on camaraderie, familiarity, mutual respect and support. The emotional ties developed over the years were valued by the co-researchers. Other researchers have demonstrated that social support provided by friends can have a positive effective on an individual's wellbeing and physical health (Harvey and Alexander, 2012; Blieszner, 2014).

Friends provide emotional and practical support through being a confidante, encouraging health checks and adherence to health care professional advice as well as participation in "meaningful activities" (Moreman, 2008; Blieszner, 2014: 27). Although findings from the current study did not identify the physical health benefits as such it is acknowledged that a number of the co-researchers exercised with their friends and without this companionship they may not have done so. The emotional benefit of having supportive friends is an important consideration in identifying ways in which older women can be supported to maintain these friendships. For example, many co-researchers used the telephone to remain in contact but the telephone allowance was withdrawn in January 2014 and its reintroduction would be of benefit.

Relationships with neighbours and local community were identified as being important by many of the co-researchers. They described a sense of security in knowing someone is nearby and having someone to call upon if they needed assistance. Research has indicated that having meaningful contact with neighbours as well as family and friends increased older people's sense of security and happiness (Ebrahimi *et al* 2013). Gallagher (2012) highlighted the importance of 'social connectedness' for older people in generating feelings of belonging and solidarity.

Social connectedness was evident in how co-researchers described being involved in their communities to a greater or lesser degree and is similar to findings by Gallagher (2012). Ashida and Heaney (2008: 888) also identified a positive association between health status and social connectedness in older people and suggest that community centres should place greater emphasis on facilitating the development of "companionship and friendship among ...participants". Most co-researchers in the current study had lived in the same area for many years. Familiarity with, and attachment to local communities was evident in how they described the services, environment, people and social networks in their neighbourhood. Wiles *et al* (2011:36) argue that ageing in one's own community is linked to a "sense of security and familiarity" describing "home as a refuge, community as a resource".

According to Walsh (2015: 79) "place matters" arguing that "the social and cultural aspects of place are critical to many older people". Therefore, the sense of belonging derived in part from being a long term resident in an area cannot be under-estimated. The importance of supporting older people to live in their own communities is a core aspect of Government policy (DOH, 2013a) and is welcomed.

However, some of the co-researchers were relatively recent arrivals in their communities. Becoming familiar and connected was challenging for these co-researchers and required some effort on their part. This included making them-selves known to local health care professionals, joining social clubs and organisations, getting to know the local community through attending church services and local events as well as being friendly with neighbours and retailers.

Pettigrew (2014) while acknowledging the importance of social connections highlights the difficulty in forming new connections as one ages. It is argued that this is even more difficult for those older women

who are new to an area and can result in social isolation (McLaughlin *et al*, 2011).Therefore, it is recommended support systems be developed for those older women who are new residents as well as continuing to support more long term residents. In the first instance, information should be provided by health and social care professionals and local communities on what community resources are available as well as being alert to the challenges of meeting and making friends as one is older and new to a community.

As many of the co-researchers had underlying medical problems they had also developed relationships overs the years with their health care professionals most notably their GPs. The nature of these relationships has been discussed in some detail in 6.2.3, but suffices to say that while many were positive and supportive, a small minority were not. In addition, a number of the co-researchers were assisted by home helps and positive relationships had developed between the co-researchers and their home helps over the years. Lindahl *et al* (2011) have described such relationships as professional friendships and advocates caution to avoid crossing professional boundaries within the informal care environment of the older person's home. However, none of the co-researchers voiced any such concerns. On the contrary, they enjoyed the social aspect of these relationships as well as appreciating the practical assistance provided.

The reduction in home care services in particular home help hours in recent years was of concern to those involved. All the co-researchers had underlying medical problems which required varying levels of management. Those who needed home help were in some way incapacitated, frail or dependent and it is acknowledged that having a chronic condition can contribute to increased isolation (Cameron, 2010).

Hicks and Conner (2014) suggest that health care professionals have roles in 1) supporting older people develop social as well as physical resources as well as 2) advocating for health policies which reflect the importance of social support. Therefore, two challenges exist in providing appropriate support for this subgroup of older women. In view of the current straitened economic climate in Ireland, the Government needs to evaluate its decision to reduce home help hours and in tandem with service providers, plan how social support provision can be maximised.

6.4.2 Older Women and Participation

Many of the co-researchers in the current study attended and participated in a variety of clubs and organisations primarily to meet people and have fun, to get out of the house and 'not get into a rut' of staying home and for some it was to combat loneliness. Similar to Dahlberg *et al's* (2015) research, widowhood for some co-researchers was linked to loneliness. Research has highlighted the negative health effects of social isolation for older women. It has been linked with loneliness, depression, decreased quality of life and poorer self-reported health (Murphy, 2006; Routasalo, 2009; Timonen *et al,* 2011; Rantakokko, 2014; Stephens *et al* 2015).

Conversely, the health benefits for older women of having a social network and being socially engaged have been reported in the literature (Cherry *et al*, 2013; Byles *et al*, 2015; Hedberg *et al,* 2015). In particular, participation in social groups has been associated with improved physical and mental health (Ní Leime and O'Shea, 2010), wellbeing (Walsh and O'Shea, 2008, Koustsogergon *et al*, 2014) and reduced social isolation (Radina, 2008).

Engagement was not confined to social clubs and organisations and reflective of the co-researchers' different interests included a range of different activities. Many of these activities incorporated learning new information to a greater or lesser degree. The concept of life-long learning

has been promoted as important in helping older people cope with age related change as well as facilitating their continued participation in society (AONTAS, 2007). Older age provided many co-researchers with the freedom and time to pursue personal interests and spend time with family and friends. This finding is supported by Quéniart and Charpentier (2012) who highlight that older women when no longer confined to schedules can chose to use this time to pursue interests and provide love and attention to family especially grandchildren.

Many co-researchers wanted to contribute in a meaningful way to their community. Examples include membership in local community and church committees, working as a volunteer with a charity and for at least one co-researcher being employed part time. According to Boneham and Smith (2006) being 'other' centred and involved in social activities can increase one's confidence. Gallagher (2012) highlights that volunteerism demonstrates altruism but also acknowledges that volunteers derive a sense of satisfaction from their work. Rossen *et al* (2008) has identified that engagement in meaningful activities is as a key aspect of successful ageing and highlights the importance of identifying and supporting individual choices and preferences rather than having generic programmes aimed at all older people. Meaningful activities typically are of interest to the individual and have "a practical and functional dimension" (AONTAS, 2007: 4; Hedberg *et al*, 2015).

It is recommended from this current study that initiatives and services aimed at facilitating participation must take cognisance of the range and diversity of older women's interests accepting that 'one size does not fit all'. Thus participation in generic activities and programmes aimed at older women can be meaningless unless they are of interest and meet the needs of the participants. For example, in this present study a minority of co-researchers were not interested in joining groups specifically aimed at older people and others were not interested in joining any formal organisations.

However, they were not isolated as they continued to participate in community life through family, friends and church services and doing errands. Gallagher (2012: 97) reports similar findings and argues that it is incumbent upon policy makers to offer "interventions without intrusiveness" and to make available services and amenities that meet the needs of older people.

There were barriers to participation and similar to Koustsogeorgon *et al* (2014) these included low income and ill health. In addition, ageing related difficulties had the potential to negatively impact on this cohort of women's ability to participate fully. Some co-researchers were reliant on family support to physically assist and enable them to attend events. The availability and accessibility of transport especially for those in rural areas is important although it must also be acknowledged that distance to bus routes is a factor in urban areas. Some co-researchers were dependent on free public transport as well as transport provided by day care centres and would have been severely inconvenienced or unable to attend if this was unavailable.

The value of the free transport benefit to older people cannot be underestimated both from the practical aspect but also from just knowing that it is available if one wants or chooses to use it. Participation can be facilitated by having physically accessible environments and transport (Older and Bolder, 2009) as well as having appropriate support personnel and equipment. However, this presents a fiscal challenge for the Government in view of continued economic difficulties as well as the assertion that the National Positive Ageing Strategy and the Age Friendly Cities and Counties initiatives be resource and cost neutral (Age Action Ireland, 2010; Walsh, 2015).

Personal lack of money directly affected some of the co-researchers in so far as they were financially curtailed in availing of full participation in clubs or social activities for example, they could not always afford to go on organised day trips or attend social events to which they were invited. This highlights the effects of having to live and manage on limited means.

While the non–contributory pension has not been reduced, it has only been increased for the first time in many years by three euros in Budget 2015 (Budget, 2015). This, together with increased living costs and reductions in some benefits had adverse effects on some of the co-researchers. Ní Léime *et al* (2015) highlights that older women have low levels of private pensions and two thirds are in receipt of the non-contributory pension. Reasons for this low level of pension cover have been discussed in 2.4.3., but briefly include: not having pensionable jobs; low paid part time employment; unpaid employment in spouses' business; raising family and caring for dependent relatives (all of which was unpaid). Of particular concern to older women is the recommendation that pension provision be linked with earning and length of working life (Ní Léime *et al*, 2015) which would clearly have adverse implications for this particular cohort.

In summary, this section has discussed the key concept of **continued engagement** in relation to the data and the literature by addressing the issues of *'older women's relationships'* and *'older women and participation'.* It discussed how relationships with God, family, friends, neighbours and community facilitate older women's continued engagement and connection with life as they age. In tandem with maintaining such relationships, older women also remained engaged through participating in a range of activities.

Similar to the other research (Manning, 2012; Hedberg *et al*, 2015) the data confirmed the importance for many older women of their relationship with God. Importantly, it broadens our understanding of the nature of this relationship. For many, it was more than a belief and religious observance, rather it was an innate part of who they were and it was knitted into the fabric of all aspects of their lives and relationships.

The data supports the findings of others (McLaughlin *et al,* 2011; Crawley and Lynch, 2012; Lowe and McBride-Henry, 2012; Stephens et al, 2015) regarding the importance of family relationships for older women and highlights the positive reciprocal nature of these relationships. Moreover, the data provides new insights into the extent of older women's contribution to family and society in Ireland which is extensive. This has resulted in older women, either by choice or circumstance, continuing with existing roles or taking up new roles when older e.g. caring for adult children with special needs, child-minding grandchildren and becoming carers for their spouses.

The data has also confirmed the importance of being socially engaged (Walsh and O'Shea, 2008; Ní Leime and O'Shea, 2010; Cherry *et al*, 2013; Ebrahimi et al, 2013; Koustsogergon *et al*, 2014; Byles *et al*, 2015; Hedberg *et al,* 2015) and emphasises the value of having friends. Ireland has changed enormously over the last two decades in relation to social mores, separation of church and state, and economically. Having friends has helped these co-researchers make sense of these changes. Furthermore and supported by the literature (Ashida and Heaney, 2008; Gallagher, 2012; Wiles *et al*, 2012) is the importance of being part of a community and having a sense of belonging.

The findings illustrate the diversity of social engagement and how not all older women are interested in joining clubs or organisations but are not necessarily socially isolated. Within the data, social engagement with home-helps and health care professionals was also identified (for some women) as important. While the literature (Lindahl *et al*, 2011) emphasises the professional nature of home help-older person relationship, the findings indicated that some of the forged relationships were more than this. Letvak (1997) has likened older women's sense of connectedness to various family, friends, neighbours and general community as a phenomenological community defined primarily by these relational connections. This concept also speaks to how the co-researchers in this current study have continued to engage with similar groups.

The challenge for Government, and thus service providers is to continue to support older women to become and/or remain engaged. While the various policies and strategies developed over the years such as the National Positive Ageing Strategy (DOH, 2013a) and the Age Friendly Cities and Counties (Age Friendly Ireland, 2015) programmes are welcome, support is required to implement them. In particular the specific needs of older women must be recognised and supports tailored accordingly.

6.5 Chapter Conclusion

This chapter has discussed the findings of this study in relation to the literature. It has demonstrated how these findings confirm and broaden current knowledge of older women's experiences. Three key concepts were identified as being central to the meaning of the older women's experience of 'retaining autonomy within a process of adaptation and continued engagement'. These concepts of autonomy, adaptation and continued engagement are inextricably linked within the experiences of this group of older women. The framework for this discussion chapter is centred on these three themes.

The discussion is underpinned by the phenomenological concepts identified from the findings and provided the lens through which the key concepts of autonomy, adaptation and continued engagement were discussed. The discussion has highlighted the similarities between these findings and other studies on ageing and health and has also indicated how the data from this research has extended our understanding of older women's experiences. This has been done throughout the chapter but to aid clarity, these have been summarised in the conclusion of each of these three sections.

Ultimately, this chapter has discussed the meaning of older Irish women's experiences of in relation to the literature. Being autonomous and retaining that autonomy was of central importance to the women's sense of self and worth. Having control and choice were highly valued and underpinned their sense of being independent. Being able to adapt to and manage changing ageing and health related needs was influenced by the women's perceptions, assessment and management of these needs and their ability to manage these challenges. In addition, being engaged in life through relationships and involvement in social activities and pursuing individual interests was very important to this group's wellbeing.

It is acknowledged that there are various supports and services available to older women that help them remain in control, be adaptable and engage with life albeit at different levels. However, this chapter also identifies how support could be enhanced. For example, the development and promotion of non-ageist attitudes especially towards older women within society as a whole but more specifically by all service providers would be of benefit. This may be facilitated through education and inculcation of more positive attitudes. Furthermore taking a gendered ageing approach to care would focus on particular needs of this cohort.

