

# Older Women's Experiences of Aging and Health: An Interpretive Phenomenological Study

Gerontology & Geriatric Medicine  
Volume 5: 1–10  
© The Author(s) 2019  
Article reuse guidelines:  
sagepub.com/journals-permissions  
DOI: 10.1177/2333721419834308  
journals.sagepub.com/home/ggm



Dympna Tuohy, PhD<sup>1</sup>  and Adeline Cooney, PhD<sup>2</sup>

## Abstract

**Objective:** This interpretive phenomenological study explored older Irish women's experiences of aging and health related issues. **Method:** Data were collected using in-depth interviews with 23 older women (coresearchers). Data analysis followed the "Vancouver school of doing phenomenology" framework and included a meta-synthesis of individual case constructions. **Results:** "Retaining autonomy within a process of adaptation and continued engagement" describes the essential meaning of coresearchers' experiences. Four themes were identified: "Being in control: Balancing needs and supports," "Navigating a changing world," "Being connected and involved," "Trying to stay well." **Discussion:** Gender shapes older women's experience of aging, health, and ill health. Three major factors moderate their experience: autonomy and control, proactivity and adaptability, and staying engaged with life. The study concludes that aging, gender, and health are intrinsically linked and collectively shape older women's experience. This is an important consideration when planning gender-appropriate health care services for older women.

## Keywords

gerontology, gender/sexuality, community, active life/physical activity

**Manuscript received:** November 9, 2018; **final revision received:** January 8, 2019; **accepted:** January 14, 2019.

## Introduction

Globally, the population is aging and the proportion of older people is rising (United Nations [UN], Department of Economic and Social Affairs, 2017). A characteristic of an aging population is the "feminisation of ageing" (World Health Organization [WHO], 2002). The older the population, the more the female to male ratio increase, worldwide women account for 61% of those aged 80 years and above (UN, Department of Economic and Social Affairs, 2017). Almost everywhere in the world women live longer than men and are more likely to experience serious illness and have co-/multimorbidities, which adversely affect their quality of life (European Commission, 2014). Furthermore, older women experience increased comorbidities against a backdrop of increased frailty, the consequence of increased longevity (Byles et al., 2010; Crawley, 2008). Older women encounter other challenges in meeting their health needs, for example, they are likely to have less financial resources to draw upon (European Parliament, 2017; Ní Léime, Duvvury, & Callan, 2015), are more likely to live alone, and there is an increased likelihood of their symptoms being attributed to the aging process rather than ill health (Hurst, Wilson, & Dickinson, 2013; Song

& 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 (Annandale, 2009). Davidson, DiGiacomo, and McGrath (2011) argue that older women "face inequities related to health and often are invisible within the discourse of aging policy" (p. 1031). For example, they note that women's research focuses on women's reproductive health and largely ignores older women and their health needs. The WHO (2007, p. 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. This study explored this gap in knowledge. The study posed two questions: (a) what are older Irish women's experiences of aging and health-related issues,

<sup>1</sup>University of Limerick, Ireland

<sup>2</sup>Maynooth University, Ireland

### Corresponding Author:

Dympna Tuohy, Department of Nursing and Midwifery, University of Limerick, Health Science Building, North Bank Campus, Limerick V94X5K6, Ireland.

Email: [dympna.tuohy@ul.ie](mailto:dympna.tuohy@ul.ie)



**Table 1.** Steps to the Vancouver School of Doing Phenomenology.

1. Sample selection
2. Silence
3. Data collection via dialogue
4. Data analysis
5. Coding
6. Individual case construction
7. Verification of the individual case constructions with the coresearchers
8. Metasynthesis of the individual case constructions
9. Comparing the essential structure with the data
10. Interpretation of the meaning of the experience
11. Verification of the findings with some of the coresearchers
12. Write-up

Source. Adapted from Halldórsdóttir (2000).

with the aim of better understanding their health needs, activities, and priorities and (b) How (and whether) health, aging, and gender intersect and impact on older women's experiences.

## Method

Interpretive phenomenology, specifically the "Vancouver school of doing phenomenology" (VS) informed the research design. The aim of this school of 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, p. 47). This choice of methodology is suited to the exploratory nature of the research questions and appropriately (in context of the discussion above) keeps older women's "voices" to the fore. The research design and process were guided by Halldórsdóttir's (2000) framework for the VS (Table 1).

## Sample

Purposive and snowball sampling were used to recruit 23 older Irish women (coresearchers) from different settings, that is, health and day care centers, retirement social clubs and church congregations. This sampling approach facilitated the recruitment of a heterogeneous sample, reflective of the diversity of older women in terms of age, domicile, health, and socioeconomic backgrounds. Demographic data are presented in Table 2.

