A qualitative systematic review on the experiences of self-management in community-dwelling older women living with chronic illnesses

Tay Zhi Ru BSN (Hons) BSc (Nursing) (Hons) Student
Adjunct Associate Professor Edward Poon Wing Hong PhD candidate, MSc Palliative Care, BHSN, Adv Dip Nsg Neuroscience, RN
Professor Desley Gail Hegney PhD, BA (Hons), DNE, COHN, CNNN, RN, RM

1. Alice Lee Centre for Nursing Studies, Yong Loo Lin School of Medicine, National University of Singapore (NUS); Singapore National University Hospital (NUH) Centre for Evidence Based Nursing: A Collaborating Centre of the Joanna Briggs Institute

Corresponding author: Tay Zhi Ru
Phone: +65 92268968
Email: tay.zhiru@gmail.com

Executive summary

Background
With the risk of chronic conditions increasing with age, older women are likely to have co-morbid chronic conditions. In addition, they may have to contend with socioeconomic issues unique to their gender which can challenge their self-management.

Objective
The aim of the systematic review was to determine the best available evidence related to the experiences of self-management among community-dwelling older women with chronic conditions, specifically non-communicable illnesses which include cardiovascular disease, chronic respiratory diseases, diabetes mellitus and arthritis.

Inclusion criteria
Types of participants included all older women with the following characteristics: aged sixty-five years and above; living in their own community dwellings; community setting rural, suburban or urban; living alone or with others; having co-morbidities and having chronic illnesses for a minimum of one year. Phenomenon of interest was experiences of self-management among community-dwelling older women with chronic conditions. Interprete
studies were considered in the review, which included but were not limited to designs like phenomenology, grounded theory, action research, feminist research and ethnography.

Search strategy
The search strategy aimed to uncover both published and unpublished studies, in English language only, and was unrestricted by time. The databases searched included CINAHL, MEDLINE, PsycINFO (Ovid), Scopus, Embase, Science Direct, Sociological Abstracts, Social Sciences Citation Index (Web of Science), Proquest and Google Scholar. Preliminary keywords were drawn from the topic of the systematic review.

Methodological quality
Each paper was assessed independently by two reviewers for methodological quality. The Joanna Briggs Institute Qualitative Assessment and Review Instrument QARI Critical Appraisal Checklist for Interpretive & Critical Research was used to appraise the methodological quality of all papers.

Data collection
Qualitative data were extracted from papers included in the review using standardized data extraction tools developed by the Joanna Briggs Institute.

Data synthesis
Qualitative research findings were synthesized using the Joanna Briggs Institute-Qualitative Assessment and Review Instrument.

Results
88 findings from six studies were aggregated into 22 categories, and then into five synthesized findings. The five synthesized findings are: (i) losing control over a failing body, (ii) maintaining control, (iii) developing self-expertise, (iv) re-defining health, and (v) relying on social support.

Conclusions
For these women, self-management involves reclaiming and maintaining their sense of control over their bodies, which is constantly threatened by their chronic illnesses. In addition, they redefine their meaning of health in the context of illness to maintain their emotional well-being in spite of their illness.

Implications for practice
Healthcare providers can assist their older female patients in maintaining their sense of control through effective symptom management and practical strategies to manage daily life. Because social support is crucial to self-management by older women, healthcare providers should include, where relevant, family members and other loved ones in patient education. Healthcare providers should also endeavour to build and maintain a positive relationship with

Zhi Ru et al. Experiences of older women living with chronic illnesses © the authors 2011 page 2779
their patients through effective communication as the provider-patient relationship is a strong influence on an older woman’s experience in self-management.

**Implications for research**

Further research is warranted in older women of other cultural backgrounds as the majority of reviewed studies focused on Caucasians in the United States.

**Keywords**

Qualitative, experience, older, women, chronic illness, self-management

**Background**

Chronic conditions are highly prevalent among older adults. The World Health Organisation (WHO) broadly defines chronic conditions as persistent communicable diseases (e.g. HIV/AIDS) and non-communicable diseases, as well as ongoing physical structural impairments. Non-communicable diseases are also traditionally known as chronic diseases, the most common ones afflicting older adults being cancer, cardiovascular disease (CVD), chronic respiratory diseases (CRD), diabetes mellitus (DM) and arthritis.