While acknowledging the merits of the 'Healthy Ireland' (DOH, 2013b) life course approach, this needs to be augmented to support the current population of older women. This approach needs to include health education and health promotion (inclusive of advocacy, mediation, enablement and empowerment) aimed at this cohort but also education of health care providers is required to address the particular needs of older women while providing individualised care.

In order to truly support the concept of supporting older women to continue to live in their own communities, this should be recognised as a statutory entitlement with adequate resources made available to ensure this. Fiscal considerations cannot be ignored and allowances, pensions and benefits need to be commensurate with being able to have a decent standard of living. Many older women provide informal care to relatives and require practical and financial support and these need to be recognised. Finally the importance of being engaged and connected with society for mental wellbeing must be recognised in a practical and supportive way by the Government at national level and service providers and communities at local level. These suggestions are discussed in more detail in the recommendations section of the next chapter.

Chapter 7

Conclusion and Recommendations

7.1 Introduction

This chapter concludes the study and makes recommendations based on the findings. Suggestions for further research are also offered. The chapter begins by outlining what this research adds to existing knowledge. This phenomenological research provides a unique, rich and in-depth view of older Irish women's experiences of ageing and health, ill health and health needs. To date, this perspective has not been articulated. Heretofore, our understanding of older women's experiences has in the main been extrapolated from international research on women's ageing and health or from national studies on ageing or health that are not specific to older women. It is acknowledged that Irish datasets are available on older people such as TILDA but there is little qualitative research on the gendered experiences of ageing (Ní Léime *et al*, 2013). While useful, this information cannot reflect the unique experiences of older Irish women.

The findings from this study demonstrate that older women's experiences are more than the sum of different aspects of their experience rather the findings provide a holistic view of the meaning of the women's experiences. As previously discussed the older women's experiences from a phenomenological perspective were situated in spatiality (lived space), temporality (lived time), corporeality (lived body) and relationality (lived human relation) and contextualised within the socio-political-cultural and economic context of Ireland. These socio-cultural, political and economic factors determine the thinking underpinning national policies and strategies for health and ageing.

These in turn influence infrastructure; availability and types of services and the education and training of service providers in relation to health and ageing. Therefore, the co-researchers' experiences in this study were impacted upon by all of these aspects and the findings reflect the reality of their experiences. Ageing and health are interlinked and neither can be looked at in isolation as both impacts on each other within the overall experience. The findings and subsequent recommendations inform policy, health and social care education, services and supports, and the overall design of a responsive health service for this particular cohort.

7.2 Impact of the Methodological Approach on the Findings

The use of an interpretive phenomenological approach was helpful to developing an understanding of older women's experiences. This approach was an appropriate choice as its focus is compatible with this study's aim, i.e. to explore the reality of older women's experiences of ageing and health related issues and to understand what these experiences mean to them within the context of specific times and places that are peculiar to these women. Therefore the existential themes of lived space, lived time, lived body and lived human relation in addition to the concepts of dasein and mitsein discussed in the thesis were important in this study.

In particular, the use of the Vancouver School of doing phenomenology enhanced this study. It is a holistic and humanistic methodology and emphasises the centrality of the co-researchers to the process. Collaboration is integral to the process whereby the co-researchers are recognised as experts in their own right and their 'voice' is valued and respected. Its methodology is a systematic way of explicating human experiences. The processes of description, interpretation, explication and

construction, facilitated understanding of the meaning of the experience.

Inevitably, there are some limitations in using any methodology to frame research. It could be argued that those who volunteered may have had a particular reason to want to participate, while those who chose not to participate could well have had different experiences. However, this is a conundrum for any research. Furthermore, the sample was localised to a particular geographical region in Ireland, but it is argued that the sample was not homogenous and included women from different walks of life and from urban, rural and semi-rural communities. This in itself is reflective of the older women population in Ireland.

Overall, the use of this methodology succeeded in developing an understanding of ageing and health from the point of view of the co-researchers. It provided understanding as to the meaning of these women's experiences within the socio-politico-cultural and economic context of Ireland.

7.3 Contribution to Existing Knowledge

In view of women's increased longevity, there have been calls for increased research on older women's experiences of ageing (Merighi *et al*, 2013; Ní Léime *et al*, 2013) and this research through its gendered perspective speaks to this call. It offers a unique perspective and provides important information and data about older Irish women's experiences of ageing and health related issues. First and foremost it provides qualitative research from the perspective of older Irish women, an area not previously reported on. The essential meaning of the women's experiences of ageing and health related issues is captured in the phrase 'retaining autonomy within a

process of adaptation and continued engagement'. The findings demonstrate the complexity of these women's experiences and it is evident that there are both positive and negative aspects to these. This research confirms that there are similarities in older Irish women's experiences and those of older women in other countries, particularly in relation to concepts of independence and autonomy; adaptation and social connectedness.

However, it also increases our understanding of older Irish women's experiences, an area not previously captured in the published research. It illustrates how there are different nuances and emphases within the current study's findings to that of other research in the area. Furthermore, it provides insight into older Irish women lives through a phenomenological lens, providing a unique perspective of the meaning of their 'being-in the-world' and 'being-with-others' and capturing the intersection of their life world existentials.

7.3.1 Concerns about Control

The desire to be self-reliant and independent was very much embedded within the co-researchers' psyche and this impacted on their decisions on whether to ask for help or support. At times they were reluctant to do so in case they were seen as not being able to cope and so no longer independent. Of concern and not previously identified in Irish research was an undercurrent of anxiety and for some fear that their 'voice' would be disregarded and their personal control and autonomy could be and was at times subverted.

7.3.2 The Importance of Home

Older women identified how important continuing to live at home was to retaining autonomy and control over their own lives. While previously identified in research, the strength of the opposition to the idea of not being able to continue to live at home was striking. Moving to a nursing home was anathema and something to be strongly avoided if at all possible. There were some very strong negative views about what nursing homes represented e.g. as being places without freedom and likened to a jail. The older women went to great lengths to continue living in their own homes including: renovations and modification; negotiations with family to have support at certain times e.g. at night; availed of state provided home help services or paid privately for these if ineligible for state support.

7.3.3 Being Pragmatic

Growing old was not something to look forward to but co-researchers believed it was important for their peace of mind to accept this stage in their life and adapt to it. Key to being content was acceptance, adaptation and having a positive approach to life. This highlights the pragmatism with which older women approached and managed ageing and health related changes i.e. adapt as needs be but seize opportunities for enjoyment.

7.3.4 A Sense of Not Being Valued

This current study confirms older women did not always feel valued within Irish society. Even though research has previously identified the adverse effects of ageism for older women, it is important to highlight that negative views can adversely impact on older women's sense of value within society as well as their personal worth and actual physical and mental health. The findings suggest (through women's experiences) that negative societal views negatively impact on national health and social service policies and strategies, service provision and financial support.

7.3.5 Remaining Engaged in Different Ways

While this research confirms the importance of being socially engaged and connected for women, it also emphasises the importance of recognising individual preferences. Typically older women wanted to remain engaged but they wanted to do so in a myriad of different ways reflecting their personal interests and views. Therefore, it important to recognise the heterogeneity of older women as a group and accept that one type of organisation or activity does not suit all.

Furthermore, this current study highlights the importance of personal friendships to older women's sense of belonging. This is of particular interest as these older Irish women were navigating a rapidly changing world with enormous changes in societal values in tandem with secularisation in Ireland. Older women were challenged to make sense of this world within the context of their own beliefs and value systems. Having friends enabled them to share experiences of ageing in this new world.

7.3.6 Extent of Older Women's Contribution to Family and Society

The concept of reciprocity and older women's contribution to society has been previously identified in international research. However, the extent of this in Irish society is unrecognised and is in fact quite extensive. For example, older women's contribution is reflected in their roles as volunteers, part time employees, members of community organisations and Church committees. Older women were not infrequently identified as being a source of support and knowledge for family especially. They were family carers for spouses and adult children with special needs. In view of the increased life expectancy of all these cohorts, there are implications for older women's ability to provide care as they age. Furthermore many older women provided childcare (for grandchildren) beyond that of being an occasional babysitter and were a valuable support to their own children.

7.3.7 Missed Opportunities for Health Assessment and Promotion

This research highlights missed opportunities for health assessment and health promotion by an integrated health care team. Co-researchers were proactive in managing their health as they aged and it is argued that health service providers could have done more to capitalise on this. Typically there was a reactive response rather than a proactive approach to older women's health care needs. They were only referred to services or seen by members of the health care team when a problem was identified as opposed to having an initial health assessment. This assessment could offer advice and education to older women enabling them to maximise functional ability and pre-empt the development of problems. These opportunities to empower older women to self-manage their health were not always availed of.

7.3.8 Mixed Relationships with Health Care Providers

In many cases older women had positive relationships with their GP who for many was their primary health care provider. The significance of the GP being familiar with the older women's medical and health history is important to highlight in so far as it takes time to build trust and confidence from the perspective of the older woman in managing her health care needs.

Furthermore the positive relationships that a number of co-researchers had with their home helps needs to be highlighted, this is an area in particular in which there is little written from an Irish perspective. However, the findings confirm that negative attitudes are held by some health care professionals as a number of older women felt they were not given adequate information, nor given the time to explore their health problems or indeed had their requests for referrals denied. There was also confirmation of the internalisation of ageist views by both older women

and some health care professionals in that both expected that older women would have ill health as they aged purely because of the ageing process. It is acknowledged that older women are likely to develop chronic health problems as they age. However, many health problems are not a consequence of the ageing process, rather there is an underlying health problem.

7.4 Contribution to Understanding Theories of Ageing and Health for Older Women

This section discusses the contribution of the findings to understanding theories of ageing and concepts of health from the perspective of older women. As previously discussed theories of ageing (2.2.2) emanate from three perspectives: biological, sociological and psychological. Health (as discussed in 2.3.1) has been described as a contested concept, having different meanings to different people (Green *et al,* 2015). The way health has been understood has been influenced by societal values and beliefs and the different perspectives embedded in biomedical and social models of health (Blaxter, 2010). It has also been argued that the gendered nature of ageing and health must be considered (Ginn and Arber, 1995; Ainsworth, 2002; Calasanti, 2008; Holstein, 2015). There are parallels between the study's findings and aspects of different theories and health concepts.

The findings in tune with the literature indicate that health is a broad concept and encompasses various determinants and dimensions (WHO, 1986; Blaxter, 2010; Scriven, 2010). They highlight the subjectivity and individuality in how health is defined. Clearly many older women had objectively measurable health problems but their view of their health varied according to their individual circumstances and beliefs about what being healthy meant to them.

For many, being healthy was on a continuum and their expectations changed as they aged and developed concomitant health problems. In this way there are similarities with Antonovsky's (1987; 1996) model of salutogenesis and the concept of 'response shift' (Rapkin and Schwartz, 2004; Barclay-Goddard *et al*, 2009) in so far as older women assessed their individual situations and identified coping strategies which helped them to adapt to their different health needs as they aged.

Ageing was negatively viewed by the co-researchers. They were also concerned about not being valued by society. These findings resonate with aspects of the 'inequality theory' with its focus on ageism (Victor, 2006). However, contrary to this theory there was little evidence of intergenerational conflict in the findings. Rather many older women spoke about the positive relationships that they have with their children and grandchildren.

The 'social exchange theory of ageing' has greater resonance with the findings of this study in that it emphasises balance within society and highlights the concept of reciprocity between generations (Hooyman and Kiyak, 2008; Touhy, 2014). In tune with this theory, the findings support the importance of reciprocity and shows there was reciprocity between the older women and society. Older women were recipients of support from family, community and society but they also provided valuable emotional and practical support to their families and communities.

Critical and humanistic theories of ageing (Phillips *et al*, 2010) focus on the positive aspects of ageing. While the findings highlight that older women felt it was important to have a positive approach to ageing, they also illustrate that ageing was not something that the co-researchers looked forward to. Therefore, while it is important to focus on the positive, ageing is more nuanced and is associated with some losses. This idea of

accentuating and supporting the positive aspects of ageing while managing the more negative aspects of ageing is reflected well in Baltes and Baltes' model of adaptation (1990).

The findings of this current study support the importance to older women of adapting to growing older and changing health status. As previously mentioned there are some similarities in how they adapted with the salutogenesis model and the 'response shift' concept but with also with Baltes and Baltes (1990) psychological model of 'selective optimization with compensation'. This model offers an explanation of how older people adapt to the ageing process and emphasises that ageing comprises both losses and gains. The co-researchers in the current study maximised ways to stay healthy and age well by appraising their situation, their abilities, support and adjusted their actions accordingly. However, Baltes and Baltes' (1990) model does not consider that some older women may not have the choice to reduce or give up certain roles, for example, those who are informal carers or who want to continue to support their families in practical ways.

The findings resonate with life course theory and approach (Arber and Evandrou, 1993; Phillips *et al*, 2010) in that the co-researchers' experiences were influenced by personal beliefs, family relationships and societal influences and the role they had as women both within family and society.

The findings contrast with psychological theories (Peck, 1968; Jung, 1971; Levinson *et al,* 1978; Tornstam, 1997) which suggest that older people focus on spiritual and personal growth, life review and are less interested in the physical aspects of ageing. The findings indicated that this was not the case for most of the co-researchers. In the face of co-morbidities and decreasing functional abilities, managing their health was an important part of their lives. They emphasised acceptance and having a positive approach to life but few spoke about introspection or life review.