## Data Collection

Data were collected through dialogues (40) with the coresearchers. These dialogues were in-depth individual interviews guided by a topic list. The times and locations of meetings were determined by the coresearchers. All except one (at her request) were audiotaped with

**Table 2.** Coresearcher Information.

Age	66 years-92 years
Marital status	Three single, seven married/partner, 13 widowed
Employment	22 retired, one worked part time
Living arrangements	11 lived alone, 12 lived with family
Domicile	12 urban, five rural, six semirural
Coresearchers' perceptions of their health	Very poor (2), poor (7), "ok" (4), good (7), very good (2), one did not give an opinion

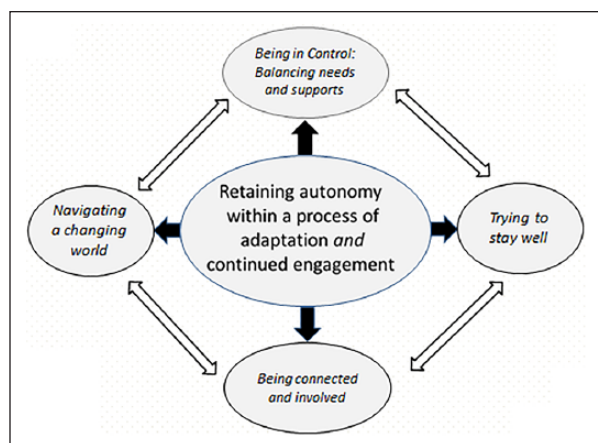
permission and transcribed verbatim. Seventeen agreed to participate in a second dialogue and data were shared with them for comments prior to this second interview (dialogue). Six women were interviewed once.

## Ethical Considerations

A fundamental aspect of the VS involves interviewing coresearchers more than once. Consequently, process-informed consent is required (O'Reilly, Parker, & Hutchby, 2011). Coresearchers were provided with written and oral information about the study and asked to sign an informed consent form agreeing to participate in the study. At each meeting, the coresearchers were reminded of the nature of the research and their decision to continue to engage was sought (O'Reilly et al., 2011). Ethical permission to conduct this study was obtained from the University Research and Ethics Committee (No. 11/Mar/06). Anonymity and confidentiality were assured, and pseudonyms were used in the study write-up.

## Data Analysis

The data analysis process equates to Steps 4 to 11 of the VS framework (Table 1). The data were analyzed by initially reading over the transcripts and listening to the audiotapes from which themes were identified from the key statements, grouped, and coded into broader main themes (Steps 4 and 5). Individual case constructions were developed for each coresearcher (Step 6). The second dialogue focused on transcript verification, coresearcher review of preliminary analysis, and further elaboration with amendments being made as appropriate. This resulted in some themes being amalgamated and new ones developed. The initial case constructions were revised to incorporate this new data (Step 7). Following this, a metasynthesis of all the individual case constructions was created (Steps 8 and 9). The final phases of the analysis included a review and feedback of a summary of the findings by five coresearchers (Steps 10 and 11). They provided feedback through the completion of a feedback form and participation in a telephone conversation. The findings were finalized and written up as a multivoiced text with the coresearchers' voices being "heard" through their contributions and their direct quotes.



**Figure 1.** Older Irish women's experiences of aging and health-related issues: Retaining autonomy within a process of adaptation and continued engagement.

### Trustworthiness, Rigor, and Reflexivity

In the VS "... an attempt must be made to build into the research process a continuing effort of questioning and critically assessing the quality of collecting, analysing, and presenting the data" (Halldórsdóttir, 2000, p. 71). This implies that if the procedures (Table 1) are well followed then rigor will have been maintained. Each step of each stage of the VS was meticulously followed. A reflective journal was kept to track each step but more importantly facilitated a "... questioning and (critical assessment) ..." of the steps taken. The process of writing this journal was guided by the cyclical process of silence, reflection, identification, selection, interpretation, construction, and verification (Halldórsdóttir, 2000). Critical reflection on each stage and in particular during analysis assisted in the management of any assumptions and preconceptions, and prevented misinterpretation of the data. Extensive quotations are included in the write-up of the findings to allow readers to judge for themselves the trustworthiness and adequacy of the analysis.

### Results

The essential meaning of the coresearchers' experiences was found to be "retaining autonomy within a process of adaptation and continued engagement" (Figure 1). This overarching theme was derived from four themes (Table 3). The findings, derived from the perspectives and experiences of the coresearchers, are informed by the unique combination of the aging process, health and ill health status all within the context of being a woman. The issue of gender is threaded through the findings and while not overtly named by the coresearchers is fundamental to their experience. This is explored further in the discussion. The findings are presented under each theme.