Older adults tend to present with multi-morbidity, or co-existence of multiple chronic conditions at the same time. Population studies have consistently shown that the prevalence of chronic conditions and co-morbidities increases with age. Although co-morbidities are frequently considered in the context of medically diagnosed diseases concurrently occurring with an index disease, they also include impairments resulting from the complex interplay of ageing and disease. These impairments can be subclinical or have atypical presentations, but are additive to the total biological dysfunction.

Because of the longer life expectancy women have in comparison to men, a disproportionately larger share of older adult populations is female. This distinct pattern is called feminisation of ageing, which in turn has important healthcare implications. Due to their longer life expectancy, chronic conditions and co-morbidities are extremely prevalent in older women, especially those of more advanced ages. The deleterious effects of chronic diseases on physical independence, especially in the context of multimorbidity, are compounded by the physical decline normally associated with ageing. Moreover, the higher prevalence of musculoskeletal diseases, especially osteoporosis and arthritis, as well as their physical and structural differences from men, also accounts for the higher rate of physical disability among older women.

Although the definition of old age is arbitrary, it is defined by a chronological age of sixty-five years and above in most developed nations. Following this definition, the current cohort of older women was born from prior to or during World War II (WWII), a period that was marked by widespread socioeconomic and political tumult. It was also an era where traditional patriarchal notions dominated.
and adjudicated that women reside within the private and domestic sphere rather than being employed and financially independent.\textsuperscript{16} Despite post-war reforms in women’s welfare and rights, such gender differences have continued to persist in most developed countries.\textsuperscript{16-18} This socioeconomic disadvantage may have important implications for older women living with chronic conditions.

Financial insecurity is one of the most salient issues associated with feminization of ageing, even in developed countries.\textsuperscript{16-21} Older women are more likely to be financially disadvantaged\textsuperscript{16, 22-24} because they do not have adequate personal savings resulting from their lower education levels, shorter work histories and lower incomes than men.\textsuperscript{16} The financial insecurity of older women is even more pronounced in Asia, where demographic ageing is occurring much more rapidly than in the West, thus straining inadequate social security systems.\textsuperscript{25} In Asia there is a strong expectation of family support underpinned by filial piety.\textsuperscript{25-26} However, traditional family support of older adults in various Asian societies is being weakened by socioeconomic consequences of modernisation.\textsuperscript{6} Migration\textsuperscript{27}, declining fertility rates and changing attitudes towards inter-generational support\textsuperscript{28} have altered traditional family support systems. This change in the social fabric of the home is threatening many older women’s economic safety net traditionally provided by their families.\textsuperscript{25} In addition, widowhood, which is highly prevalent among older women due to their longevity over men, further removes any form of socioeconomic support that marriage confers to them\textsuperscript{22-24} particularly in developing countries where older and widowed women are the poorest amongst the poor.\textsuperscript{26, 29} The economic vulnerability of older women, therefore, presents a major challenge in living and coping with chronic conditions.

As a corollary of gender relations, many older women across cultures have traditionally identified themselves with their care giving roles which can continue to persist into old age at the expense of their health.\textsuperscript{22, 30} Their care work mainly includes, but is not confined to, household chores\textsuperscript{31-33}, grandparenting\textsuperscript{30-31} and spousal support.\textsuperscript{30} Chronic conditions in older women can disrupt their social roles through functional impairment, thus leading to perceived role loss that undermines their emotional well-being.\textsuperscript{33-34}

In addition to causing physical disability, chronic conditions coupled with ageing may also produce undesirable changes in one’s physical appearance. In an agest and gendered society, the objectification of the female body can lead to rejection of older women whose bodies defy cultural representations of feminine beauty which is portrayed by youth.\textsuperscript{30, 35} As a result, living with chronic conditions may cause older women to suffer a negative body image that is not only derived from their physical disabilities, but also more importantly their perceived physical deformation.\textsuperscript{35}

