

REFERENCE:

- Roy, D. E., & Giddings, L. S. (2011, online early). The experiences of women (65-74 years) living with a long-term condition in the shadow of ageing. *Journal of Advanced Nursing*. doi:10.1111/j.1365-2648.2011.05830.x
- Roy, D. E., & Giddings, L. S. (2012). The experiences of women (65–74 years) living with a long-term condition in the shadow of ageing. *Journal of Advanced Nursing*, 68(1), 181-190. doi:10.1111/j.1365-2648.2011.05830.x

TITLE

The experiences of women (65-74 years) living with a long-term condition in the shadow of ageing

ABSTRACT

Aims. This paper reports on a study that explored experiences of women (65-74 years) as they grow older while living with a long-term condition. The phenomenon of focus was ‘ageing with a long-term condition’, rather than the experience of developing a long-term condition after reaching older adulthood.

Background. People with long-term conditions are living into older age. There is limited literature on the nexus of ageing with a long-term condition. It is known that ageing shapes and is shaped by women’s experiences of living with a long-term condition.

Methods. In this interpretive descriptive study, nine women participated in a series of three focus groups held in 2007 and 2008. Transcripts were analysed thematically and participants given the opportunity to respond to the analysis.

Findings. ‘In the shadow of ageing’ was the overarching theme. The women reported that although their long-term condition remained the referent point in their daily lives, for others including health professionals, the focus was on their appearance and the effects of older age. To overcome the back-grounding of their long-term condition, the women used ‘strategies already-in-place’; it became ‘just another thing to deal with’. Ageing, however, remained ‘a privilege’.

Conclusion. If health professionals focus on age and its concomitant effects, rather than a woman’s long-term condition, they are at risk of delivering inappropriate care. They need to be prepared to advocate for the special needs of older women who live with a long-term condition, and remain cognisant of the women’s resourcefulness and expertise developed over time.

SUMMARY STATEMENT

What is already known about this topic

- People in many countries are living longer and are more likely to age-with or develop long-term conditions.
- Ageing shapes and is shaped by women's experience of living with a long-term condition.
- A person's experience of living with a long-term condition foreshadows the ageing process.

What this paper adds

- The condition remains the referent point for women as they age with a long-term condition while others, including health professionals, often foreground and privilege age.
- Women with a long-term condition in the age group 65-74 years are less likely to feel as socially isolated as when they were younger.
- Ageing with a long-term condition is different from living with a condition that develops when one is older.

Implications for practice

- Nurses need to be alert to the possibility that a person's long-term condition may inadvertently be overshadowed by age-related assumptions.
- The age of onset and length of time since diagnosis of a long-term condition should be ascertained as part of a comprehensive and contextual nursing assessment of women living with long-term conditions.
- Nursing care should complement clients' already developed strategies and expertise in living with a long-term condition.

Key Words

Long-term conditions, chronic illness, primary health care, interpretive description, women's health, ageing, nursing

INTRODUCTION

Globally there is an awareness of the increasing burden of long-term conditions as populations age (World Health Organisation 2005). Many people with existing long-term conditions are living longer as a result of changing management strategies and improved access to health services. Planning for and living into older age is now more common-place. In this paper we report the findings of an interpretive descriptive study that explored the topic of women ageing with long-term conditions in Aotearoa New Zealand. The phenomenon of focus is 'ageing with a long-term condition' and not the experience of being diagnosed after reaching older adulthood. For the purposes of the study, we defined 'ageing' as the process of getting older, incorporating biological, physiological, social, cultural and economic changes. We use the term 'long-term condition' rather than chronic illness or chronic condition to describe any on-going, long-term or recurring condition that can have a significant impact on a person's life (Ministry of Health 2008).

Background

Research since the 1980s has highlighted the physical, social and psychological effects for women living with a long-term condition (Sexton and Munro 1988, Thorne 1990, Bendtsen and Hornquist 1994, Schaefer 1995). A meta-study by Thorne and Patterson (1998) which analysed 158 qualitative studies of chronic illness from 1980-1996, showed a shift in focus from 'loss and burden' to transformative interpretations of the experience of living with a long-term condition. Studies since the late 1990s have highlighted the multifaceted complexity of women's experiences, which can be both burdensome and transformative (see for example Koch et al. 1999, Koch et al. 2002, Cudney et al. 2002, Sullivan et al. 2003, Kralik et al. 2005, Winters et al. 2006, Shawler and Logsdon 2008, Roy, 2001).