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

The importance coresearchers placed on *having control and being independent* is evidenced by how much they valued their independence and their fierce determination to retain the right to choose what they wanted to do and how they wanted to live their lives. This was demonstrated in various ways including being self-reliant, making one's own decisions, and being able to come and go as they pleased,

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

Being independent involved balancing risk taking and safety; many pushed themselves to do what they wanted even in the face of incapacity and increasing health problems. However, wanting to be autonomous was tempered by the knowledge that there were factors, which can erode independence, including fear that their personal autonomy could be taken from them as they aged. Rosy feared that her family might "put" her in a nursing home against her wishes,

They might put me into a nursing home. I wouldn't fancy going into a nursing home. . . .

Many coresearchers were reluctant to ask for help as they felt this suggested that they were no longer able to cope. Éilis spoke about how she gradually came to recognize that she needed to accept help to care for her husband.

I did get help after I gave in to it. . . . I thought I should be able to do it [alone]

Several *external influences* affected coresearchers' independence and choices including financial, personal, and home security and safety. In contrast to older men, many older women in Ireland have little or no work-related pensions as many worked in the home and/or had to resign their jobs when they married due to a marriage bar (until 1973), which precluded married women from public servant jobs. Even for those who worked in family businesses, their spouse was the designated main earner and the women were identified as relatives assisting and not eligible to claim a contributory pension. These factors have had an adverse effect on older women's finances. Financial security undoubtedly made it easier for some of the women to live independently, not least because it made possible for them to access additional services to support their independence. However, the economic recession caused coresearchers to worry that their benefits would be reduced or removed. Those with private health insurance continued to pay the scheme because they considered it essential if they want to stay healthy and have early access.

**Table 3.** Themes and Subthemes of “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
Subthemes	(1) Having control and being independent (2) External influences on well-being	(1) Living with the negatives 2) Slowing down 3) Adapting to a changing world	(1) Maintaining relationships (2) Making the effort to engage and stay engaged	(1) Being healthy (2) Staying healthy

I bought insurance . . . my priority in life is to keep healthy, I think that's a [personal] responsibility. (Niamh)

Feeling safe and secure positively influenced how coresearchers felt. They took action to maintain their independence, for example, being careful, using handrails and walking canes to prevent falling, and planned how to contact someone if they did fall. Some emphasized the importance of having monitored personal alarm systems (PAS) as Michelle explained,

I fell . . . I was there for two days . . . they had to break in the door . . . I was just cold as ice . . . I'm always frightened . . . I'm very careful. I have my panic button.

### Theme 2: Navigating a Changing World

For many, age and aging had negative connotations, believing it adversely affected their health. It was a difficult phase of life as they felt sad about what they were losing or could no longer do. Coresearchers also spoke of not feeling valued, believing that there is a general negative or even ageist societal attitude toward aging older women.

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

Others also believed that age limited their opportunities to take care of their health, for example, in Ireland cervical screening ceases at 64 years and breast cancer screening at 69 years.

. . . from sixty five onwards we're dumped. . . [they] forget about us but that's not right. . . they should bring in something that's specifically for older people . . . 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. (Noirin)

Aging was linked with declining health and all hoped for a quick death. They feared having debilitating conditions, being incapacitated, and needing extensive help and care. None of them wanted to have to go to a nursing home or be a burden on their families.

I wouldn't like to be lingering on . . . and everyone tending to me. I'd hate that. . . (Winifred)

However, *Slowing down* captured both negative and positive aspects of coresearchers' experiences. They became aware of taking longer to recover from physical activity with less energy reserves to draw on. They adapted to this by pacing themselves. The view that “everything is down to old age” was not unusual. They believed that as they aged, their health would be compromised and so had lower expectations about it. Many older women have co- and multimorbidities including this cohort. Coresearchers also reported that some health problems were attributed to the aging process by health care professionals. However, coresearchers sometimes failed to recognize new problems or an exacerbation of existing problems, putting their symptoms down to normal aging. Not all problems can or should be attributed to general decline and there may well be an underlying pathology or problem that requires investigation and treatment.

Growth and decline were juxtaposed in so far as coresearchers' health and abilities were declining, but there were also opportunities for personal development. They had less responsibilities and more freedom to relax and pursue personal interests. It was also a period of contemplation for many, enabling them to reflect on life, mortality, and God. The concept of personal development in conjunction with the aging process and development of health problems is captured by Niamh.

I have to deal with the awareness of my nearer closeness to decline and simultaneously my intellectual growth [which] appears to me . . . to be faster than it ever has been in my life.

Coresearchers were also *adapting* to physical and psychological changes including changed appearance, bereavement and loss, and new roles. Changes in physical appearance directly related to aging such as wrinkles, graying hair, body shape, and posture were psychologically difficult to deal with as they were a stark and obvious reminder of aging.