Older women in this study emphasised the importance of physical health as it enabled the more positive aspects of ageing e.g. staying engaged. Helping older people to optimise their physical health and functional abilities is an important finding for health professionals. Earlier theories have rightly been criticised for too great an emphasis on physical ageing or physical health (WHO, 2002; Hooyman and Kiyak, 2008 and Touhy, 2014). However, this study shows physical health is valued by older women and they worked to maintain and improve their physical health. It is suggested that more contemporary theories of ageing may underplay the importance of physical health.

As previously identified there are no specific theories on gender and ageing but this study does contribute to the discussion on how ageing, health and gender intersect. It confirms that there are socio-cultural and economic influences and aspects to female ageing such as 'sense of worth', appearance and changing role (for some retirement but many either take on or continue to be informal carers and child minders). As previously outlined maintaining physical health was an important part of their experience and it helped them to stay independent staying in control. This in tandem with being pragmatic and staying positive is important considerations in the older women's experience.

In summary, the findings confirm that health is multidimensional and complex. However, they do not directly correlate with any one theory of ageing rather the findings resonate with aspects of a number of theories. This highlights the multifaceted nature of ageing and health for the older woman and emphasises the challenge for theorists to develop a theory of ageing for older women which can encompass the complexities of ageing and health for them.

7.5 Contribution to Applying the Vancouver School of doing Phenomenology

There have been many studies using this research approach (**Appendix 2**). However, apart from some guidance by Halldórsdottir (2000), there is relatively little written on 'how to do' or apply this design. Therefore, I spent a considerable amount of time thinking and planning the practical aspects to applying the Vancouver school of doing phenomenology. This section highlights key factors which contribute to understanding its application specifically: sample heterogeneity; dialogue and the collaborative nature of the research including process consent; developing individual case constructions and meta-synthesis of these; ensuring rigour and trustworthiness of the study; and the use of silence in data collection preparation and in data analysis .

Halldórsdottir (2000:58) highlights the importance of including individuals "who have typical and atypical experience" of the phenomenon. Sample heterogeneity is important so effort and time is required in deciding and planning who to interview and how to recruit the co-researchers. This time should not be underestimated. For example, in this study co-researchers were recruited throughout the geographical area from urban, rural and semi-rural communities through a range of different organisations and services.

I did not want to confine the sample to just one or two sources such as health centres only as this may have resulted in a relatively homogenous sample. Therefore, I made a deliberate attempt to have as wide ranging number of sources as possible in order to ensure a heterogeneous sample. This involved developing comprehensive data-bases of gatekeepers and local organisations such as health centres, day care centres, retirement groups, senior citizen clubs and Church congregations which took a considerable amount of time to compile.

Within the Vancouver school of doing phenomenology, dialogue (interview) with co-researchers is emphasised as key to developing an understanding of the experience. Therefore, it is important that the researcher's interview skills incorporating a conversational style are developed. Co-researchers are equal partners within the research process. Having a rapport with the co-researchers facilitates the development of trust and respect. Although not specifically recommended in the literature on the Vancouver school of doing phenomenology, a pilot study was invaluable in my preparation for this aspect of the study in particular. Evaluation of this helped me clarify my questions. It provided me with insight on my interview technique and informed my approach to the subsequent interviews.

As co-researchers are offered the opportunity to participate in second interviews, process consent is crucial within the Vancouver school of doing phenomenology. It is important to reiterate at every encounter the voluntary nature of participation and freedom to withdraw without prejudice. The development of a rapport with the co-researchers is an important aspect in process consent. Helping the co-researchers feel at ease and comfortable enables them to continue to participate or to withdraw if they want to.

The Vancouver school of doing phenomenology provides a clear framework on the practical aspects of doing research. While this is useful to guide the research process, researchers need to recognise it is more complex and organic than just a linear progression through the twelve steps. For example, step six refers to the development of individual case constructions, however, within step seven further interviews (dialogues) are recommended to provide opportunities to seek further clarification and verification of findings.

Therefore, individual case constructions need to be revisited and adjusted to reflect the data from the second interviews. The use of second interviews and final verification in steps seven and eleven aids in the iterative process reflects the development of understanding as a reciprocal process within the hermeneutic circle.

While not in the literature but in order to aid my interpretation of the co-researchers' individual experiences, I found it useful to devise conceptual models of each individual case construction. Typically these models were circular and comprised the key themes of the experience. An overarching theme represented the essential meaning of each woman's experience (**Appendix 17**). This visual aid helped clarify my thinking and understanding of their experiences and may be a useful aid to others using the Vancouver school.

The Vancouver school of doing phenomenology does not offer a specific framework for ensuring trustworthiness within the research process. Therefore, drawing from the literature on studies using this methodology, five key areas were identified (3.7.5) as a guide to ensure rigour and trustworthiness. It is suggested this framework may be useful to other researchers.

The importance of being reflective cannot be underestimated in this methodology. Reflectivity enables the researcher to explore their views, attitudes and responses and is integral to the research process. Halldórsdottir (2000) emphasises the need to take time, to be silent and prepare for data collection and analysis. By having 'silence' as a step in the framework (Table 3.2) and as a stage in the cyclic process (Figure 3.3) it reminds the researcher to stop, think and prepare.

Finding ways to be quiet and calm and find 'silence' was critical to being open to 'hearing' the co-researchers' account of their experiences both during data collection and analysis. Simple things such scheduling plenty of time to drive to an interview or arranging my schedule so as to incorporate time to be 'silent' before actively beginning to analyse the data were invaluable.

7.6 Recommendations

Recommendations are provided on how services, health care professionals and policy makers can respond to the needs and views of older women as identified within this study. The recommendations focus on identifying what developments are needed and/or how current health and social care services and supports can be further developed.

7.6.1 Recommendations for Health and Social Care Delivery

Health and social care delivery needs to embrace older women's desire to retain autonomy and support them to do so. As older women frequently have chronic health conditions, they will have different needs at different times depending on their illness trajectory. The health and social care provided or offered needs to take cognisance of this. These recommendations are aimed at health care provision within the community[9]. However, it is recognised that older women may at times require secondary and/or tertiary health care. The care delivery across all these different sites needs to be integrated. The specific recommendations are:

- Involve older women in service planning and delivery by ensuring that older women are invited and facilitated to participate in policy

[9] As previously acknowledged the National Clinical for Older People programme and the Integrated Care programme (HSE) are to address services for older people in the community, general practice and primary care. However, it is not known what the proposed plan is or when it is to be launched.

and strategy development through widespread advertising of these fora in the media and at local level e.g. health centres, GP practices, community notice boards.

- Adopt a collaborative gender sensitive, person-centred, enabling and goal setting approach to health and social care provision whereby older women's views and choices are respected. Health and social care professionals need to familiarise themselves with and implement gender sensitive policy within their practice.
- Ensure older women are offered a comprehensive health assessment and health care management plan which informs, educates and offers them treatment, enabling them to pre-empt potential problems, maximise their intrinsic capacity and strengthen their functional ability. This should be done at primary care level.
- Continue the development of an integrated service within community and primary care teams which liaise with secondary and tertiary services as required. This requires close collaboration and open channels of communication between health professionals within these different sectors.
- Place emphasis on health education and health promotion for older women. These programmes need to focus on supporting ways to maximise functional ability and strengthen intrinsic capacity as recommended by WHO (2015). These programme need to include 1)strengthening physical health e.g. exercise, healthy diet 2)smoking cessation and responsible alcohol consumption 3)developing ways to look after mental and psychological health including bereavement counselling, preparing for retirement and coping with loneliness 4) learning to live with chronic illness and conditions. Programme delivery should occur where and when older women access health and social care delivery.

- Provide easily accessible information on existing health and social services. This should include information on entitlements, grants and services. Older women need to be made aware of the availability of this information. This information should be made available in GP practice, primary health care centres and health centres.
- Provide information on older person groups and organisations as well as broader community activities to all older women but specifically to older women who have recently moved to an area. This information should be made available in GP practices, primary health care centres, health centres, community and church noticeboards.
- Provide support to enable older women to continue to live in their own homes through assessment of needs; advice and advocating for increased support as necessary. Health and social care professionals can advise older women on where to access information on grants to modify homes, and advice and advocate on how to access increased home help hours. Depending on older women's preferences, provide support and facilitate partnered-decision making of older women and their families.
- Support older women who provide informal care to family. This should include service provider assistance and education, advocacy, provision of equipment and respite care.

7.6.2 Recommendations for Education

In view of an ageing female population, health care professionals must be educated to provide appropriate and timely health care to older women. Therefore, education curricula for health care professionals at both undergraduate and postgraduate level should be reviewed and revised to ensure that graduates have the knowledge, skills and attitudes to provide appropriate care to older women. Specific recommendations include:

- Involve older women in curriculum development and delivery for health care professionals by inviting older women to participate in planning and review of curricula.
- Explore new entrants and existing health care professionals' underlying attitudes and views about older women. This will provide insight and a platform from which to develop increased awareness and understanding of the detrimental effects of ageism upon older women's health and wellbeing.
- Devise a curriculum which promotes a gender sensitive, person centred, enabling, goal-setting ethos to health care provision.
- Through theoretical and clinical teaching and learning, develop gerontological competencies within the context of a gender sensitive approach to care. Gerontological competencies refer to core competencies of health assessment, management and evaluation of care of older women and men within the context of their individual bio-psycho-social and economic situations. Specific attention for older women's health needs to be given to bone health; falls; respiratory and cardiovascular health; diabetes; frailty; memory; depression; poly-pharmacy; continence problems; sensory impairment (e.g. hearing, vision); breast and cervical cancers, and multi-morbidities.
- Develop teaching, health education and health promotion skills tuned to the needs of older women. Inculcate the concept that these skills must be an integral part of health care planning and provision. Specific areas of health promotion have been identified previously (7.6.1)
- Develop knowledge, skills and attitudes to work both intra and inter professionally so that integrated care can be provided to older women across community, primary, secondary and tertiary services.

7.6.3. Recommendations for policy makers

The desire by older women to retain autonomy needs to be recognised and supported in the development and delivery of policies and strategies.

- Involvement of older women in policy and strategy development to ensure approaches to ageing policies and strategies are appropriately tailored to meet older women's needs. Older women need to be invited to participate in policy and strategy development forums.
- Acknowledge the role older women play in society. Recognise and reward the concept of reciprocity within the relationships of older women and their families and their communities. Many older women play a valuable role in supporting family, providing emotional support and child care. In particular older women who are informal carers to family members should be supported emotionally, financially and practically. A commitment to this should be reflected in government policy and its implementation.
- Support older women's adaptation to changing health and age related needs by increasing inter-sectoral collaboration between various bodies at strategic and operational level. It is acknowledged that many organisations have individual strategies on ageing and/or health. However, co-operation between older women representatives, health and social care providers, environmental agencies, legal and security (Gardaí), welfare and pension providers needs to be increased in order to provide a more integrated targeted approach to supporting older women adapt to ageing and inter- related health needs. Having focused steering groups with representation from relevant bodies would assist in this.
- In view of espoused Government commitment to supporting older people to live in their own homes there needs to be a statutory entitlement for community care services. This would demonstrate that both continuing residential care and community care services

support are equally valued. Older women should have a real choice to avail of either or none of these options. Reverse the decision to reduce home help hours, as home help can be important in supporting older women to remain in their own homes. Furthermore, provide increased availability of grants to modify homes as necessary.

- Continue to promote anti-ageing strategies and publicity campaigns. Specifically develop ways in which female ageing is seen as part of life rather than something to be feared. This should include increasing intergenerational communication (e.g. older women meeting and working with school children and younger adults) and influencing media's generally negative depiction of older women (advocating for an increase the number of older women writers, presenters and actresses).
- Review access to screening for older women and determine the validity of using age as a criterion for access.
- Support older women to remain socially engaged through supporting opportunities for meaningful activities. Governmental initiatives and services aimed at facilitating participation must take cognisance of the range and diversity of older women's interests accepting the individual interests of older women. Generic activities and programmes aimed at older women in general can be meaningless unless they are of interest and meet their individual needs. Opportunities may include but are not limited to the following: development of further education courses; develop employment and volunteering opportunities; supporting involvement in community and social groups. Furthermore, reinstate the telephone allowance as having a telephone is a useful way to stay in touch especially for those who are living alone and/or incapacitated.

7.7 Directions for future research

There are two main suggestions for future research arising from this study.

- In view of older women's different health care experiences it is timely to explore health care professionals' attitudes, knowledge and understanding of the health needs of older women within the context of their ageing experience.

- Many of the older women emphasised the importance of being proactive and looking after their health. In view of the importance of preventive health care, it would be useful to explore the level of health promotion and health education provided to older women by health care professionals.

In conclusion it is fitting that the co-researchers should have the last word in this study about their experiences of ageing and health related issues and so I return to a quote from Aoife which summed up the need to accept growing older as a natural part of life.

> *"No one wants to grow old. You try and keep young as long as you can. But then you just gradually get there and accept it and its grand...I suppose that's just nature"*

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Appendix One: Literature Review Search Strategy

This search strategy documents the inclusion and exclusion criteria, keywords, language, Boolean operators and the search sources including specific organisations, grey literature and electronic databases. Both electronic and hand searches were undertaken. The literature was searched numerous times over the period of the study (from 2010 to beginning of 2016).

Inclusion criteria	Older women aged from 60 years as some countries use this as the start of old age; experiences, views and perceptions; ageing; living in the community and papers written in English.
Exclusion criteria	Younger women, not residential care, papers not written in English
Keywords:	Old, older, elder, ageing, women, health, experiences, perceptions
Language	English
Boolean operators	AND/ NOT/OR; Wildcard e.g. wom?n (for woman/women); "root" used in the form of an asterix e.g. old* for old, older
Years	Typically within the last ten years although some predate 2005

Hand-searching

In order to find studies and other relevant information which may have been missed in the other searches, journal papers and editorials as well as conference papers and books were hand-searched. Book topics included health, older people, gerontology, ageing, older women and gender.