There are significant bodies of literature on the physical, social and psychological effects of ageing (Touhy 2008) and on long-term conditions in older age (Harvey and Silverman 2007, Harvey 2008, Warren-Findlow and Prohaska 2008, Warwick et al. 2010). Recent attention has been given to the nexus between ageing and living with a long-term condition (Giddings et al. 2007, Harrison et al. 2010, Shawler and Logsdon 2008, Goodwin and Compton 2004, Shearer 2009). Whether women ageing with a long-term condition or disability were in a young age group (22-37 years) (Goodwin and Compton 2004) or older (50-65 years) (Giddings et al. 2007) they recognise the importance of self-care. Motivation for their vigilance was primarily the prevention of co-morbidities that could further challenge their independence. Knowing how to navigate the healthcare system was important in maintaining health-promoting lifestyles (Giddings et al. 2007, Harrison et al. 2010). Participants in Goodwin and Compton's (2004) and Giddings et al.'s (2007) studies also described the self-perception of being older than their chronological years. They knew 'older age' having already confronted some of the physical, emotional, cognitive and social changes usually associated with getting older.

The focus on the nexus between ageing and living with a long-term condition is continued in this study where we explore the experience of older women (65-74 years) as they age with a long-term condition. By studying women within bounded age groups the age related contextual factors are more effectively highlighted (Giddings et al. 2007).

THE STUDY

Aim

The aim of the study was to explore the experiences of women aged 65 to 74 years as they grow older while living with a long-term condition.

Design/Methodology

Protocols developed by Giddings et al. (2007) based on an interpretive methodology (Thorne 2008, Thorne et al. 1997, Thorne et al. 2004) guided the study. The meanings of ageing with a long-term condition were co-created by the women in this study through the telling of their stories and were interpreted by us.

Participants

Nine women aged between 65 and 74 years, who self-identified as living with a long-term condition, were recruited into this study using purposive sampling strategies. The women had lived with their primary long-term condition for four to 33 years. These included, singularly or in combination, rheumatoid arthritis, osteoarthritis, diabetes, multiple sclerosis (MS), respiratory disorders, and cardiac conditions (Table 1). Participants either responded to advertising brochures available through local support networks or were contacted through snowball sampling. Their attendance at the focus groups often involved careful strategising, planning and energy expenditure. The size of the focus group (n=9) provided an optimal number for sharing personal insights and observations of the phenomenon (Krueger and Casey 2000).

Data collection

A three-focus group series (Giddings et al. 2007) was carried out between June 2007 and April 2008. Interaction triggered women's memories, opened up discussion (Webb and Kevern 2001) and ensured in-depth descriptions of their experience (Krueger and Casey 2000) (Table 2). Focus groups were conducted in a private room in an educational institution in Aotearoa New Zealand. Seating arrangements were made to accommodate each woman's needs, including wheelchair access. A rectangular table enabled visual contact and observation of non-verbal communication. The focus groups were co-facilitated by the researchers (x2).

The first focus group (120 minutes) established rapport between the women and the researchers; agreement of ground rules (e.g. confidentiality issues); and group processes. General questions guided the discussion. These included: What are your thoughts about being your age and living with a long term condition? Do you have particular concerns about ageing and living with a long term condition? The second focus group (135 minutes), held two months later, explored some of the issues raised during the first. These included decreasing social isolation and maintaining control of their lives. One woman who could not attend this focus group discussed the issues later in an individual interview (40 minutes).

The third focus group (120 minutes), held eight months later, enabled the group to explore and give validity to our preliminary findings. The women expanded on their stories previously told, which both challenged and added richness and robustness to our understanding and interpretation. They were delighted to catch up with one another and update us and each other on their recent experiences. The women's commitment to the group and the study was evident in the stories two women told

about the challenges and difficulties they had to overcome to attend the group that day.

Ethical considerations

The study was approved by our institutions' research ethics committees. Informed consent was obtained from all study participants at their first focus group. They were reminded at the beginning of subsequent groups of the agreed ground rules regarding confidentiality, right to withdraw and the availability of counselling services if needed (no participant requested this service). The transcriptionist signed a confidentiality agreement.