Through a life-course perspective, the older woman’s experience of living with chronic diseases can be viewed as a complex interplay of biological, demographic, psychological, social and economic factors.\textsuperscript{36} Biomedicine tends to view ageing through the prism of illness, focusing on physical decline.\textsuperscript{37} The theory of successful ageing, which focuses on avoiding disease and preserving optimal physical and mental health,\textsuperscript{38} may be one-dimensional and thus underscore the medicalisation of old age and its associated chronic conditions.\textsuperscript{30, 35, 37} This leads to society assigning older adults to the
sick role and thus, perpetuating an ageist stereotype of them being ill and dependent. In contrast, the concept of health-within-illness argues that an individual can experience well-being despite living with chronic conditions because they serve as a potential catalyst for personal growth. Moreover, the overemphasis on the negativity of having chronic conditions in old age can overlook the potential of older women to transcend their unique physical and socioeconomic limitations to continue to pursue meaning in their lives. In the context of feminization of ageing, extensive research into older women’s experiences of living and coping with chronic conditions is thus warranted. This is particularly important since the feminization of ageing is a global phenomenon, and research should be culturally sensitive, targeted at older women from diverse social, economic and cultural backgrounds. In doing so, healthcare professionals can adopt a more holistic view towards their older female patients’ experiences of chronic conditions as being more than physical suffering, which also encompasses their strength and resilience evident in their self-management strategies.

**Objectives**

The aim of this review was to critically appraise, synthesize and present the best available evidence related to the experiences of self-management among community-dwelling older women with chronic illnesses, specifically non-communicable illnesses which include cardiovascular disease (CVD), chronic respiratory diseases, diabetes mellitus (DM) and arthritis.

Specific questions on their experiences included the following:

What does living with chronic illnesses mean to community-dwelling older women?

What self-management strategies do community dwelling older women with chronic illnesses use?

What issues do community-dwelling older women with chronic illnesses face in self-management?

What feelings do community-dwelling older women with chronic illnesses have about self-management?

**Definitions of terms**

For the purpose of this review, definitions were assigned to the following terms below.

**Experiences**

This review specifically examined the experiences of older women in their self-management of chronic illnesses.

**Older women**

For the purposes of this review, an older woman is chronologically defined as sixty-five years of age and above. It should be noted that the definition of old age is arbitrary, but worldwide, with the
exception of Africa and other Indigenous cultures (where it can be considerably younger), an older adult is typically defined as being sixty-five years and above.\textsuperscript{15}

**Chronic illnesses**

Although ‘disease’ and ‘illness’ are commonly used interchangeably in the literature, ‘illness’ is used in this review to emphasize the human experience of having a ‘disease’. ‘Disease’ refers to a pathologic process from the biomedical perspective. A chronic illness thus represents having any condition which is permanent, leaves residual disability, is caused by non-reversible pathological alteration, requires special training of the patient for rehabilitation, and/or may be expected to require a long period of supervision, observation, or care.\textsuperscript{41}

**Self-management**

Self-management refers to ‘the individual’s ability to manage symptoms, treatment, physical and psychosocial consequences and lifestyle changes inherent in living with a chronic condition’.\textsuperscript{42}

**Community dwelling**

Community dwelling refers to residence within the community, and excludes any form of institutionalization.

**Inclusion Criteria**

**Types of participants**

In this review we considered publications that included all older women who had the following characteristics:

- Are aged sixty-five years and above (with no limitations to any specific age groups within this population)
- Live in their own community dwelling
- Live in a community setting that may be rural or urban
- May live alone or with others (i.e. families)
- Have co-morbidity/co-morbidities, defined as having at least two non-cancer chronic illnesses, which include the following four common chronic diseases: cardiovascular disease (CVD), chronic respiratory diseases, diabetes mellitus (DM) and arthritis. The rationale for excluding cancer as a chronic illness was to focus on the experience of living with non-cancer chronic illnesses, which were considered to likely present challenges different from cancer.
- Have chronic illnesses for a minimum duration of one year
This review excluded any study that involved participants who had the following characteristics:

Aged below sixty five years

Male

Living as a resident/patient at any healthcare institution (i.e. hospital, nursing home or hospice)

Did not have co-morbidity, or was diagnosed with cancer

Studies on the experiences of family members or caregivers of these older women were excluded.