Grey literature

Grey literature searched included written and oral information and included conference abstracts and presentations; symposia, workshops, fora; media reports/programmes; formal and informal telephone calls, emails and meetings.

Organisations

International

United Nations (UN) World Health Organisation (WHO), European Union (EU), European Commission (EC); International longitudinal studies e.g. The English Longitudinal Study of Ageing (ELSA), Berlin Ageing Study (BASE), The Australian Longitudinal Study on Women's Health (ALSWH); International Association of Gerontology and Geriatrics (IAGG) and The Royal College of Nursing (RCN).

National

Irish governmental departments and statutory bodies including Department of Health; Department of Social and Family Affairs; Office for Social Inclusion; Central Statistics Office; Equality Authority; Department of Justice, Equality and Law Reform; Citizens Information Board (a public information service); the Health Service Executive.

Non–governmental organisations including: Centre for Ageing Research and Development in Ireland (CARDI); The Irish Longitudinal Study on Ageing (TILDA) ; All Ireland Gerontological Nurses Association (AIGNA); Older and Bolder; Age Action Ireland; Active Retirement Ireland; Age and Opportunity; Older Women Network; National Centre for the Protection of Older People (NCPOP); Third Age including the support and advocacy service for older people (SAGE); Older People's Empowerment Network (OPEN); Institute of Public Health in Ireland; Economic and Social Research Institute of Ireland (ESRI); Irish Centre for Social Gerontology (ICSG); Irish Gerontological Society (IGS); The Social Policy and Ageing Research Centre (SPARC); National Women's Council of Ireland (NWCI); National Council on Ageing and Older People (NCAOP); Women's Health Council; St Vincent de Paul; Age Friendly Ireland, Age Friendly Cities and Counties Programme; Irish Nursing and Midwifery Board.

Electronic Data Bases

Academic Search Complete; CINAHL PLUS; Medline; Psych ARTICLES ; Psych INFO; Social Sciences Full text (H.W. Wilson) through EBSCO Host interface **;** Cochrane Database of Systematic Reviews ; SCOBUS; SAGE; Science Direct; PubMed; ASSIS via Pro quest; Biomed Central; Open Access publishers; Internurse.

Appendix Two: Selection of Published Research Studies using "the Vancouver School of doing phenomenology" framework

Date Published	*Authors, Titles and Journals*	*Brief synopsis of the studies*
2002	Arman, M., Rehnsfeldt, A., Lindholm, L. & Hamrin, E. *The face of suffering among women with breast cancer-being in a field of forces* Cancer Nursing 25(2), 96-104	**Aim:** To explore the suffering experiences of women with breast cancer. **Sample:** n= 17 women and 16 carers. **Findings** The experience affected the women's inner existence and values including their views of themselves, life and death, and their relationships with significant others and healthcare personnel.
2002	Lindholm, L. Rehnsfeldt, A. & Arman, M. *"Significant others' experiences of suffering when living with women with breast cancer"* Scandinavian Journal of Caring Sciences 16(3) 248-255	**Aim:** To explore how significant others experience being close to a woman suffering from breast cancer. **Sample:** n= 17 women and 16 carers. **Findings:** Significant others experience deep often unrelieved suffering whereby they identify themselves as being prisoners of a situation of uncertainty and powerlessness when supporting the woman.
2005	Magnusdottir, H. *"Overcoming strangeness and communication barriers: a phenomenological study of becoming a foreign nurse"* International Nursing Review 52(4) 263-269	**Aim:** To explore the lived experiences of foreign nurses working in Icelandic hospitals. **Sample:** n=11. **Findings:** The participants felt that as they were outsiders they had to overcome strangeness of a new work environment, culture, language barrier and ultimately they had to overcome these challenges in order to belong.

Date Published	***Authors, Titles and Journals***	***Brief synopsis of the studies***
2005	Petursson, P. *GPs' reasons for "non-pharmacological" prescribing of antibiotics* Scandinavian Journal of Primary Health Care 23 (2) 120-125	**Aim:** To study GPs' reasons for prescribing antibiotics in situations with low pharmacological indications (non-pharmacological prescribing). **Sample:** n=16, aged 32 to 67 years. **Findings:** Reasons were an unstable doctor-patient relationship due to lack of continuity of care, patient pressure in a stress-loaded society, the doctor's personal characteristics and the doctor's insecurity and uncertainty.
2008	Hansdóttir, H. & Halldórsdóttir, S. *Dialogues on Death: A Phenomenological Study on Views of the Elderly Toward Life and Death and End-of-Life Treatments* Open Longevity Science, 2, 29-35	**Aim:** To examine elderly individuals' views on life, death and treatment at the end-of-life and develop an understanding for the basis of these. **Sample:** n=8, aged from 72-91 years. **Findings:** They all agreed that it was necessary to limit life prolongation if there was: no hope of recovery, much suffering, compromised mental and physical abilities, no possibility of living a decent life and being a burden to others. Attitudes towards end-of-life treatment were based on the likely outcome, an evaluation of their own lives, the impact on lived ones, experience of illness, death and loss, ethical aspects.
2008	Ingadottir, B. & Halldórsdóttir, S. *To discipline a "dog": the essential structure of mastering diabetes.* Qualitative Health Research 18 (5), 606-619	**Aim:** To explore the patients' experiences of mastering diabetes in particular their experiences of adhering or not adhering to treatment regimens. **Sample:** n=11, aged between 28-84 years. **Findings:** Mastering diabetes is a constant attempt to live a normal life balancing the treatment regime with physical and psychosocial wellbeing.

Date Published	***Authors, Titles and Journals***	***Brief synopsis of the studies***
2008	Karlsson, A., Arman, M. & Wikblad, K. *Teenagers with type 1 diabetes- a phenomenological study of the transition towards autonomy in self-management* International Journal of Nursing Studies 45, 562-570	**Aim:** To explore the transition towards autonomy in self-management. **Sample:** n=32. **Findings:** Self- reliance and the support of others are helpful in making the transition to self-care management.
2008	Sigurgeirsdottir, J. & Halldórsdóttir, S. *Existential struggle and self-reported needs of patients in rehabilitation.* Journal of Advanced Nursing 61 (4), 384-392	**Aim:** To increase understanding of patients' experience of rehabilitation and self -care needs. **Sample:** n=12 aged between 26 and 85 years. **Findings:** Being a rehabilitation patient involves an existential struggle i.e. need to cope with and adapt to the changes in their lives and to identify their needs regarding this.
2009	Blondal, K. & Halldórsdóttir, S. *The challenges of caring for patients in pain: from the nurse's perspective* Journal of Clinical Nursing 18 (20), 2897-2906	**Aim:** To explore nurses' experiences of caring for patients in pain. **Sample:** n=10. **Findings:** It is challenging caring for patients in pain and these include understanding patient needs and dealing with personal moral dilemmas, gatekeepers (e.g. physicians) organisational hindrances.
2009	Gudmannsdottir, G.D. & Halldórsdóttir, S. *Primacy of existential pain and suffering in residents in chronic pain in nursing homes: a phenomenological study.* Scandinavian Journal of Caring Sciences 23 (2), 317-327	**Aim:** To examine the experiences of chronic pain of residents living in nursing homes. **Sample:** n=12, aged between 74-97 years. **Findings:** Indicate that it is not just the challenges of successful pain management but also the experiences of loss and reconciliation associated with needing to live in residential care**.**

Date Published	***Authors, Titles and Journals***	***Brief synopsis of the studies***
2010	Petursdottir, U., Arnadottir, S.A. & Halldórsdóttir, S. *Facilitators and barriers to exercising among people with osteoarthritis: A phenomenological study.* Physical Therapy 90 (7) 1014-1025	**Aim:** To increase knowledge of the experience of exercising among people with osteoarthritis and to identify the barriers and facilitators to exercise. **Sample:** n=12, aged 50-82 years. **Findings:** Influencing factors included individual attributes; personal experience, social environment and physical environment.
2010	Skuladottir, H. & Halldórsdóttir, S. *The quest for well-being: self-identified needs of women in chronic pain* Scandinavian Journal of Caring Sciences 25 (1)1-11	**Aim:** To study self-reported needs of women in chronic pain. **Sample:** n=5, aged 36-53. **Findings:** The overriding theme was the quest for wellbeing: physically, mentally, emotionally and socially**.** They were learning to live with the pain and searching for support, caring and connection and normalcy.
2011	Rampino, L. *The innovation pyramid: A categorization of the innovation phenomenon in the product-design field*. International Journal of Design, 5(1), 3-16.	**Aim:** To determine how to better demonstrate the contribution design makes to product innovation by observing product innovation as a phenomenon. **Sample:** 40 innovative products were chosen as the phenomena to be observed. **Findings:** Three possible levers of a design-driven innovation process emerged: form, mode of use, and technology resulting in an innovation pyramid.
2012	Bjornsdottir, G., Arnadottir, S.A. and Halldórsdóttir, S. *Facilitators of and barriers to physical activity in retirement communities: experiences of older women in urban areas.* Physical Activity , 92 (4) 551-562	**Aim:** To understand the physical activity experiences of older women living in retirement communities and what they experience as facilitators of and barriers to physical activity. **Sample:** n=10, aged 72-97 years. **Findings**: Influencing factors included the specifics regarding the women's health and levels of functioning as well as the physical and social environments.

Date Published	***Authors, Titles and Journals***	***Brief synopsis of the studies***
2012	Sigurdardottir, S., Halldórsdóttir, S. & Bender, S.S. *Deep and almost unbearable suffering: consequences of childhood sexual abuse for men's health and well-being*Scandinavian Journal of Caring Sciences 26; 688–697	**Aim**: To explore the consequences of childhood sexual abuse for Icelandic men's health and wellbeing. **Sample:** n= 7, aged between 30-55yrs. **Findings:** "deep and almost unbearable suffering of which there is no alleviation in sight".
2013	Sigurdardottir, S. & Halldórsdóttir, S. *Repressed and silent suffering: consequences of childhood sexual abuse for women's health and well* Scandinavian Journal of Caring Sciences 27 (2) 422-432	**Aim:** To explore the consequences of childhood sexual abuse for women's health and well-being. **Sample:** n=7, aged 30-65 years. **Findings:** The main result is that time does not heal all wounds. As a result of the abuse all experienced repressed and silent suffering in all aspects of their lives.
2014	Bjorgvinsdottir , K. & Halldórsdóttir, S. *Silent, invisible and unacknowledged: experiences of young caregivers of single parents diagnosed with multiple sclerosis* Scandinavian Journal of Caring Sciences 28 (1), 38-48	**Aim:** To study the personal experience of being a young caregiver of a chronically ill parent diagnosed with MS. **Sample:** n=11 and were young adults. **Findings:** They felt silent, invisible and unacknowledged and received limited support from professional. Their care giver role restricted their ability to live a 'normal' childhood and they found their responsibilities arduous.
2014	Karlsdottir, SI, Halldórsdóttir, S. & Lundgren, I. *The third paradigm in labour pain preparation and management : the childbearing woman's paradigm* Scandinavian Journal of Caring Sciences 28 (2), 315-327	**Aim:** To explore women's experiences regarding labour pain preparation and management in normal childbirth. **Sample:** n=14, seven primiparous and seven multiparous women. **Findings:** Labour was described as a 'challenging journey' with different landmarks such as preparation for the pain, the context of the pain and their management of the pain.

Appendix Three: Request to Organisations for assistance in recruitment.

Dympna Tuohy
Phone: xxxxxxxxxx
Mobile: xxxxxxxx
Email: xxxxxxxxxxxx

Dear Colleague,

My name is Dympna Tuohy. I am a registered nurse and a lecturer in nursing. I am a PhD student at the School Nursing and Midwifery, NUI Galway. I am currently undertaking a research study, exploring older women's experiences of ageing and health related issues in Ireland.

The percentage of older people in Ireland is increasing. Women tend to live longer when compared with men. Internationally there have been a number of studies that have explored older women's health concerns, but there is little published material from an Irish perspective that have explored older women's experiences of ageing and associated health issues. I would like to increase our knowledge in this area.

To do this, I would like to interview women who are:

- Competent
- Aged 65 years and over
- Living in the community

This research excludes:

- women who are younger than 65 years
- women who cannot give informed consent

The women in this study will be volunteers and self-selecting. However, I would appreciate it if you would consider helping me recruit women for this study by displaying a poster on your notice board/website.

What happens next?

- You read the attached information sheet aimed at women taking part in the study
- You decide if you would like to help me recruit women to take part in the study
- If you decide that you will help, you complete the attached 'Statement of interest for organisations' and return it to me the envelope provided. You can also
    - Phone me on xxxxxx (landline) or xxxxx (mobile)
    - Email me at xxxxxx

I will then contact you to discuss the study further and answer any questions that you might have about this research.

Who approved this study?
The Research Ethics Committee, NUI Galway has granted ethical approval for this study.

Thank you for taking the time to read this information sheet and considering my request for help with this important study. I fully understand if you do not wish to be involved but I hope you will consider helping me in the recruitment phase of this research study.

Yours sincerely,

_____

Dympna Tuohy

Appendix Four: Participant Information sheet for potential participants.