Data analysis and Rigour

The focus group digital recordings (x3) and individual interview were fully transcribed. Following previously developed analytical processes (Giddings et al. 2007) a broad interpretive analysis of data was completed after the first group to inform discussion for the second. To maintain rigour, the first analytical findings were then put aside. The combined data from the first two focus groups and individual interview were then analysed using thematic interpretive processes (Thorne 2008, Thorne et al. 1997). The guiding questions were, 'What is happening here?' and 'What is this telling us about ageing with a long-term condition?' We engaged in a dialectic between the data and the developing theoretical concepts, resisting early conceptualization into broad themes or recourse to themes identified in our earlier study (Giddings et al. 2007). Conceptual themes vied for prominence. For example, themes of 'not out of the ordinary' and 'a privilege to grow older' were at some stage sub-themes of each other (Table 3). The third focus group and subsequent analysis helped clarify these relationships. At this point we also asked, 'How are these women's experiences similar to or different from those of the women in our previous study?' (Giddings et al. 2007). This comparative analysis between age groups increased our understanding of the influence of changing contexts that come through ageing with a long-term condition.

The analytical processes as they progressed clarified an issue that had been somewhat troubling us since the first focus group. Two of the women who reported a recent diagnosis (< 5 years) of a primary long-term condition (coronary heart disease and Type 2 diabetes) at the age of 70 years told subtly different stories from the other participants (n=7) who had been diagnosed prior to 55 years of age. These differences came to be integral in framing our interpretation; they acted as 'negative cases' within the analysis process (Brodsky 2008). These not only strengthened our findings but also contributed to the rigour of our research in challenging our assumptions concerning the outcomes.

We also checked our processes and analyses with an experienced interpretive researcher and clinician. The feedback affirmed the robustness of our approach and opened our interpretation to further critique. Several constructs were renegotiated and repositioned. This "thoughtful clinician test" (Thorne et al. 2004, p.17) supported the credibility of our interpretation. Our processes and reflexive account provide the information necessary for evaluation of the plausibility (rigour) of the findings (Koch and Harrington 1998).

FINDINGS

The findings reflect the experiences of nine women (65-74 years) ageing with a long-term condition. The themes derived primarily from the experiences of seven of the women who were first diagnosed with a long-term condition prior to the age of 55 years. The experiences of the two women more recently diagnosed at 70 years of age, acted as ‘negative cases’ in the analysis; their stories illuminated the themes because of their contrasting nature.

‘In the shadow of ageing’ was the study’s overarching theme. In this age group the appearance and effects of older age have become more central than the long-term condition in the women’s interactions with others. For the women, however, their long-term condition remained the referent point in organising daily life, interpreting functioning and understanding their world. In many contexts their long-term condition became less visible as if shadowed by ageing. Becoming older was also ‘just another thing’ that the women needed to deal with; they had well developed strategies to use in response to the challenges associated with ageing. For the women it was a ‘privilege to grow older’; something many thought they might never experience.

In the shadow of ageing

The overarching theme, ‘in the shadow of ageing’, highlights the experiences of the women in the study as they live with the challenges of ageing with a long-term condition. In new encounters with others, including health professionals, the women reported that people often assumed their symptoms and limitations in function were related to their age and not their long-term condition. A poignant example was offered when the participants met for the third time (Focus Group 3). One of the women (68 years) with MS shared her recent experience of being admitted to hospital following complications of steroid therapy. From the time she was admitted she felt that people saw her as an ‘old woman’ and not as a person living with MS. She believed that the nursing staff not only saw her as older than her years, but also assumed she had “*had a stroke*”, a condition affecting many clients in that ward. These assumptions, she felt, negatively influenced the attitudes of her caregivers and the care she received:

The staff were marvellous but they didn’t know anything about MS. They thought that I’d had a stroke... You know, I quite understand why they thought that I’d had a stroke because a lot of the other patients had had them (FG3/2).

It was a few weeks until this woman felt strong enough to call on her personal support network to challenge these assumptions. She used strategies developed over the years of living with her long-term condition. With the help of friends she was able to take action that led to her eventual discharge home. For example, to assist in her mobilisation she asked a friend to bring in her electric wheelchair. The wheelchair symbolically then drew the attention of the nursing and other staff to the existence of her MS; shifting the focus of care.