You're getting frailer and thinner. . . your pants are getting big. Your legs are getting smaller and the shoes are getting big. . . sometimes I just . . . cry. (Kelley)

Coresearchers had to adapt not only to the changes in their appearance, but also to functional ability. Adjustment was evident in how coresearchers had modified and adapted their homes in response to their



changing abilities and needs (e.g., PAS, handrails, visual aids). This was difficult as it reinforced for many, that they were no longer as able as they had been. However, they conceded that these were necessary and conversely the changes enabled them to be more autonomous. They also described how navigating and adapting to the environment beyond their home was mentally and physically challenging. Therefore, decisions on where they would go and what exercise they would take were based on their assessment of their ability to walk/drive safely, the level of difficulty of the activity, and the availability of public transport. In assessing their ability and weighing up the risks, they retained personal control.

In addition to physical adaptations, coresearchers also had to adjust to retirement, which was a major change. Work role status, camaraderie, and social interaction as well as the sense of purpose that employment afforded them had been beneficial. Suzanne was still adjusting several years later to her retirement from teaching.

I've lost my jizz . . . 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?, . . . my life was useless . . . I'm [was] no use to anyone." So that was a very tough year.

Finally, some coresearchers had new unanticipated roles of carer for their husbands. Being a carer within the context of personal aging, increased health problems and decreased functioning, which was challenging.

### Theme 3: Being Connected and Involved

*Maintaining relationships* was core to being connected and involved. Positive relationships with immediate family were important. A minority of the coresearchers had husbands/partners and they highlighted the companionship and support afforded by these relationships.

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

However, coresearchers were concerned about what would happen if either they or their husband/partner died or if they needed to be cared for.

Involvement in everyday family life provided further opportunities to stay connected. There was reciprocity within these relationships, for example, Úna provided child care for her grandchildren and also meals for her sons, but felt there was mutual benefit for herself and her family. She developed a relationship with her grandchildren while helping her daughter with child minding. Cooking for family encouraged her to eat a balanced diet, which she might otherwise have foregone.

I've two of them coming to me for their dinner every day. . . if they weren't coming . . . I don't think I'd bother. . .

Furthermore, some had arrangements with neighbors to be taken to run errands and shopping. There was a mutual benefit to this as coresearchers often "kept an eye" on their neighbor's house when they were away. Many enjoyed socializing with friends and involvement in community groups, enabling coresearchers to stay connected with their local communities. In addition, the presence of God and religion in their lives was crucially important to many coresearchers and helped sustain them. Faith and participation in church services were very important for their emotional well-being and was part of the fabric of their everyday lives.

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

Central to being connected and involved was *making the effort to engage and stay engaged*. Coresearchers had different reasons for staying engaged such as wanting to avoid getting in the habit of staying home all the time, wanting to experience new activities, wanting to remain positive and/or active, having family responsibilities, which necessitated staying engaged, and wanting to combat loneliness. Loneliness had a negative impact on well-being as Kelley (a widow of several years who lived alone) explained,

. . . your family can't [always] be here with you . . . once the darkness comes you're all alone. . . the phone wouldn't even ring. Lonesome, very lonesome. . .

Coresearchers combated loneliness by making efforts to socialize and occupying themselves by watching television or having hobbies. Éilis explained the importance of this.

I was determined I was going to get out . . . I had seen it with my husband. He gave up . . . he didn't want to go out anywhere and was sitting there . . . gazing at the television.

Sometimes it was hard to make the effort but they felt it important to try,

. . . you have to keep pushing. . . be determined. You have to make the effort . . . [its] not easy to do that. (Siobhán)

### Theme 4: Trying to Stay Well

Coresearchers offered personal and differing definitions of *being healthy*, such as 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. There was no one definition, illustrating that its meaning is difficult to articulate and indicative of the different interpretations and meanings people ascribe to being healthy. Coresearchers defined being healthy from their personal frame of reference within their individual

context of the aging process, increased dependency, abilities and presence of underlying chronic, and/or acute ill health. Regardless of the different emphases they placed on different areas, what is clear is that being healthy was feeling well within the context of their own individual situations.

*Staying healthy* captured coresearchers' experiences and views on what they should do to stay healthy. Preventive health care was important to ameliorate deterioration of existing problems and to avoid new illnesses or conditions. Strategies included being proactive, being active, eating well, and following advice. Coresearchers prioritized some activities over others, this was influenced by individual health beliefs as to the level of importance of certain practices to overall well-being, belief in the efficacy and/or effectiveness of certain actions, motivation and personal belief in what they felt they could/ could not achieve. 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. (Noirín)

Many coresearchers tried to preempt the development of problems by having regular GP check-ups and also sought advice from day care centers, pharmacists, and health centers depending on what the problem was. Most coresearchers' initial point of contact with the health care services was through their GPs who referred them as necessary to other service providers. Having a good relationship with health care professionals was seen as important in health care maintenance. Core aspects of a positive relationship included trust, respect, humor, confidence, time, feeling attended to, feeling at ease, and valued as well as familiarity with patients' medical histories. 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.