"An exploration of older women's experiences of ageing and health related issues in Ireland"

Information for women who may take part in the study

Who is carrying out the study?
My name is Dympna Tuohy and I am carrying out this study. I am a registered general nurse, a lecturer in nursing and PhD student at the School of Nursing and Midwifery, NUI Galway.

What is the study about?
In Ireland, there is little known about older women's experiences of ageing and associated health related issues. This research aims to fill this gap asking older women about their individual experiences.

Who are older women?
Older women are women aged 65 years and over.

What does the study aim to do?
The study aims to

- Look at older women's experiences of ageing
- Find out what older women think about their health as they get older.
- Find out what older women's health needs and concerns are
- Find out how older women manage their health needs
- Find out what sources of help or resources do older women have if any
- Look at current policies and strategies and see if they meet the needs of older women

Who is taking part?
The research is among women who:

- are aged 65years and over
- who are living at home

This research excludes:

- women who are younger that 65 years
- women who cannot give informed consent

What happens when a women agrees to take part in the study?
If you agree to take part in the study:

- I will ask you to sign a consent form, giving me permission to interview you for the study
- I will interview you at a time, day and place that suits you
- The interview will last one hour or less
- My aim is to hear and record your experiences. I will ask you a range of open-ended questions, which you are free to answer, or not answer, in whatever way you choose

What happens if a woman refuses to take part?
If you do not want to take part, or do not want to answer particular questions, I will respect your decision. I will not ask you to explain your decision. Taking part is entirely your choice.

What will you ask people about?
I will ask you about your experiences of ageing and what your views are regarding your health as you grow older. I will ask you about your health needs and concerns as you age as well as exploring how you manage these. I will ask to identify any sources of help or resources that you have.

Will you record the interview?
Yes, I will record the interview. This will allow me to write up your views and opinions. If you take part, you may have a copy of the taped interview if you wish.

Do those taking part need to sign a consent form?
Yes. If after reading this information sheet and asking me any questions about the study, you agree to take part in the study, I will ask you to sign a consent form before I interview you.

What does a woman's consent mean?
If you consent to take part in the study, it means you give me permission to:

- Interview you so I can get information about your experiences
- Record the interview
- Use the information you give me, without using your name, in reports and publications to explain your experiences of ageing and associated health related issues.

Is there any risk to taking part?
I don't foresee any risks for you being involved in the study. However, should you become upset when talking about your experiences I will stop the interview straight away and provide some time for you to talk about your feelings, if you wish. The interview will only be continued if you are satisfied that it will not cause you further upset.

Can those taking part stop the interview after it has started?
Yes, you may stop the interview at any time. You do not have to give any reason.

Do you offer any advice?
If you wish, I can give you a list of support services.

Is the interview confidential?
Yes. I will not inform anyone that you took part in the study. I will make sure that your name, details or any other information that might reveal your identity will not appear anywhere in any publication or presentation resulting from this study. I will label the interview with a code number and no names will appear anywhere on them. If you wish to talk to other people about the study you are free to do so.

What are the benefits of the study?
There are no direct benefits for you in taking part in this study. However, it is hoped that the information and knowledge generated from this study will help others understand older women's experiences of ageing and associated health related issues. It is anticipated that this understanding will have an impact on the policy decisions and services available to older women living at home.

How long will the interview take?
The interview will last up to one hour.

Is there a fee for taking part?
No, there is no payment for taking part in the study.

Will there be just one interview?
I may ask you to take part in more than one interview but you can choose whether or not to be interviewed more than once.

Who approved this research?
NUI Galway, Research Ethics Committee has granted this study, ethical approval. Dr Adeline Cooney, Senior Lecture, School of Nursing and Midwifery, NUI Galway is supervising this research.

What is the next step?
If you wish to take part please:

- Fill in the attached "Statement of Interest" form and return it in the envelope provided
- If you have a preferred time for me to contact you please state that
- Phone me on xxxxxx (landline) or xxxxx (mobile)
- Email me at xxxxxx

How can people get more information?
If you would like more information, or if you do not understand anything in this information sheet, please contact me. I will be happy to discuss or explain any of the details with you.

Thank you for taking the time to read this information sheet and considering my request for help with this important study. I fully understand if you do not wish to involved, but I hope you will consider taking part. Thank you in anticipation. Dympna Tuohy.

If you have any concerns about this study and wish to contact someone independent and in confidence, you may contact the Chairperson of the NUI Galway Research Ethics Committee, c/o Office of the Vice President for Research, NUI Galway, ethics@nuigalway.ie

Appendix Five: Poster

A study exploring older women's experiences of ageing and health related issues in Ireland

Are you a woman

- Aged 65 years and over
- Living in the community

If you can answer 'yes' to these questions, I would like to hear your story.

My name is Dympna Tuohy. I am a registered nurse and a lecturer in nursing. I am a PhD student with the School of Nursing and Midwifery, NUI Galway. Talking to you, will help me understand more about your experiences of ageing and health related issues. This information will increase our knowledge in this area.

For more information or if you would like to be involved, please phone me, Dympna on xxxxxx (mobile) or xxxxx (landline) or email me on xxxxxxx.

Dr Adeline Cooney, School of Nursing and Midwifery, NUI Galway is supervising this research.
This research is approved by the NUI Galway Research Ethics Committee.

Appendix Six: Letter of Introduction to Potential Participants.

Dympna Tuohy
Phone: xxxxxxxxxx
Mobile:xxxxxxxx
Email: xxxxxxxxxxxx

Dear Ms XXXXX,

My name is Dympna Tuohy. I am a registered nurse and lecturer in nursing. I am a PhD student at the School of Nursing and Midwifery, NUI Galway. I am writing to you to see if you would be willing to take part in a research study that I am carrying out, "An exploration of older women's experiences of ageing and health related issues in Ireland".

The number of older people in Ireland is increasing. Women tend to live longer than men. There have been some international studies that have explored older women's health concerns, but there is little published on this topic in Ireland. I would like to increase our knowledge in this area. To do this, I would like to interview women who are:

- Aged 65 years and over
- Living at home.

In my study, I would like to:

- Look at older women's experiences of ageing
- Find out what older women think about their health as they get older.
- Find out what older women's health needs and concerns are
- Find out how older women manage their health needs
- Find out what sources of help or resources do older women have, if any
- Look at current policies and strategies and see if they meet the needs of older women

I would be very grateful if you would think about taking part in this study. Your involvement is entirely voluntary and it is your choice. I attach an information sheet about the study to give you more details.

What happens next?

- Please read the information sheet
- Decide if you would like to participate in the study
- If you decide that you will take part, you complete the attached “statement of interest” form
- Return the “statement of interest” form to me in the envelope provided
- I will then contact you a week or so after receiving the “statement of interest form” to discuss the study. This week provides you with more time to consider your decision to participate and gives you time to read the “informed consent form”
- If you are still happy to take part, I will arrange to interview you at a time, date and place that suits you
- When we meet, I will answer any further questions you may have
- I will ask you to fill in the consent form when we meet
- When you have this done, I will interview you

If you need any more information about this research study or if anything in this letter is unclear, please contact me on xxxxx (mobile) or xxxx (landline) or email me: xxxxxx.

If you decide to take part in this research study, I look forward to hearing from you.

Thank you for taking the time to read this and I do hope you will consider becoming involved in this research study.

Yours sincerely,

_____

Dympna Tuohy

Appendix Seven: Expression of Interest form by potential participant.

"An exploration of older women's experiences of ageing and health related issues in Ireland"

If you would like to reply by post, please fill in this form and tick yes or no.

Statement of Interest

Please let me know if you will or will not take part in the research by:

- Filling in this "Statement of interest form" and sending it to me in the enclosed stamped addressed envelope or
- Phoning me on xxxx (mobile) or xxxx (landline)
- Emailing me at xxxxxx

Name:

tick yes or no

I would like to hear more about this research: Yes

No

If you ticked 'no' but you know a woman who may be interested in the study, please feel free to give her this information sheet.

If you ticked 'yes', please fill in the details below

Address:

Phone: Email:

What is the best day to contact you? What is the best time to contact you?

Thank you for reading this and showing an interest in this study. I will be in contact with you shortly.

Appendix Eight: Consent Form

Consent form for women taking part in the study, by signing this form you agree to take part in this study.

- I freely and voluntarily agree to be part of this research study
- I have had the opportunity to ask questions and all my questions have been answered to my satisfaction
- I understand that all information collected in this study will be treated as confidential and that my identity will remain confidential
- I have read the study information sheet and this consent form
- I understand that I am free to withdraw from this study at any time

Your name	
Your contact number	
Your signature	
Today's date	
Would you like a copy of the transcribed interview?	

Researcher's contact details: Dympna Tuohy, xxxx (mobile) or xxxxx (landline) or email me xxxxx.

Statement of researcher's responsibility

I have explained the nature and purpose of this study and the procedures to be taken. I have offered to answer any questions and have fully answered any such questions. I believe that the person named above understood my explanation and has freely given informed consent.

Researcher's signature	
Today's date	

For researcher's use only

Participant's code	

Appendix Nine: Ethical Approval

National University of Ireland, Galway
Ollscoil na hÉireann, Gaillimh

Reference: 11/MAR/06
Date: 29th March 2011

Ms Hanora Dympna Tuohy
Allisons Field
Farneigh
Newport
Co Tipperary

Sent on behalf of Dr Brian McGuire, Vice Chair, Research Ethics Committee

Dear Ms Tuohy

RE: Ethical Approval for "An exploration of older women's experiences of ageing and health related issues in Ireland"

I write to you regarding the above proposal which was submitted for Ethical review. Having reviewed your response to my letter, I am pleased to inform you that your proposal has been granted APPROVAL.

All NUI Galway Research Ethic Committee approval is given subject to the Principal Investigator submitting an annual report to the Committee. The first report is due on or before 31st March 2012. Please see section 7 of the REC's Standard Operating Procedures for further details which also includes other instances where you are required to report to the REC.

Yours Sincerely

OFFICE OF THE VICE-PRESIDENT FOR RESEARCH
MAR 2011
NUI, GALWAY

Dr Brian McGuire
Vice Chairperson
Research Ethics Committee

Office of the Vice-President for Research
Oifig an Leas-Uachtaráin um Thaighde

National University of Ireland, Galway,
Galway, Ireland.
Founded in 1845

Tel: +353 91 495312
Fax: +353 91 494591
e-mail: vpresearch@nuigalway.ie

Appendix Ten: Interview Guide.

"An exploration of older women's experiences of ageing and health related issues in Ireland"

Interview Guide

General introductions

The opening statement

I am interested in older women's experiences and perceptions of growing older and whether, in your view, this has impacted on your health.

Topics to focus the interview

The topics below will be used to initiate and facilitate discussion. Examples of questions are included.

- **Ageing:**
- What does growing older mean to you? Tell me about your experiences of growing older
- **Health and ageing**
- What does being healthy mean to you? Do you think growing older has affected your health? If so, in what way?
- **Health needs and concerns**

As you grow older, do you have any particular health needs? If so, tell me about them? How do you manage your health needs?

Have you any concerns for your health as you grow older, will you tell me about these? How do you manage your health concerns?
Do you think these needs and concerns will increase as you grow older? If yes, in what way? If not, why is that, do you think?

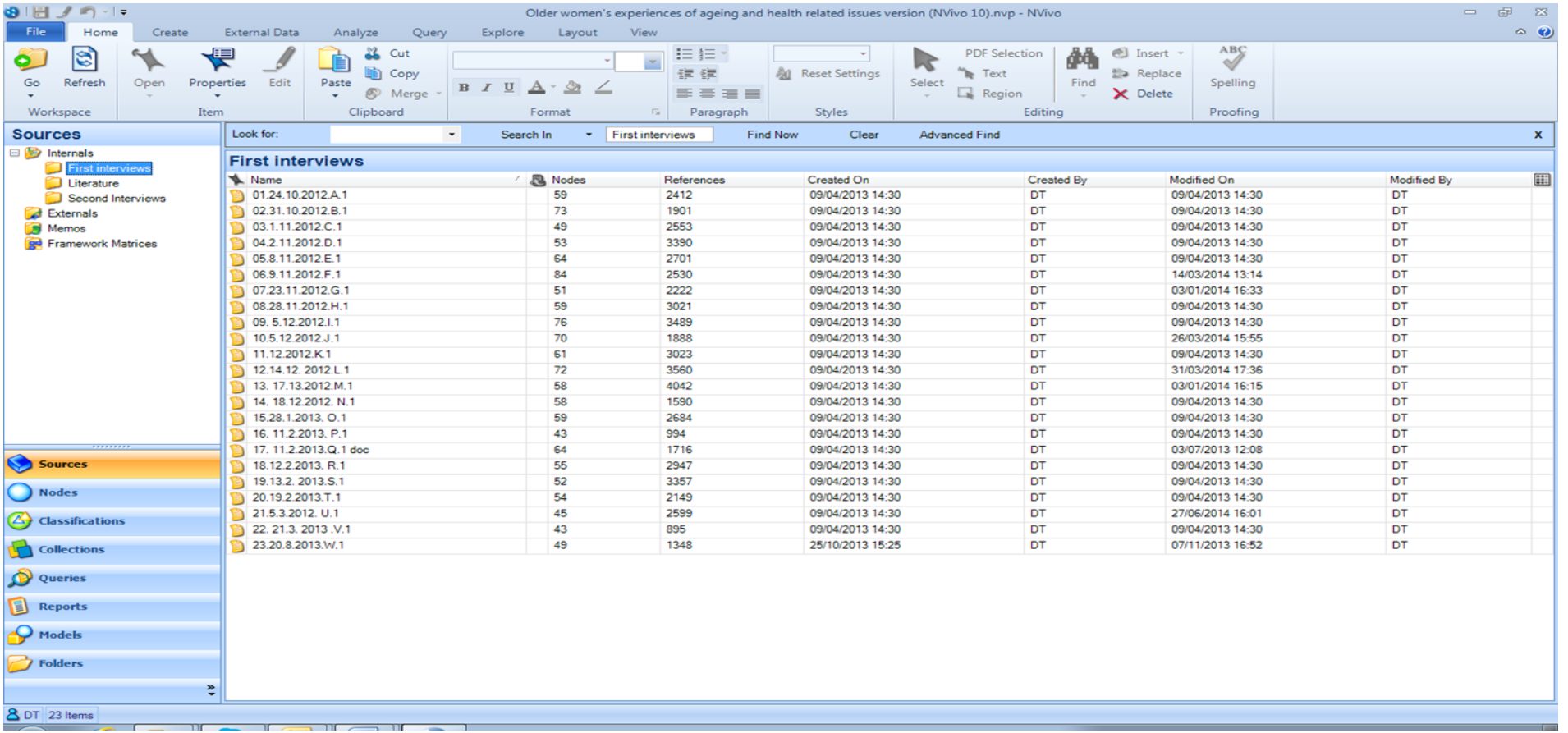
Sources of support

Do you need any support in managing your health as you grow older? If yes, do you have someone to help….who is that? What kind of support do you need or want?