Phenomenon of interest

The review considered studies that investigated the experiences of self-management among community-dwelling older women with chronic illnesses.

Types of studies

The review considered interpretive studies that illuminated experiences of self-management of chronic illnesses by community-dwelling older women, including, but not limited to, designs such as phenomenology, grounded theory, action research, feminist research and ethnography.

Context

The review sought to understand the experiences of community-dwelling older women throughout the world, so as to elucidate any universal commonality which may exist across all cultures.

Search strategy

The search strategy aimed to find both published and unpublished studies, unrestricted by any timeframe. A three-step search strategy was utilised in this review. An initial limited search of MEDLINE and CINAHL was undertaken followed by analysis of the text words contained in the title and abstract, and of the index terms used to describe the article. A second search using all identified keywords and index terms was then undertaken across all included databases. Thirdly, the reference list of all identified reports and articles was searched for additional studies.

The databases searched included: CINAHL, MEDLINE, PsycINFO (Ovid), Scopus, Embase, ScienceDirect, Sociological Abstracts, Social Sciences Citation Index (Web of Science), Proquest and Google Scholar. The search strategy did not limit studies by date. However, only studies reported in the English language were considered in this review. Critical search terms were identified as...
‘experience’, ‘older’, ‘women’, ‘chronic illness’ and ‘self-management’. ‘Feminization of ageing’ was originally included in the systematic review protocol, but was later omitted because the focus was on the self-management experiences of older women living with chronic illnesses, not on the consequences of feminization of ageing. An initial scoping was done in databases providing MeSH search (i.e. CINAHL and MEDLINE) to identify keywords and related terms which included the following:

<table>
<thead>
<tr>
<th>Keywords</th>
<th>Related terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience</td>
<td>Lived experience, meaning of</td>
</tr>
<tr>
<td>Older (adult)</td>
<td>Aged, elderly</td>
</tr>
<tr>
<td>Women</td>
<td>Female</td>
</tr>
<tr>
<td>Chronic illness</td>
<td>Chronic disease, chronic condition</td>
</tr>
<tr>
<td>Self-management</td>
<td>Self-care</td>
</tr>
</tbody>
</table>

In databases without MeSH search (i.e. PsycINFO, Scopus, Emtree, ScienceDirect, Sociological Abstracts, Social Sciences Citation Index and Google Scholar), the abovementioned list was used instead. For details and results of these search strategies, refer to Appendix I.

**Methods of the review**

**Assessment of methodological quality**

Methodological quality of the studies was assessed using the Joanna Briggs Institute (JBI) Qualitative Assessment and Review Instrument (QARI) Critical Appraisal Checklist for Interpretive & Critical Research (Appendix II). Two reviewers independently appraised each study. There are ten questions on this checklist and a cut-off point of 6/10 was set to include studies into this review. This level was chosen because it was considered high enough to establish a level of methodological rigor, but still provide a representative set of studies to analyze.

**Data extraction**

Qualitative data were extracted from papers included in the review using standardized data extraction tools from the Joanna Briggs Institute Qualitative Assessment and Review Instrument (JBI-QARI) (Appendix III).
Data synthesis

Qualitative research findings were pooled using the Qualitative Assessment and Review Instrument JBI-QARI. This involved the aggregation or synthesis of findings to generate a set of statements that represented that aggregation, through assembling the findings (Level 1 findings) rated according to their quality, and categorizing these findings on the basis of similarity in meaning (Level 2 findings). These categories were then subjected to a meta-aggregation in order to produce a single comprehensive set of synthesized findings (Level 3 findings) that were used as a basis for evidence-based practice.