To summarize, the coresearchers' experiences are more than the sum of different aspects of the experience and the findings provide a holistic view of the meaning of the women's experiences. The coresearchers did not separate the experience of aging from gender, health issues, and the management of ill health viewing them as inextricably linked within their experience. Older women had a strong desire and determination to retain autonomy and continue to be the decision maker in their own lives. The desire to be autonomous required them to adapt to aging and to their changing health status to continue to engage with life on their terms. Their experiences were influenced not only by physical factors but also by social, psychological, political, and economic factors, which combined to affect their decision making and ability to retain autonomy, adapt, and remain engaged.

## Discussion

Gender was found to shape older women's experience of aging, health, and ill health. Three factors were found to be at central to their experience, that is, autonomy and control, proactivity and adaptability, and staying engaged with life.

Autonomy means having free will, being independent, and having the right to self-determination (Welford, Murphy, Wallace, & Casey, 2010). Integral to the concept of autonomy is being in control of one's own life (Welford et al., 2010). Consequently, retaining autonomy does not preclude an individual from accepting support (Berthelsen & Frederiksen, 2014). However, many coresearchers found it difficult to adapt to receiving rather than providing support. The desire to be self-reliant and independent was very much embedded in these coresearchers' psyche, and this had an impact on whether they asked for help or support, for example, Eilis not wanting to ask for help in caring for her husband (referred to above) They resisted ceding control, fearing it could lead to their personal control being subverted. This is a legitimate concern, as it is known that, in comparison with older men, older women's sense of personal control declines as they age (Ross & Mirowsky, 2002). Ross and Mirowsky (2002) identify several factors that account for some of the age-based effect of gender on perceived control: education, personal employment history, household income, and physical functioning. Specifically, the coresearchers feared that their independence could be eroded by ill health and/or a diminution of their personal control by others, as exemplified by Rosie who worried that her family would be able to put her in a nursing home despite her not wanting this. They protected their right to self-determination and resisted unwanted intervention by either family and/or health care professionals. For example, Agnes was proud of being headstrong and doing what she wants to do regardless of whether her family agrees or not. In tune with the findings of others, their acceptance of help and support was nuanced and conditional on the type of help being offered (Allen & Wiles, 2013; Foster & Neville, 2010; Hedberg, Brulin, & Aléx, 2009; Song & Kong, 2015). This thinking is reflective of how older women understand autonomy, that is, a trade-off involving making pragmatic choices to maintain independence and remain autonomous. These choices sometimes involved accepting help (including accepting that help is needed), but what mattered was that they dictated the form this help took. This is an important consideration for health care professionals. They need to understand, respect, and support older women's right to self-determination if they are to offer the right help in the right way.

Consistent with the findings of others (Quéniart & Charpentier, 2012), this study found older women work to retain autonomy as illustrated by making proactive decisions about lifestyle, housing and health maintenance (includes but not limited to diet, exercise, weight

control, health checks, making house renovations, having home security and personal alarms). This study demonstrates how being pragmatic was important to having peace of mind. Pragmatism enabled the coresearchers to adapt but also to seize opportunities for enjoyment. The coresearchers did not like growing older but key to being content was acceptance, adaptation, and having a positive approach to life. Having a positive attitude enabled coresearchers accept and adapt in a proactive and pragmatic way to change and is similar to Wurm and Benyamini (2014) contention that the concept of realistic optimism facilitates effective coping. Being proactive was emphasized by coresearchers as helping them adapt by taking personal responsibility in managing age- and health-related problems. They also identified ways (e.g., pacing) in which they responded to decreased functional abilities, decreased energy levels, and adverse effects of underlying medical conditions. Knowing one's own body enables older women to evaluate their health status (Roberto & 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, p. 39) but not all of the coresearchers were aware of this information or knew how to access it. The challenge, therefore, is how to help older women know what questions to ask as well as how to easily access information. This study found that opportunities for health assessment and health promotion were missed insofar as there tends not to be a proactive approach to older women's health care needs. Typically, they were treated for an illness or condition as opposed to having regular health-focused assessments or being involved in health promotion programs. Therefore, health care professionals should provide comprehensive health assessment and health care management plan that informs and educates, enabling older women to preempt the development of problems, maximize their intrinsic capacity, and strengthen their functional ability.