The other participants were shocked by the woman’s story and expressed surprise. But in the ensuing conversation they came to the realisation that they too were experiencing their age as the trigger for some people’s reactions to their impairments. In such situations it was their age not their long-term condition that evoked response. Although the referent point for other people was often the women’s age, for the women it remained their long-term condition: “*when something happens, your first thought is ‘it is MS’*” (FG3/1).

Not out of the ordinary

The situation in which people assumed the women's impairments were part of getting older rather than something they had lived with for many years, fitted with their contention that amongst their peer group having "*something wrong*" was no longer an exception. They were no longer 'out of the ordinary': "*it's very rare for somebody our age not to have something wrong, or some problem*" (FG2/1).

All the women perceived themselves within their peer group as 'not out of the ordinary'. For seven of the women this contrasted with their earlier experiences in living with a long-term condition of 'standing out' and 'being different'. For example, they spoke of either reducing hours of paid employment or retiring "*years earlier*" than their friends due to physical demands of the long-term condition. One woman recalled with sadness of having to "*drop out of team sports*" and of not being able to dance, while at the same time working to conceal her MS from all but close family, as she did not want to stand out:

I used to play cricket and netball and then because of the lack of coordination, I was put into the reserves and eventually dropped altogether. But it was very easy to hide. ... I would have hated when my kids were at school for them to have had a sick mother, so I tried to take part in everything and hid it (FG3/2).

The women no longer felt 'out of place' as many of their peers were now being diagnosed with long term conditions such as diabetes and cardiovascular disease. Their friends and peers were now experiencing some of the physical and social limitations that these women had endured for many years. Friends and peers had 'caught up': "*There's the rare one who's got perfect health*" (FG2/1). Indeed, the stories of the two women (our 'negative cases') who had a more recent diagnosis of a long-term condition (<5 years) were examples of peers who had 'caught up'. They frequently asked questions of the other women and shared stories that indicated that they were only beginning to develop strategies for living with their condition.

Being 'not out of the ordinary' contributed to the context in which the women's long-term condition could be 'less visible': "*Everybody's got some little or big thing, so we get equalised*" (FG2/1). The women talked about how they had become more involved in peer group social activities that now more suited their physical abilities. For example, they were now able to meet regularly with friends for a walk and a coffee whereas previously they could not easily engage in vigorous social activities such as a game of tennis or a "*night out on the town*" (FG1/3). They agreed, however, that while things were becoming more equal, they still had to live with the limitations of their long-term condition; such as physical and mental fatigue, functional impairment, and the need for continual monitoring of symptoms for successful self management.

The women already knew what it was like to experience the physical, emotional, cognitive and social changes associated with getting older. For example, most of the women reported reduced energy levels and an inability to get through a full day without resting: "*My close friend, who is 84, is on the go for 16 hours a day. And I said, "You are so lucky. I sleep 10 hours a day, sometimes 11". I still wake up tired and I have to have a rest in the afternoon*" (FG3/9). As another woman reminded the

group, “*I think chronic illness speeds up ageing*” (FG3/2). Physically, the women will always be ‘older’ than their peers.

Just another thing to deal with

Although ageing had overshadowed their long term condition in some contexts, for the most part (with the exception of the ‘negative cases’) the women experienced ageing with a long term condition as ‘just another thing to deal with’. It appeared to be just another challenge among the many they already faced.

One of the challenges was the possible progression or exacerbation of their condition and/or an additional diagnosis. Five of the women reported developing other long-term conditions. A woman with a thirty three year history of rheumatoid arthritis had five years earlier developed bowel cancer and now lives with a colostomy: “*I’ve learnt how to live with it. It doesn’t stop me from doing anything and it’s just another thing I cope with*” (FG1/3). Another woman who had lived with asthma and bronchiectasis for more than twenty years had been diagnosed with rheumatoid arthritis eighteen months prior to the first focus group and with systemic lupus erythematosus between focus groups two and three. She too approached these new diagnoses and their impact as ‘just another thing to deal with’. Laughingly she said:

I’m the proud owner of another autoimmune disease since I was here last time. So the number’s gone up and up and up and the rheumatologist won’t treat me unless he contacts the respiratory specialist and the respiratory specialist says ‘I don’t dare give you any medication until I’ve confirmed with the rheumatologist’. And so it goes on (FG3/9).