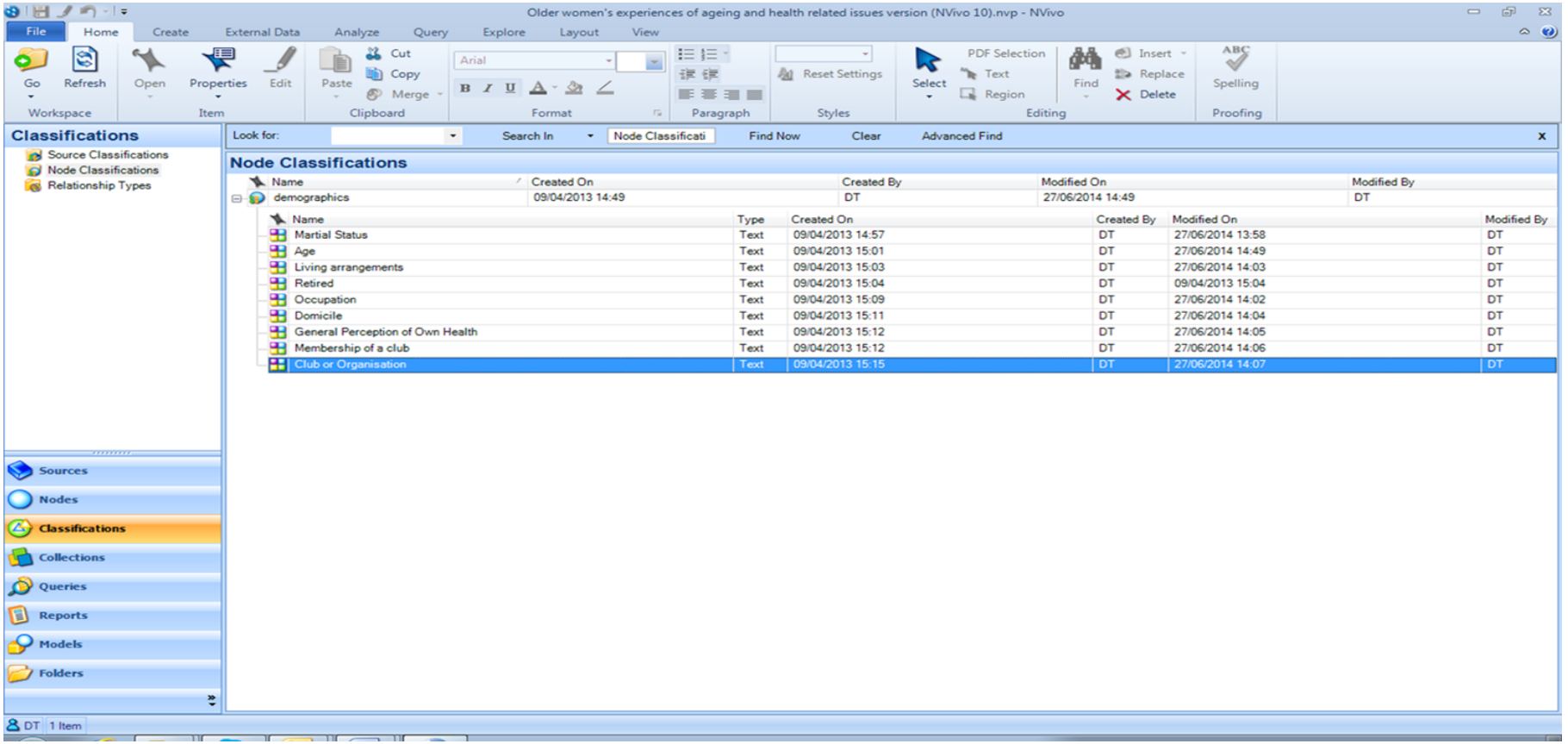
Current strategies and Policies

Do you think there are any policies or strategies in place that help you as you get older? If so, will you tell me about them? If not, do you think there should be some, Will you give me some examples?

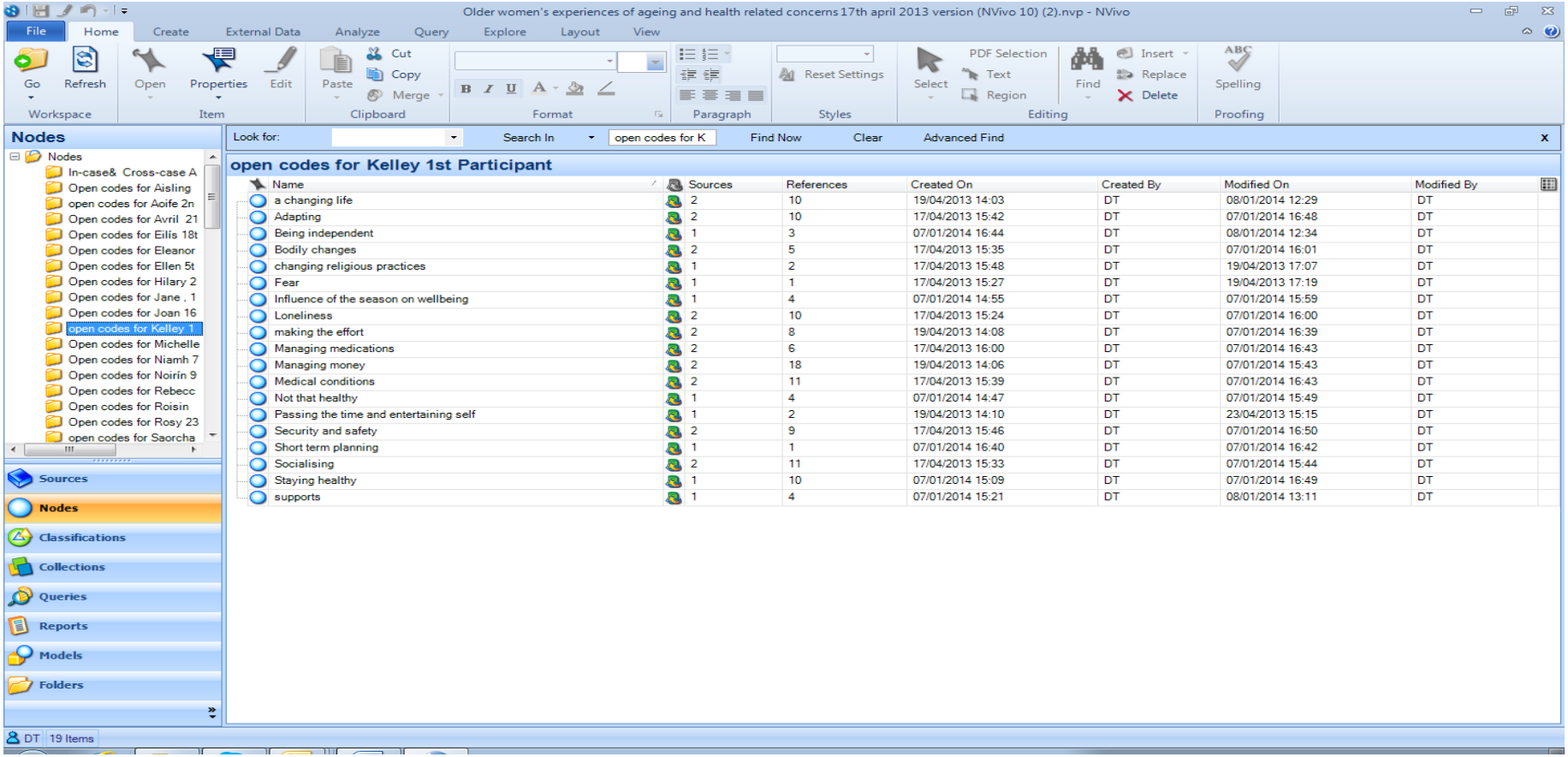
Appendix Eleven: 1st interviews in Internal Source File



Appendix Twelve: Case Node Classification set on co-researchers' demographic data