Results

Description of studies

The search strategy used produced a total of 7380 results, from which 26 studies were identified to be relevant to the objectives of the systematic review based on the assessment of the titles of studies. Titles were selected if they included the aforementioned keywords that suggested relevance to the topic of the systematic review. After evaluating the 26 studies’ abstracts, eight studies were excluded based on the inclusion criteria and exclusion criteria. Articles of the remaining 18 studies were retrieved for a full review, following which, 12 were also excluded based on the inclusion and exclusion criteria (See Appendix V). This left six studies to be included in the systematic review (See Appendix IV). A hand search of reference lists of studies retrieved was also performed, but did not produce additional studies which satisfied the inclusion criteria. Figure 1 depicts the search process:

All included studies undertook qualitative methodologies to accomplish the general aim of investigating the experience of older women living and coping with chronic illness. Please refer to appendix IV for further details.

Participants in the included studies were community-dwelling older women with chronic conditions, which included cardiovascular disease, chronic respiratory diseases, diabetes mellitus and arthritis. The data collection method used in all studies was face-to-face interviews. Data analysis methods varied in these studies (refer to appendix IV), but were consistent with the qualitative methodology used in each individual study.
Methodological quality

All selected studies showed good methodological quality, with scores ranging from seven to a maximum of ten points. One scored seven out of ten\textsuperscript{43}; two scored eight\textsuperscript{31, 44}; and three scored full points\textsuperscript{45-47}. Methodological weaknesses included: not stating the cultural or theoretical background of researcher (2 studies\textsuperscript{31, 43}); not addressing the researcher influence on research (3 studies\textsuperscript{31, 43-44}); and not specifying a qualitative research tradition or methodology (2 studies\textsuperscript{43-44}). Nonetheless, these studies provided useful and credible findings which are relevant to the topic of the systematic review. Refer to Appendix IV for the characteristics of the included studies.
Meta-synthesis Results

Meta-synthesis of the seven included studies identified 88 findings, which were in turn aggregated into 22 categories, and then into 5 synthesized findings. The five synthesized findings are namely: (i) losing control over failing body, (ii) maintaining control, (iii) developing self-expertise, (iv) redefining health, and (v) relying on social support.

Meta-synthesis 1: Losing control over the failing body

Clinicians should assist older women in their self-management of chronic conditions by understanding their fear for the loss of control over their failing bodies. The perceived loss of control over the failing body underscored the experiences of older women with chronic illnesses. At the onset of chronic illnesses, these older women perceived a loss of control when their undiagnosed conditions produced physical symptoms they had never experienced before. As their chronic illnesses continued to progress following diagnosis, their inability to control their physical symptoms and their loss of independence diminished their sense of control. The loss of independence can be interpreted in two ways. While it can mean the loss of freedom to do what one wants to do, it also encompasses the inability of the body to function on its own, thus requiring external support by mechanical devices or other people (see Figure 2).

![Figure 2: Losing control over the failing body](image)

Category 1: Fear of emerging symptoms

- 1 finding: Fear of emerging symptoms
- 5 findings: Unpredictability of physical symptoms
- 2 findings: Stubborn symptoms
- 12 findings: Unable to do what one wants to do

**Losing control over the failing body**

Older women with chronic illnesses experience loss of control over their bodies.
Prior to diagnosis of their chronic conditions, some older women experienced fear towards their emerging symptoms as they did not understand such abnormalities were manifestations of underlying medical conditions.

Finding: When chronic osteoarthritic pain started occurring, the older Korean American women did not know what caused it and were fearful of it. (C*)

“The starting point was having pain; I feel misery over having this pain.”46 (p. 682)

*C’ is the abbreviation for ‘credible finding’.

Category 2: Unpredictability of physical symptoms

Physical symptoms experienced by older women with chronic illnesses were often variable, thus frustrating their efforts to control them from affecting their daily lives. One source of unpredictability was the occurrence of physical symptoms, while another was their responsiveness to interventions. Due to the unpredictability of their physical symptoms, older women with chronic illnesses had to grapple with constant uncertainty towards their bodies.