When the women were faced with an additional diagnosis, such as cancer or rheumatoid arthritis, their previous experience had prepared them to better deal with the new situation. They already had strategies in place and knew the tricks; something the two women more recently diagnosed (‘negative cases’) were beginning to learn.

The women used ‘strategies already in place’ to navigate the new challenges of ageing with a long-term condition. For example, they had overtime ‘cultivated’ relationships with others who knew and recognised their different needs within particular contexts. Support was cultivated to enable everyday activities and to meet their health needs. Some examples:

I have selected shops that I go to ... I have cultivated shop assistants all over (FG3/4).

Well I think in the end I more or less discharged myself ... they discharged me and I just rang my taxi driver friend and I got home (FG3/2).

It’s important to cultivate the right group of health professionals, and that’s trial and error in a way isn’t it? You have to be selective ... but we can change - thank goodness for that (FG2/2).

The women also created personal support networks to assist them in their decision making and the everyday demands of living with a long-term condition. Networks were variable, but a number included knowledgeable friends, family and others in the community, such as the local pharmacist. For example, one woman acted on the advice of a friend who was a diabetes nurse specialist. Her friend recognised that she

was not receiving optimal care for her diabetes from the general practitioner (GP), and urged her to change: “*She kept saying to me, ‘change your GP, change your GP’*” (FG1/4). Other women talked of using their networks in similar ways:

The pharmacists, my goodness, they’re a fund of knowledge about a lot of things. I ring my pharmacist and say ‘is this okay?’ or ‘I’ve forgotten something’ and her response is always spot on [appropriate]; she’s really good (FG2/9).

The women ‘knew the tricks’ to ensure access to services in their everyday activities in living with a long-term condition. The ‘tricks’ involved knowing and using existing systems. For example, the women told stories of requesting special assistance at airports when travelling. As well as saving energy and avoiding fatigue, receiving this assistance meant airport processes (such as customs and immigration) were navigated very quickly:

I ask for a wheelchair and assistance at the time of booking. It makes life so much easier. You go past massive queues ... you can go straight through. They’re responsible for you until you leave that building so they will assist you through all the queues. They will even help you get your luggage; it’s a magic carpet (FG3/1).

The women knew the importance of ‘planning ahead’ and being informed. For example, a number reported checking out the accessibility of the venue prior to coming to the first focus group. One woman commented: “*I’m always very careful about planning*” (FG1/9). The women also knew ‘tricks’ to use when diagnosed with another condition. They adapted and modified strategies that had previously worked: “*I think I have just learnt as I’ve gone along*” (FG1/6). For example, they reported how they chose to access private health services to circumvent the waiting time in the public system when they deemed matters urgent: “*I decided if something wasn’t urgent I would go public, but if it was needed I would go private*” (FG1/9).

‘Becoming informed’ appeared now to be second nature to the women; they had become critical consumers of health information. They knew, for example, the “good and the not so good” websites and how to differentiate one from another. They knew the importance of harnessing the right resources, for example, finding the ‘right’ health professional for a given situation: “*I thought, ‘I’ve heard about Arthritis New Zealand and they must be able to help me’. So I looked in the phone book and I found an arthritis educator just ten minutes drive away; she’s been amazing*” (FG3/9).

Privilege to grow older

Ageing was not taken for granted. The women were aware that it was a privilege to grow older; some had thought they “*wouldn’t get this far*”. They reflected that they were “*still here*” in spite of their living with a long-term condition, while some of their family and friends had died from acute illnesses; they were not here to experience older age: “*A lot of the people who were supportive of me when I was diagnosed are no longer with us; leukaemia, heart attack, you name it (FG2/7).*

To these women, life was to be celebrated: “*You’ve got to really enjoy the now. That’s why it’s called the present. It is a present (FG3/2).*” This self-affirming belief was reflected in their attitude to daily living: “*Grab life with both hands, we’re here! We might have a chronic illness, we might be older but we’re not going to let it beat us*

(FG1/4). The women told stories of how they made the most of each day: *I just believe that you take every day as it comes and appreciate the here and now rather than dwelling too much on what's going to happen in the future* (FG1/6). They concentrated too, on what they could do, rather than what they could not do:

I've tried to concentrate on all the positive things I can do and have learned to accept the negative. It's a matter of accepting yourself and where you're at. The negative side is that feeling of uselessness, not being in control and not being able to do things. But you train yourself to think about all the things you can do (FG2/1).