The findings also confirm 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 challenge it (e.g., paternal, negative and at times ageist attitudes, negative relationships with health care professionals). Negative views of aging can be internalized by older women (Clarke, Griffin, & Maliha, 2009; Clarke, Griffin, & PACC Research Team, 2008; Holstein, 2015). The coresearchers found bodily changes difficult to accept, in particular, changing physical shape and appearance (e.g., gray hair, wrinkles, skin, posture, weight gain/loss, sight & hearing problems and conditions such as leg ulcers, arthritis, and osteoporosis). These obvious signs of aging were unwelcome. Coresearchers described wearing shoes and

clothes, which were comfortable rather than fashionable. In a way, this reinforced the concept that older women's appearance does not matter (Clarke & Bennett, 2013; Winterich, 2007). Adapting and accepting this new and different physical form challenged many in how they saw themselves physically as women. However, many coresearchers still felt it is important to look well and made efforts to do this. For some, it was through makeup, hair dye, clothes, and losing weight; which could be argued as being in line with societal views of valuing youth over age particularly in relation to women (Winterich, 2007) or that older women want to look well for their own pleasure (Paulson & Willig, 2008) or indeed likely that it is a combination of both. However, aging 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. Linked with this was how they felt about having to adapt to their environment and adapt their environment to accommodate aging and health-related change. According to Sixsmith et al. (2014, p. 8) "home is gendered space" and for older women it symbolizes their central role in family life. Within this study, home modifications brought into sharp focus how the role and capabilities of coresearchers were very changed from when they were younger and were for example, a mother of young children, homemaker, partner, or carer and the "glue," which kept the family together. These modifications symbolized their transition to older age, whereby old age encapsulated a changed meaning of coresearchers' sense of self, not least within the context of being a woman from the perspectives of changes in mothering, caring, loving, and nurturing roles. To promote positive and healthy aging of other women, efforts to change societal attitudes need to be increased further. 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, p. 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. Therefore, health and social care professionals need to familiarize themselves with and implement gender-sensitive policy with their practice.

A third important findings was how the coresearchers' desire and efforts to remain engaged and connected with life were integral to their health and well-being as they aged. This included their relationships with family, friends, communities, God, but also the importance they placed on personal development and personal interests. The data confirmed the importance for many women of their relationship with God (Hedberg et al., 2015; Pudrovska, 2015), but adds a further dimension as 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. Teachings, rituals, and practices associated with their religious beliefs provided them with an order and code for living, which they found reassuring. Many derived satisfaction and peace of mind from their beliefs as well as feeling energized by attending religious services. Recognition of this positive impact on their well-being and health is important.

The findings indicate that female gender roles of nurture and caring were maintained but had changed from the perspective of both who was being cared for and the coresearchers themselves. Research by Flynn and Mulcahy (2013) and Rowbotham, Carroll, and Cuskelly (2011) identify that carers experience a range of emotional problems and coresearchers in the current study particularly worried about and felt responsible for their husband/children. Thus, within the context of all parties aging and having different needs, the dynamics of these relationships were changing and need to be recognized at local and national level. For example, older women (who are aging and experiencing health problems) providing care to adult children and/or spouses require practical and emotional support including respite, home help, equipment and financial help. What is perhaps underestimated is the extent of older women's contribution to society they deserve support for the work that they do.

This study confirms the importance of being connected with neighbors and local community. Social connectedness for older people can generate feelings of belonging and solidarity (Gallagher, 2012) and Ashida and Heaney (2008) identify a positive association between health status and social connectedness in older people. Participation in social groups has been associated with improved physical and mental health (Ní Léime & O'Shea, 2010), well-being (Koutsogeorgou et al., 2014) and reduced social isolation (Radina, 2008). Most coresearchers were long-term residents of their communities, and familiarity with, and attachment to these was evident. The sense of belonging in one's own community cannot be underestimated and supporting older people to live in their own communities is a core aspect of most Governments' policy, which is welcome.

Barriers to participation included low income, ill health and, aging-related difficulties. Participation can be facilitated by having physically accessible environments and transport (Older and Bolder, 2009) as well as having appropriate support personnel and equipment. Ní Léime et al. (2015) highlights that older women have low levels of private pensions and two thirds are in receipt of the state pension. Thus, limited increases in the pension (Budget, 2015), together with increased living costs and reductions in some benefits meant some women could not fully participate because of lack of money. The challenge for service providers is to continue to support older women to become and/or remain engaged. This presents a fiscal challenge for

Governments in view of continued economic difficulties and increasing aging populations (Cuevas, Karpowicz, Mulas Granados, & Soto, 2017; Department of Health, Ireland, 2013; Nerlich, 2018). Furthermore, these initiatives have a generic approach to older people with little in the way of specifically addressing gender differences and needs, so consideration on how best to support older women must be considered within the context of their bio-psycho-social, cultural, and economic needs.

### *Limitations*

The older women who participated in this study have different life experiences, not least in terms of their different ages, living arrangements, employment histories, and marital status. Nevertheless, they share similar experiences and concerns about their aging and health, many of which mirror issues raised in the literature, suggesting that these experiences are not limited to Irish women only. Halldórsdóttir cautions that the results of VS are not generalizable (Sigurgeirsdóttir & Halldórsdóttir, 2008), emphasizing that each person's experience is unique, and the same holds true for this study. Clearly the experiences of women who chose not to volunteer are not captured and it may well be that these women have very different experiences. To offset this possibility, the sampling strategy was planned to capture a wide and differing range of experiences, for example, coresearchers were deliberately recruited through routes other than those who attended health care services. Furthermore, 40 interviews (dialogues) with 23 women is a large data set in context of a qualitative study. Given the breadth and richness of the data collected, these findings offer an important insight into the older women's experience of aging and health.