Finding 1: Initial experiences of older women living with osteoarthritis were full of uncertainty. One source of uncertainty was the waxing and waning of symptoms. (U**) "I don’t know, I could be fine one day and then the next day I get up and I can hardly walk. There are times I’ve used canes. Sometimes, it gets so bad in my legs that I walk with a cane anywhere from two to three weeks and then it’ll subside and move into some other place.”45 (p.51)

**U’ is the abbreviation for ‘unequivocal finding’.

Finding 2: Older women with osteoarthritis experienced uncertainty towards their management of symptoms in terms of successful outcomes. (U)

"Sometimes, I take two Daypro and sometimes I take one. But, I don’t see much benefit. Maybe psychologically, I’m doing something to help it. In my mind, I feel better. But I don’t think it has helped much.”46 (p.52)

Finding 3: Older women with Stage II heart failure perceived a loss of self-control from their physical symptoms. (U)

"I’m not used to not being in control. The dizziness terrifies me. Once it starts to go, once the room starts going around, I...you don’t have any control. That’s a horrible feeling. HF has changed my"
sense of control. I'm not as secure as I was. I'm worried I won't be able to do for myself, and have to ask for help." (p.445)

Finding 4: The experience of fatigue in older women with chronic heart failure was variable, causing unpredictable fluctuations in physical activity. (U)

"Then I can suddenly have made lunch and everything one day, and I sit down and then I get so tired, so uuuuuhhhhh." (p.293)

Finding 5: Some older women with osteoarthritis developed a fear of falling due to impaired mobility. (U)

"I'm leery of walking, especially on ice. I'm scared cause I know what it would mean if I fell. I have a fear of fracturing something." (p.50)

Category 3: Stubborn symptoms

Another characteristic of physical symptoms contributing to a perceived loss of control was their refractoriness to treatment. Even though older women with chronic illnesses applied various interventions to alleviate their physical symptoms, these symptoms persisted even though their intensity might decrease temporarily.

Finding 1: Constant fatigue and pain were pervasive and debilitating problems for older women with chronic illnesses. (U)

"It is an ache you can't describe and it never goes away, just like a toothache. It drives you crazy until you take something...Even when I take the pills it is still there." (p.488)

Finding 2: Older Korean American women experienced frustration with living with chronic osteoarthritic pain because it continued to persist despite treatment. (C)

"It doesn't seem as though anything is good for arthritis." (p.682)

Category 4: Unable to do what one wants to do

Being unable to do what one wants to do was a major cause of perceived loss of control in older women with chronic illnesses. Chronic conditions often produced in these older women body limitations undermining their physical independence. As a result, they were unable to perform many activities that they used to do in their daily lives, leading to considerable emotional suffering.
Finding 1: Older women with osteoarthritis cannot perform household chores they want to do so. (U)

"I would give my fortune to be able to scrub my own floor, but I just cannot stand the pain of getting on my hands and knees." (p.49)

Finding 2: Older women with osteoarthritis had to give up their hobbies. (U)

"I'm crocheting, all of a sudden my needle gets stiff in my hands, and I have to stop. So, I had to just give it up." (p.50)

Finding 3: Older women with Stage II heart failure experienced loss in physical activity. (U)

"I want to go to places, but...there's things I never had to think about before. I would have said 'Sure', and just left. But now, it's the heat, and the crowds, and do I have to climb hills when I get there, do I have to go up stairs when I get there?" (p.445)

Finding 4: Older women's experiences with osteoarthritis began when they started to experience functional limitations impacting on their daily lives. (U)

"I used to do more work. I used to get tired, sure you're stiff and everything. Heck, I used to shovel snow." (p.48)

Finding 5: Physical symptoms caused by chronic illnesses restricted the older women's participation in activities constituting their lifestyles. (U)

"I drop everything I pick up, which disturbs me because I like newborn babies. I was a friend's babysitter a few years ago and she is going to have another baby and it is just killing me that I won't be able to hold that baby." (p.487)