This participant gave examples including: *There are things I can do because I have the time. For the young ones, grandma is always sitting in the chair, the wheelchair or the easy chair at home, and if you want someone to read to you, grandma's there. So, yes, you concentrate on what you can do to overcome what you can't do* (FG2/1).

The themes and sub-themes, as interpreted from the women's stories, captured their resilience in the face of ageing with a long-term condition. Although now 'not out of the ordinary' and often faced with assumptions concerning their age that at times overshadowed their living with a long-term condition, these women had strategies in place that enabled them make the most of each day and celebrate the privilege of growing older.

DISCUSSION:

Strengths and limitations

Strengths of this study were the ongoing interpretive analyses and the use of a three-focus group series (Giddings et al. 2007). This approach provided a richness and depth to the interpretation of the women's experiences of ageing with a long-term condition. A limitation of the study was the homogeneity of the group. The participants were predominantly Pakeha¹ women, who identified as middle class. The findings therefore may not be transferable to men or to women from other socioeconomic groups or non-Pakeha. These 'unheard voices' may contribute responses that could challenge and modify our interpretation. It is also possible that women less resilient in ageing with a long-term condition did not volunteer to participate: their energy may have been directed elsewhere.

Ageing with a long-term condition

This study contributes to the literature on the nexus of ageing with a long-term condition. It shows how people, including health professionals, when interacting with women aged 65-74 years, are likely to attribute functional limitations and appearance to their age or an age-related illness, rather than a long-term condition. Ageing is foregrounded and privileged over the long-term condition. This finding challenges and extends Touhy's (2008) position that ageing and disease "are separate entities although frequent companions" (p. 3). His conclusion may hold for women newly diagnosed with a long-term condition, but ignores the complexity and interconnectedness of these two entities for women who have lived with a long-term condition for many years. For these women the referent point for everyday living and

¹ New Zealander of European descent

decision making remains their long-term condition. The majority of women in this study when confronted with situations where age overshadowed their long-term condition, drew on strategies developed over many years to deal with what they viewed as 'just another barrier' to ageing well. When the long-term condition becomes less visible as if overshadowed by ageing, women are at risk of receiving inappropriate care and services.

Another key finding was that women in this age group (65-74 years) no longer felt 'out of the ordinary' in relation to their peers. This extends the findings of our previous work with women aged 50-65 years (Giddings et al. 2007). The younger women described 'feeling less out of place' as their peers were 'catching up' and beginning to experience some of the physical and social limitations they had been living with for many years. In the current study the women reported that few in their peer group had "*perfect health*"; in a sense peers had now 'caught up'. This was clearly illustrated in the cases of the two women more recently diagnosed (<5 years). The increased incidence of long-term conditions in this age group, combined with the effects of ageing, meant that peer group social activities were now less physically demanding and more enabling of the women's participation. While the women in our earlier study "knew the loneliness that could come from the change in social networks that isolated them from peers and social activities" (Giddings et al. 2007, p. 560), for the women in this study, social isolation was not an issue. This contrasts with the general expectation that social isolation increases with age and altered health status (Nicholson 2009).

Our findings also show that ageing with a long-term condition is different from living with a condition (that may become 'long-term') that develops when one is older. As our 'negative cases' showed, the women newly diagnosed, had yet to develop expertise, strategies and resilience in living with their condition. The other women were 'advantaged' by having lived with a long-term condition for many years. Few studies take into account the effect of the length of time since diagnosis on how people age with their long-term condition. Although the chronic illness trajectory model (Corbin 1998) draws attention to the importance of where people are 'at' on their illness journey, this seems to be overlooked in practice when people reach older age. Nursing literature on ageing rarely differentiates between the experiences of people newly diagnosed with a long-term condition and those who have lived with one for many years; age overshadows the long-term condition.

CONCLUSION:

For the women in the study ageing was matter-of-fact although not taken for granted; it was a 'privilege to grow older'. Although they were no longer 'out of the ordinary' in relation to their peers, they were at risk of their long-term condition becoming invisible as if overshadowed by age. Findings from this study can alert nurses and other health professionals to the possibility that a person's long-term condition may inadvertently be overshadowed by age-related assumptions. If health professionals focus on older women's age and its concomitant effects, rather than the centrality of the long-term condition in their lives, they are at risk of delivering inappropriate care. Health professionals, therefore, need to be prepared to advocate for the special needs of older women who have lived with a long-term condition for many years.