### **Conclusion**

This phenomenological research study provides a unique, rich, and in-depth view of older women experiences of aging and health, ill health, and health needs. The overarching theme "retaining autonomy through a process of adaptation and continued engagement" captures the essential meaning of their experiences. This illustrates the women's determination to remain independent and in control of their lives as they age. It also reflects their acceptance of the need to adapt to the aging process and their changing health needs within the context of remaining engaged with life through personal interests and relationships with some or all of the following: God, family, friends, community, and health service providers. The findings demonstrate that women's experiences are more than the sum of different aspects of their experience rather they provide a holistic view of the meaning of the women's experiences. Crucially, it shines a light on the intersection between



aging, health, and gender. These are interlinked and none should be looked at in isolation, as each have an impact on the other. These findings add to the body of knowledge on older women's experiences and should be considered when planning and developing services for older women.

### Acknowledgments

The authors are indebted to the women who participated in this study and who gave so generously of their time.

### Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

### Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: D.T. thanks the University of Limerick who generously funded a PhD scholarship supporting this research.

### ORCID iD

Dympna Tuohy  <https://orcid.org/0000-0001-6240-0315>

### References

- Allen, R. E. S., & Wiles, J. L. (2013). Receiving support when older: What makes it ok? *The Gerontologist*, *52*, 670-682.
- Annandale, E. (2009). *Women's health and social change*. London, England: Routledge.
- Ashida, S., & Heaney, C. A. (2008). Differential associations of social support and social connectedness with structural features of social networks and the health status of older adults. *Journal of Aging and Health*, *20*, 872-893.
- Berthelsen, C. B., & Frederiksen, K. (2014). Safeguarding self-governance: A grounded theory of older patients' pattern of behavior in relation to their relatives in fast-track programme. *Grounded Theory Review*, *13*(2), 30-42.
- Budget. (2015). Retrieved from <http://www.budget.gov.ie/Budgets/2015/2015.aspx>
- Byles, J., Dobson, A., Pachana, N., Tooth, L., Loxton, D., Berecki, J., . . . Powers, J. (2010). *Women, health and ageing: Findings from the Australian Longitudinal Study on Women's Health*. Canberra: Australian Government Department of Health and Ageing.
- Clarke, L. H., & Bennett, S. (2013). You learn to live with all the things that are wrong with you: Gender and the experience of multiple chronic conditions in later life. *Ageing & Society*, *33*, 343-360.
- Clarke, L. H., Griffin, M., & Maliha, K. (2009). Bat wings, bunions, and turkey wattles: Body transgressions and older women's strategic clothing choices. *Ageing & Society*, *29*, 709-726.
- Clarke, L. H., Griffin, M., & PACC Research Team. (2008). Failing bodies: Body image and multiple chronic conditions in later life. *Qualitative Health Research*, *18*, 1084-1095.
- Crawley, M. (2008). *The way we are, facts about older women in Ireland in 2008*. Dublin, Ireland: Older Women's Network.
- Cuevas, A., Karpowicz, I., Mulas Granados, C., & Soto, M. (2017). *Fiscal challenges of population ageing in Brazil*. Washington, DC: International Monetary Fund.
- Davidson, P. M., DiGiacomo, M., & McGrath, S. (2011). The feminization of aging: How will this impact on health outcomes and services? *Health Care for Women International*, *32*, 1031-1045.
- Department of Health, Ireland. (2013). *The national positive ageing strategy*. Dublin, Ireland: Stationery Office.
- European Commission. (2014). *Population ageing in Europe: Facts, implications and policies*. Brussels, UK: Author.
- European Parliament. (2017). *Empowering women in the EU and beyond: Economic and financial resources*. Retrieved from [http://www.europarl.europa.eu/RegData/etudes/BRIE/2017/599306/EPRS\\_BRI\(2017\)599306\\_EN.pdf](http://www.europarl.europa.eu/RegData/etudes/BRIE/2017/599306/EPRS_BRI(2017)599306_EN.pdf)
- Flynn, R., & Mulcahy, H. (2013). Early-onset dementia: The impact on family care-givers. *British Journal of Community Nursing*, *18*, 598-606.
- Foster, P., & Neville, S. (2010). Women over the age of 85 years who live alone: A descriptive study. *Nursing Praxis in New Zealand*, *26*(1), 4-13.
- Gallagher, C. M. (2012). Connectedness in the lives of older people in Ireland. *Irish Journal of Sociology*, *20*, 84-102.
- Halldórsdóttir, S. (2000). The Vancouver school of doing phenomenology. In B. Fridlund & C. Hildingh (Eds.), *Qualitative methods in service of health* (pp. 47-81). Lund, Sweden: Studentlitteratur.
- Hedberg, P., Brulin, C., & Aléx, L. (2009). Experiences of purpose in life when becoming and being a very old woman. *Journal of Women & Aging*, *21*, 125-137.
- Holstein, M. (2015). *Women in late life: Critical perspectives on gender and age (diversity and aging)*. London, England: Rowman & Littlefield.
- Hurst, G., Wilson, P. M., & Dickinson, A. (2013). Older people: How do they find out about their health? A pilot study. *British Journal of Community Nursing*, *18*, 34-39.
- Koutsogeorgou, E., Davies, J. K., Aranda, K., Zissi, A., Chatzik, M., Cerniau, M., . . . Leonardi, M. (2014). Healthy and active ageing: Social capital in health promotion. *Health Education Journal*, *73*, 627-641.
- Nerlich, C. (2018). *The 2018 ageing report: Population ageing poses tough fiscal challenges* (European Central Bank Economic Bulletin 4/2018). Retrieved from [https://www.ecb.europa.eu/pub/economic-bulletin/focus/2018/html/ecb.ebbox201804\\_04.en.html](https://www.ecb.europa.eu/pub/economic-bulletin/focus/2018/html/ecb.ebbox201804_04.en.html)
- Ní Léime, Á., Duvvury, N., & Callan, A. (2015). Pension: Gender, ageing and work in austerity. In K. Walsh, G. M. Carbney, & A. Ní Léime (Eds.), *Ageing through austerity: Critical perspectives from Ireland* (pp. 63-78). Bristol, UK: Policy Press.
- Ní Léime, Á., & O'Shea, E. (2010). *Well into older age: Age & opportunity and the evidence*. Dublin, Ireland: Age & Opportunity.
- Older and Bolder. (2009). *What does positive ageing mean to older people?* Dublin, Ireland: Author.
- O'Reilly, M., Parker, N., & Hutchby, I. (2011). Ongoing processes of managing consent: The empirical ethics of using video-recording in clinical practice and research. *Clinical Ethics*, *6*, 179-185.
- Paulson, S., & Willig, C. (2008). Older women and everyday talk about the ageing body. *Journal of Health Psychology*, *13*, 106-120.