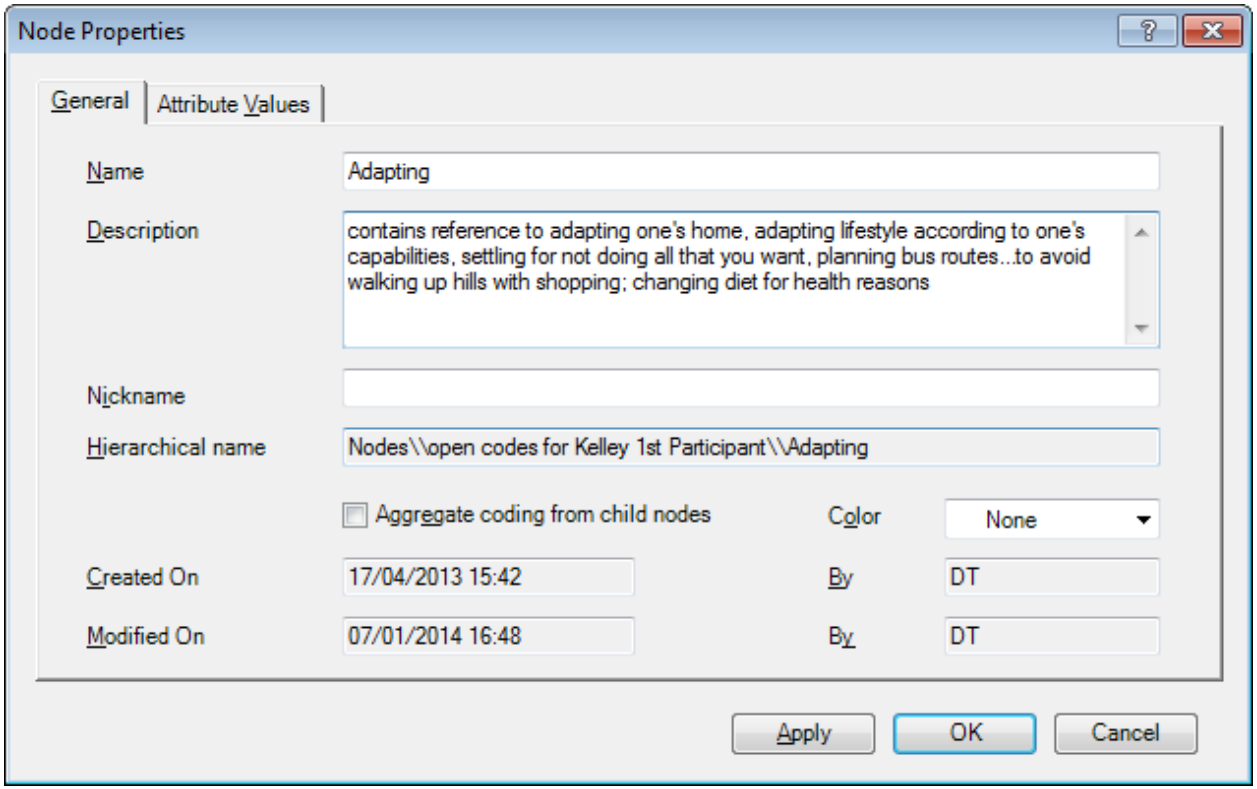
Appendix 13: Open Coding for Kelley



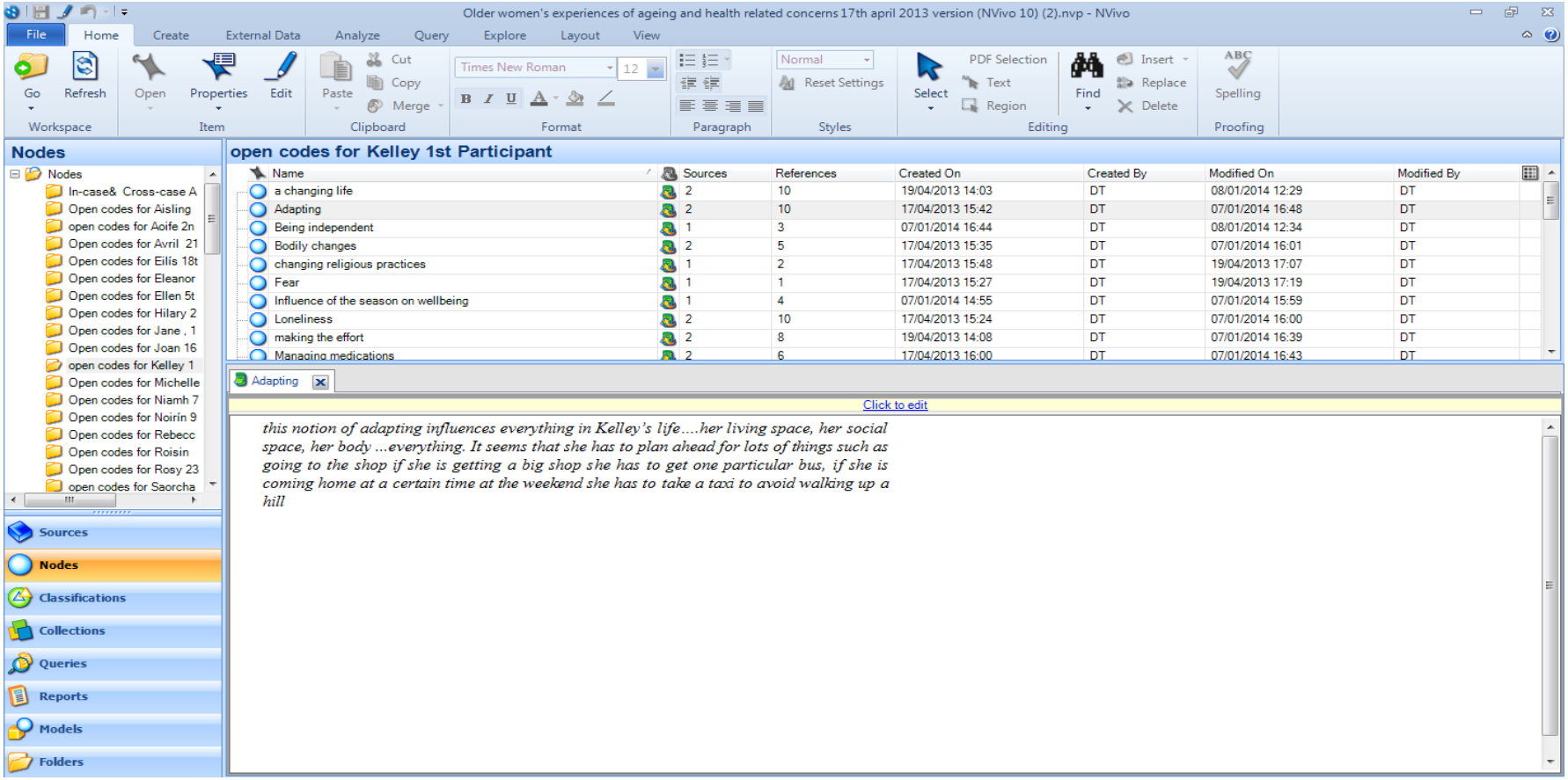
open codes for Kelley 1st Participant

Name	Sources	References	Created On	Created By	Modified On	Modified By
a changing life	2	10	19/04/2013 14:03	DT	08/01/2014 12:29	DT
Adapting	2	10	17/04/2013 15:42	DT	07/01/2014 16:48	DT
Being independent	1	3	07/01/2014 16:44	DT	08/01/2014 12:34	DT
Bodily changes	2	5	17/04/2013 15:35	DT	07/01/2014 16:01	DT
changing religious practices	1	2	17/04/2013 15:48	DT	19/04/2013 17:07	DT
Fear	1	1	17/04/2013 15:27	DT	19/04/2013 17:19	DT
Influence of the season on wellbeing	1	4	07/01/2014 14:55	DT	07/01/2014 15:59	DT
Loneliness	2	10	17/04/2013 15:24	DT	07/01/2014 16:00	DT
making the effort	2	8	19/04/2013 14:08	DT	07/01/2014 16:39	DT
Managing medications	2	6	17/04/2013 16:00	DT	07/01/2014 16:43	DT
Managing money	2	18	19/04/2013 14:06	DT	07/01/2014 15:43	DT
Medical conditions	2	11	17/04/2013 15:39	DT	07/01/2014 16:43	DT
Not that healthy	1	4	07/01/2014 14:47	DT	07/01/2014 15:49	DT
Passing the time and entertaining self	1	2	19/04/2013 14:10	DT	23/04/2013 15:15	DT
Security and safety	2	9	17/04/2013 15:46	DT	07/01/2014 16:50	DT
Short term planning	1	1	07/01/2014 16:40	DT	07/01/2014 16:42	DT
Socialising	2	11	17/04/2013 15:33	DT	07/01/2014 15:44	DT
Staying healthy	1	10	07/01/2014 15:09	DT	07/01/2014 16:49	DT
supports	1	4	07/01/2014 15:21	DT	08/01/2014 13:11	DT

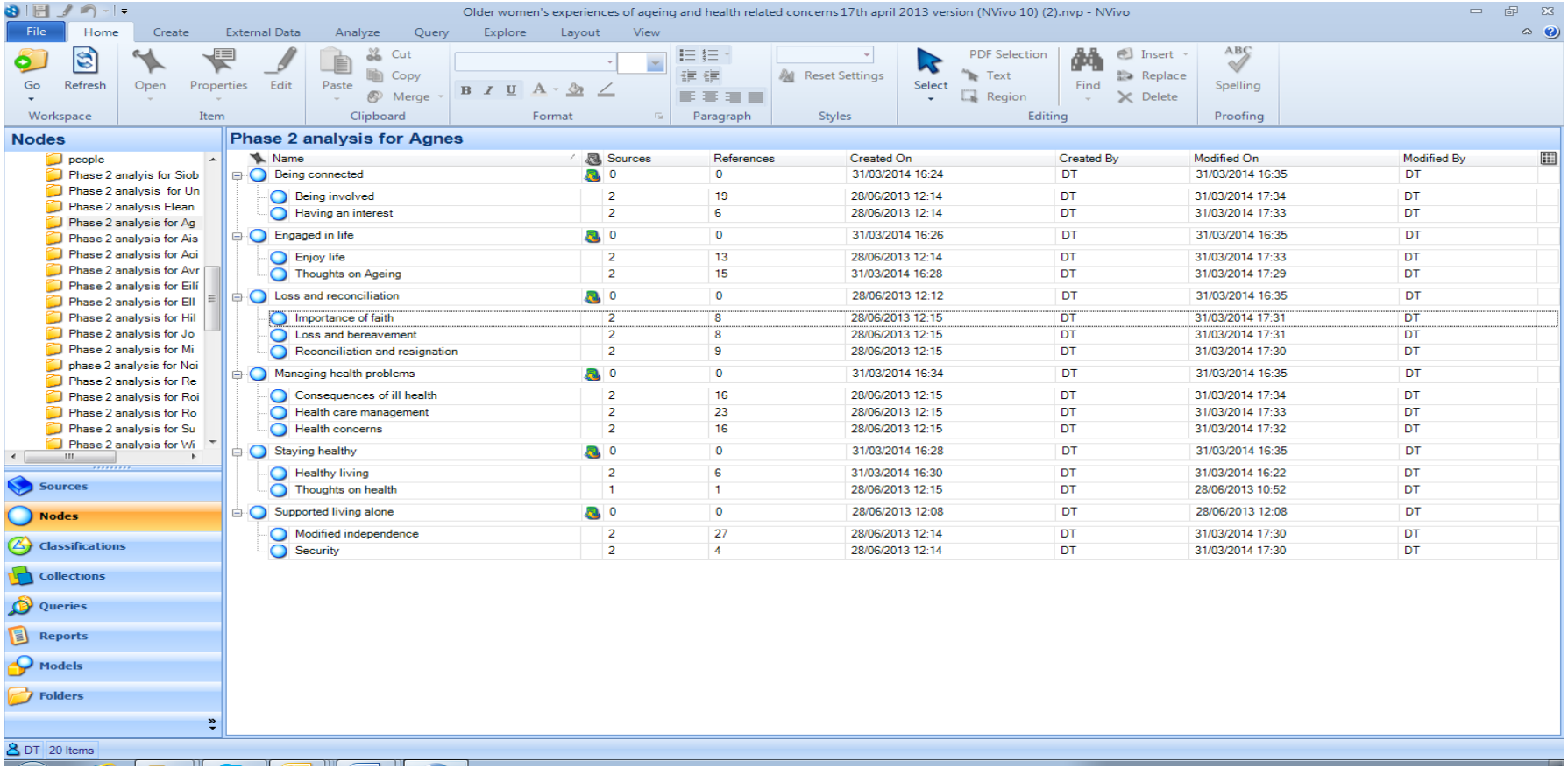
Appendix 14: Description of a Free Node from Kelley, i.e. “Adapting”



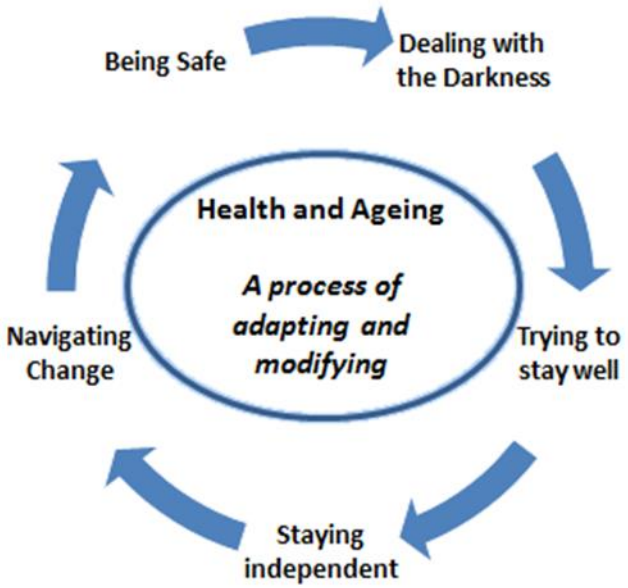
Appendix 15: Memo for One of Kelley's Free Nodes, "Adapting"



Appendix 16: Parent and Child Nodes for Agnes

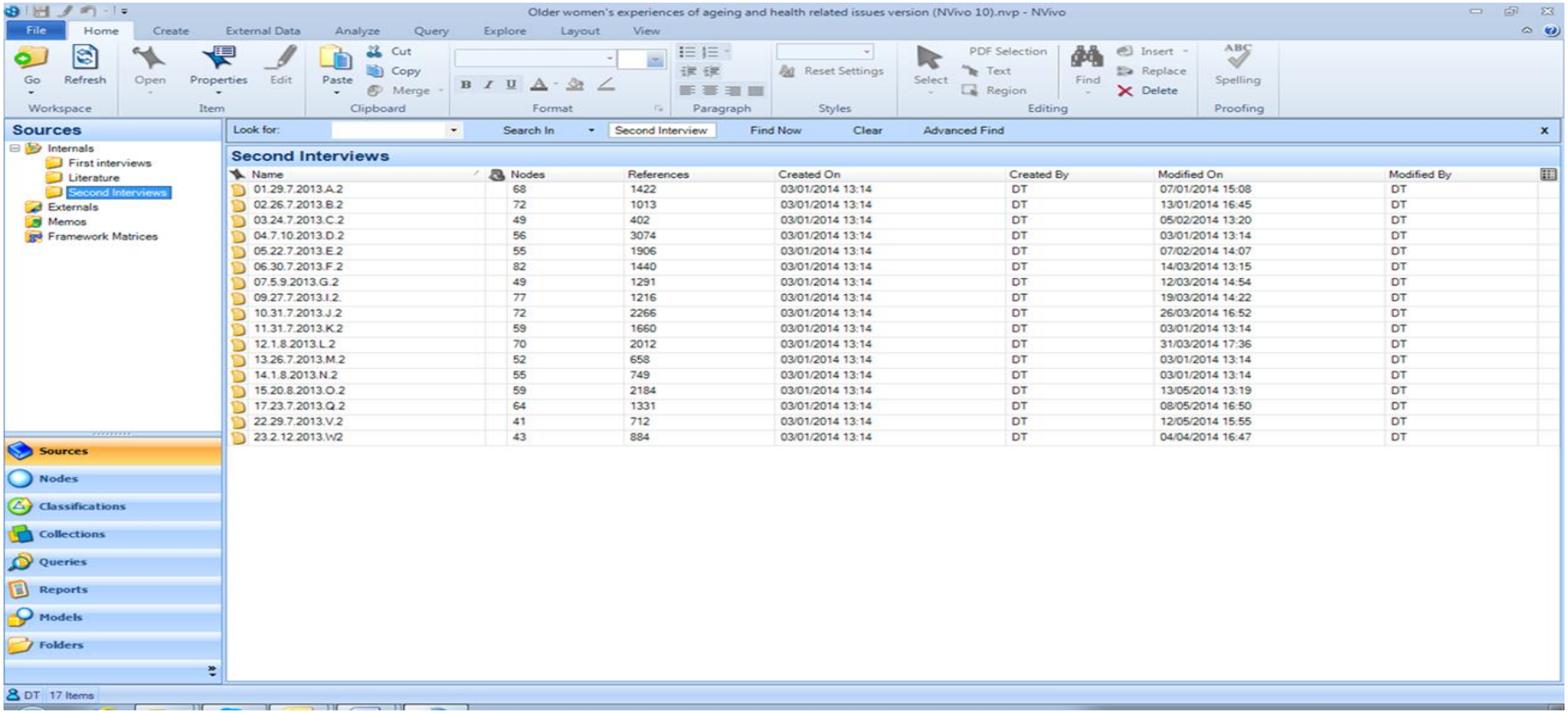


Appendix 17: Individual Case Construction. Example of an individual case construction: Model representing individual case construction of Kelley's experience of ageing and health related issues