Kirkvold (2010) supports our contention that health professionals need to remain cognisant of their clients' resourcefulness and expertise developed over time. For example, when a client with an existing long-term condition receives a new diagnosis, health professionals should work with their already developed strategies. There is need for more research to explore the nexus of ageing with a long-term condition. Studies are needed that compare the effect of time since diagnosis and the impact of co-morbidities on the experiences of older women as they age with a long-term condition.

Table 1 Participant demographic profile (n=9)

Woman (age in years)	Age in years at diagnosis (years since diagnosis)	Primary LTC*	Secondary/subsequent LTC* (years since diagnosis)
1 69	50 (19)	Multiple sclerosis	Nil
2 68	35 (33)	Multiple sclerosis	Nil
3 70	37 (33)	Rheumatoid arthritis	Bowel cancer (7 yrs)
4 72	52 (20)	Diabetes Type 2	Glaucoma (3 yrs)
5 74	70 (4)	Diabetes Type 2	Nil
6 65	45 (20)	Osteoarthritis	Coronary heart disease (2 yrs)
7 68	38 (30)	Asthma	Osteoarthritis (9 yrs)
8 74	70 (4)	Coronary heart disease	Nil
9 66	46 (20)	Asthma and Bronchiectasis	Rheumatoid arthritis (1.5 yrs) Systemic lupus erythematosus (<1 yrs)

* Long-term condition (LTC)

Table 2 The three-focus group series

Focus groups	Duration (minutes)	Participants
Focus group 1 (June 2007)	120	7
Focus group 2 (August 2007)	135 40 (individual interview)	9
Focus group 3 (April 2008)	120	9

Table 3 Themes and subthemes

Central theme: in the shadow of ageing

Theme 1: in the shadow of ageing

Subtheme: age as referent point

Subtheme: long-term condition as referent point

Theme 2: not out of the ordinary

Subtheme: others have caught up

Subtheme: no longer out of place

Subtheme: long-term condition less visible

Theme 3: just another thing to deal with

Subtheme: strategies already in place

Subtheme: cultivating support

Subtheme: knowing the tricks

Theme 4: a privilege to grow older

Subtheme: never thought I'd get this far

Subtheme: ageing as a celebration

Subtheme: making the most of each day

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Table 1 Participant demographic profile (n=9)

Woman (age in years)	Age in years at diagnosis (years since diagnosis)	Primary LTC*	Secondary/subsequent LTC* (years since diagnosis)
1 69	50 (19)	Multiple sclerosis	Nil
2 68	35 (33)	Multiple sclerosis	Nil
3 70	37 (33)	Rheumatoid arthritis	Bowel cancer (7 yrs)
4 72	52 (20)	Diabetes Type 2	Glaucoma (3 yrs)
5 74	70 (4)	Diabetes Type 2	Nil
6 65	45 (20)	Osteoarthritis	Coronary heart disease (2 yrs)
7 68	38 (30)	Asthma	Osteoarthritis (9 yrs)
8 74	70 (4)	Coronary heart disease	Nil
9 66	46 (20)	Asthma and Bronchiectasis	Rheumatoid arthritis (1.5 yrs) Systemic lupus erythematosus (<1 yrs)

* Long-term condition (LTC)

Table 2 The three-focus group series

Focus groups	Duration (minutes)	Participants
Focus group 1 (June 2007)	120	7
Focus group 2 (August 2007)	135 40 (individual interview)	8 1
Focus group 3 (April 2008)	120	9

Table 3 Themes and subthemes

Central theme: in the shadow of ageing

Theme 1: in the shadow of ageing

Subtheme: age as referent point

Subtheme: long-term condition as referent point

Theme 2: not out of the ordinary

Subtheme: no longer out of place

Subtheme: others have caught up

Subtheme: long-term condition less visible

Theme 3: just another thing to deal with

Subtheme: strategies already in place

Subtheme: cultivating support

Subtheme: knowing the tricks

Theme 4: a privilege to grow older

Subtheme: never thought I'd get this far

Subtheme: ageing as a celebration

Subtheme: making the most of each day