- Pudrovska, T. (2015). Gender and health control beliefs among middle-aged and older adults. *Journal of Aging and Health, 27*, 284-303.
- Quéniart, A., & Charpentier, M. (2012). Older women and their representations of old age: A qualitative analysis. *Ageing & Society, 32*, 983-1007.
- Radina, M. E. (2008). When I am an old woman, I shall wear purple. *Journal of Women & Aging, 20*, 99-114.
- Roberto, K. A., & McCann, B. R. (2011). Everyday health and identity management among older women with chronic health conditions. *Journal of Aging Studies, 25*, 94-100.
- Ross, C. E., & Mirowsky, J. (2002). Age and the gender gap in the sense of personal control. *Social Psychology Quarterly, 65*, 125-145.
- Rowbotham, M., Carroll, A., & Cuskelly, M. (2011). Mothers' and fathers' roles in caring for an adult child with an intellectual disability. *International Journal of Disability, Development and Education, 58*, 223-240.
- Sigurgeirsdottir, J., & Halldorsdottir, S. (2008). Existential struggle and self-reported needs of patients in rehabilitation. *Journal of Advanced Nursing, 61*, 384-392.
- Sixsmith, J., Sixsmith, A., Fange, M. A., Naumann, D., Kucsera, C., Tomsone, S., . . . Woolrych, R. (2014). Healthy ageing and home: The perspectives of very old people in five European countries. *Social Science & Medicine, 106*, 1-9.
- Song, M., & Kong, E.-H. (2015). Older adults' definitions of health: A metasynthesis. *International Journal of Nursing Studies, 52*, 1097-1106.
- United Nations, Department of Economic and Social Affairs. (2017). *World population ageing 2017 highlights*. New York, NY: United Nations.
- Welford, C., Murphy, K., Wallace, M., & Casey, D. (2010). A concept analysis of autonomy for older people in residential care. *Journal of Clinical Nursing, 19*, 1226-1235.
- Winterich, J. K. (2007). Aging, femininity, and the body: What appearance changes mean to women with age. *Gender Issues, 24*, 51-69.
- World Health Organization. (2002). *Active ageing: A policy framework*. Geneva, Switzerland: Author.
- World Health Organization. (2007). *Women, ageing and health: A framework for action*. Geneva, Switzerland: Author.
- Wurm, S., & Benyamini, Y. (2014). Optimism buffers the detrimental effect of negative self-perceptions of ageing on physical and mental health. *Psychology & Health, 29*, 832-848.