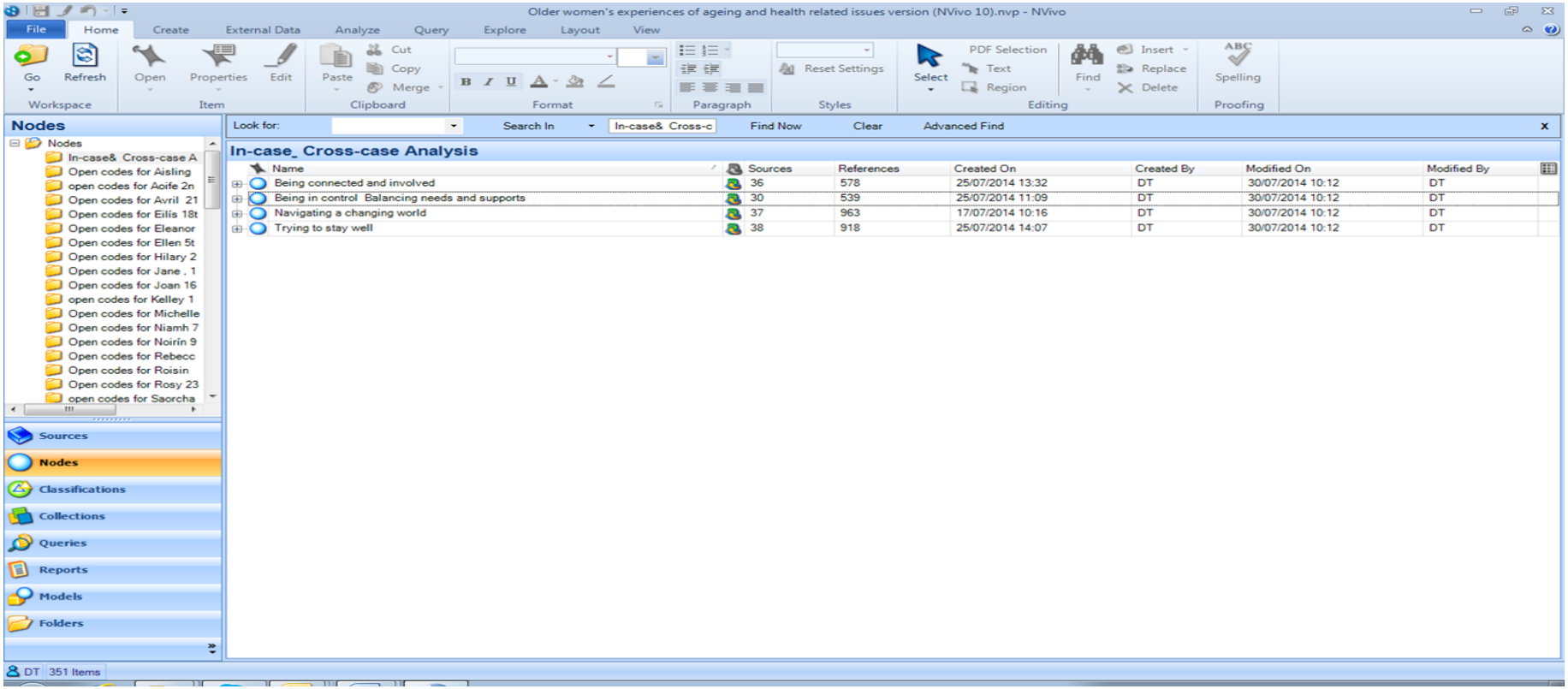


Main theme *Tree node (parent)*	Sub-theme *Child nodes*
Navigating change	Adapting; Bodily changes; A changing life; Changing religious practices; Short term planning
Staying independent	Independence; Supports; Managing money
Trying to stay well	Staying healthy; Not that healthy; Influence of the seasons on health; Managing medications; Medical conditions
Being Safe	Fear; Security and safety
Dealing with the darkness	Loneliness; Socialising; Passing the time and entertaining self; Making the effort.

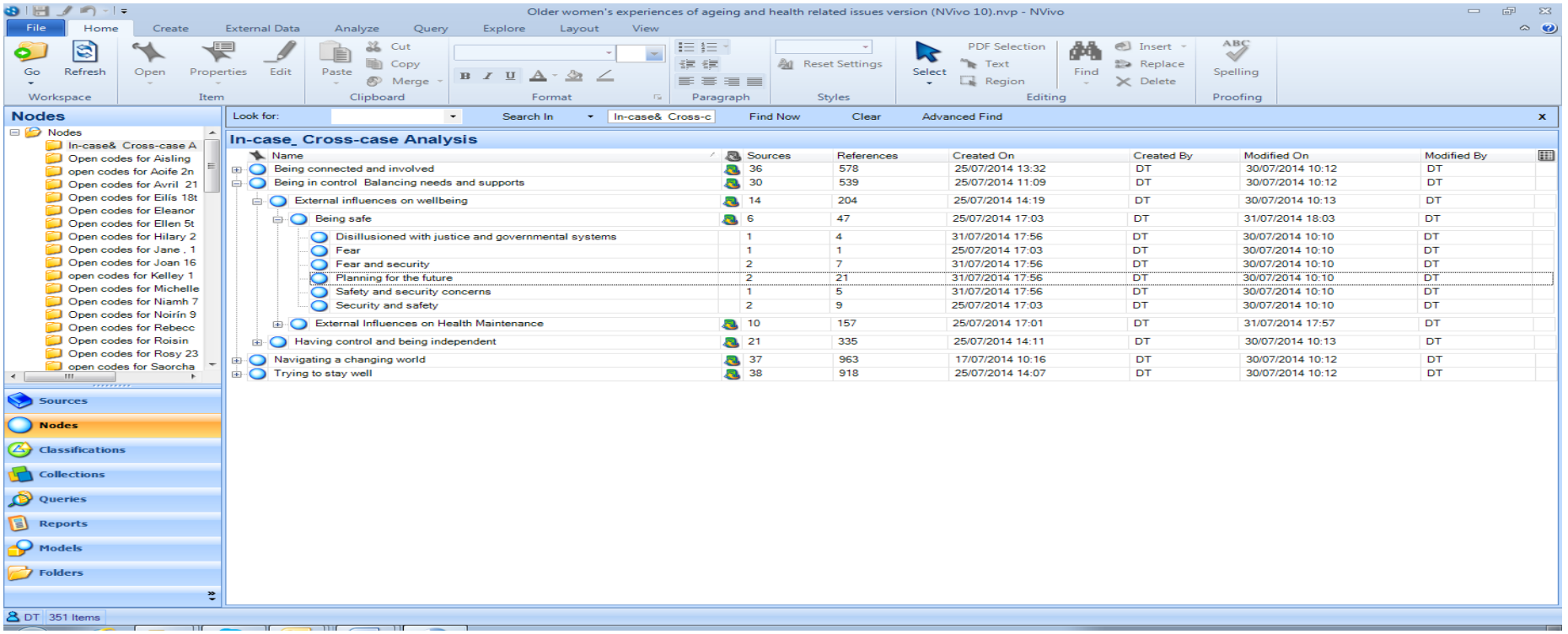
Appendix 18 Second Interviews: Internal source file



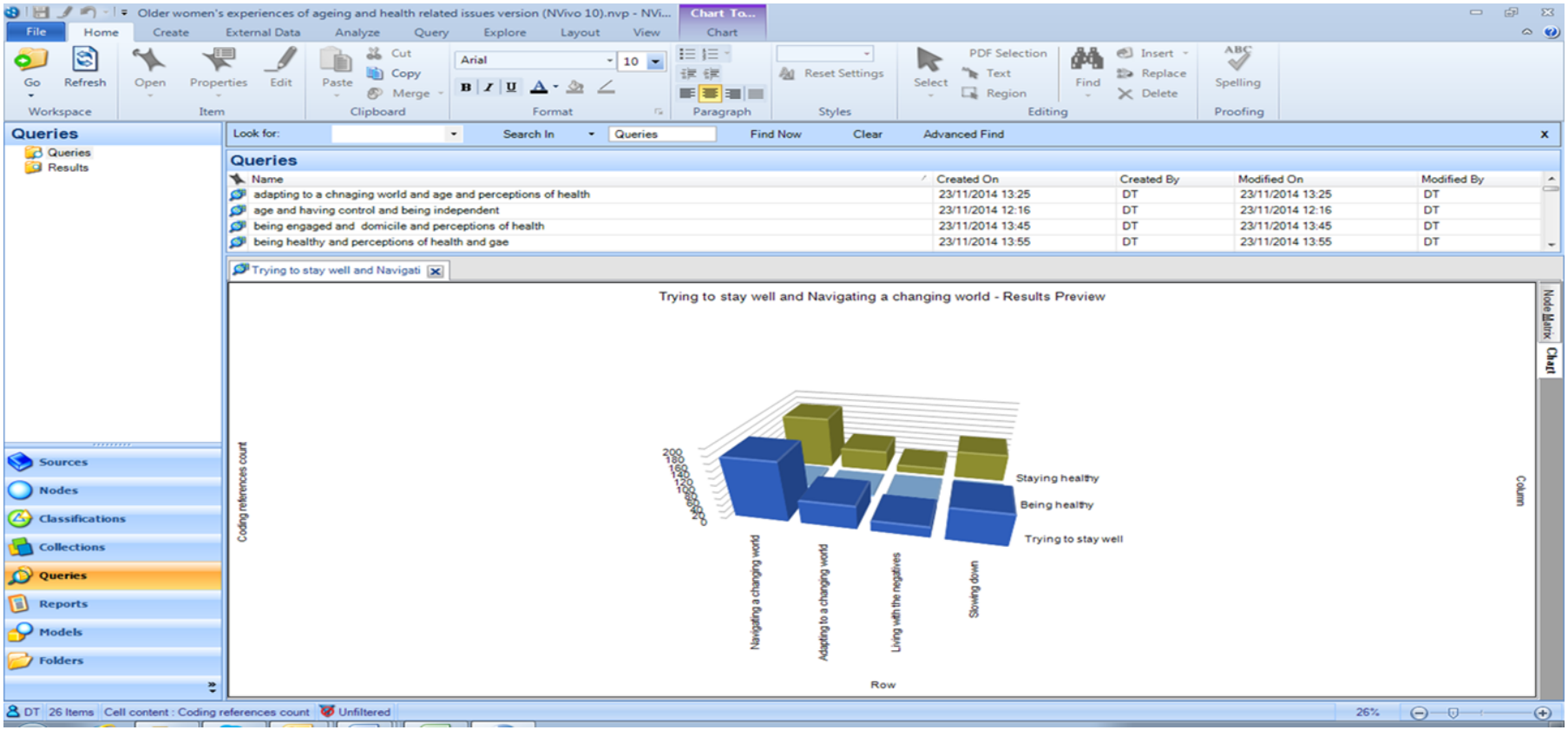
Appendix 19: In Case/Cross Case Analysis: Four main findings of the study



Appendix 20: Descendent Nodes, "Being in Control: Balancing Needs and Supports" Note: This node has two child nodes: External influences on wellbeing and Having control and being independent……each of which have a number of child nodes and they in turn have child nodes.



Appendix 21: Matrix Coding query to explore the relationship between “Trying to stay well” and “Navigating a changing world”.



Appendix 22: Feedback Letter

Covering letter requesting feedback on the summary of findings

Address
Mobile:xxxxxxxx
Email: xxxxxxxxxxxx
29th July 2014

Re: Research study of "Older women's experiences of ageing and health related concerns"

Dear xxxxx,

The last time we met, you expressed an interest in reading the findings of the study that you kindly participated in.

I am finalising this part of the study and have included a summary of the preliminary findings for your information. The findings are still tentative at this stage and I have some more work to do, so they won't be for wide distribution for a while yet.

You may recall I interviewed over twenty participants for the study and so the findings represent the views and experiences of all of the women involved.

I am interested in your thoughts on the findings and whether they are broadly reflective of your health concerns and issues within the context of your experience of ageing. If you would like to comment on the findings, I have enclosed a short feedback form and stamped addressed envelope. On the other hand, if you would like to talk to me about them, we could have a 5-10 minute phone conversation (I would ring you when it suits you, you can fill in on the form when would be a good time).

I would like to thank you once again for taking part in this research study, it is much appreciated.

Yours sincerely,

Dympna Tuohy

Appendix 23: Feedback Form for summary of findings

"An exploration of older women's experiences of ageing and health related issues in Ireland"

Feedback on Summary of Preliminary Findings

Name:

<u>Your comments on the preliminary findings</u>

Do you think these findings reflect the key aspects of ageing and health concerns for older women? Tick **yes**…… or **no…….**
If you would like to give your opinion on the findings and whether they broadly reflect your experiences, please add your comments here.

Please let me know if you <u>would</u> or <u>would not</u> like to take a follow up telephone call from me about your views on the preliminary findings, this would take 5-10 minutes.

I would like a follow up phone call, tick **yes**…… or **no…….**

If you ticked 'yes', please let me know what your phone number is and when is a good time to ring you.

Your phone number	
When is the best day to contact you?	
When is the best time to contact you?	

Thank you for taking the time to read this and for your participation in this research study, *Dympna Tuohy, 29th July 2014*