Finding 6: Some older women experienced their chronic illness as a past event which had no impact on their current lives. (U)

"[Health problems] got in the way...just when I was in hospital, that's all. I haven't had to change the way I do things at all." (p.486)

Finding 7: Some older women experienced their chronic illnesses as a concrete physical problem, in terms of a specific symptom or a collective of symptoms affecting their functional abilities. (U)

"I don't get down and scrub the floors anymore. It hurts my shoulder to run the vacuum...[her husband] runs the vacuum but he doesn't like to...It hurts me to iron also. I don't iron like I did." (p.484)
Finding 8: Some older women could not accept their restrictions of living with osteoarthritis. (U)
"I see a lot of old women really not having the problems I have with walking and doing things. I keep saying why can't that be me. You are so curtailed on what you can do and you feel so useless. Being in the house. I'm not able to go anywhere."\(^{45}\) (p.50)

Finding 9: Fatigue experienced by older women with chronic heart failure impacts on their whole life situation. (U)
"Now I feel like I'm living as half a person … because I don't have the energy for anything."\(^{43}\) (p.292)

Finding 10: Fatigue experienced by older women with chronic heart failure causes an involuntary reduction or cessation of both household tasks and previously-appreciated leisure activities, which can bring sorrow. (U)
"You feel a little...well, bad at everything you may want to do this or that, but you just don't have the energy...you see that you should clean, but..."\(^{43}\) (p.292)

Finding 11: Functional limitations caused by chronic illnesses can be experienced by these older women as slowing down, such that they could not accomplish as much as they used to in a given period of time. (U)
"You can't move around as easily, and it takes you two or three times as long to get the usual things done...I have to keep reminding myself that I can't do as much in a given amount of time as I used to."\(^{44}\) (p.488)

Finding 12: Older women with chronic illnesses experience functional limitations. (C)
"...even the simple things like using the vacuum cleaner, it just [wears] me out."\(^{37}\) (p.680)

Meta-synthesis 2: Maintaining control
Clinicians should help older women maintain their sense of control over their chronic conditions by symptom management and providing practical guidance in reducing the risk of experiencing role loss through physical and emotional adjustments to illness. Clinicians also need to consider the affordability of treatment regimens with respect to their patients' financial status. Older women with chronic conditions endeavour to maintain a sense of control over their illnesses. The essence of self-management is preventing their chronic conditions from disrupting their lives. These older women attain their sense of control through a two-pronged approach, which involves making both psychological and practical adjustments to their illnesses. In addition, maintaining control is underpinned by having a positive attitude towards living with an illness, which is characterised by determination and perseverance (see Figure 3).
Category 1: Fighting against physical symptoms

Older women with various chronic conditions strove to overcome their physical symptoms to prevent their health from declining further. In doing so, they demonstrated their desire to control their conditions from overpowering them, at least psychologically. Failure to overcome their physical symptoms caused them to feel overwhelmed by their illnesses, thus indicating a loss of control, as exemplified by the last finding.

Finding 1: Older women with chronic heart failure fought against their fatigue by avoiding inactivity, so as to minimise their dependency on others. (U)

“You just have to struggle and get up ... you have to practice that ... because I know how things go if you get too dependent on your bed; people have to come in and help you more often.”43 (p.293)
Finding 2: Older women with osteoarthritis accepted their chronic condition through their determination and control. (U)

"The main thing is you can’t let it get you down. Even if it hurts, you just gotta keep doing it. If you want to overcome it, you gotta keep trying to keep doing it so that maybe instead of it hurting a lot, it’ll hurt a little bit." 45 (p.66)

Finding 3: Some older women with chronic conditions saw themselves as ill and being overwhelmed by their illnesses. (U)

"I can’t do nothing. I told you, [my] neck [is too stiff to turn], I can’t see. I can’t go when it’s cold some place; I can’t walk around. Same thing every day, that’s all...I want to die. Believe me, I suffer too much." 44 (p.494)

Category 2: Adjusting self-expectations of functional capacity

Maintaining control involves an internal strategy of adjusting one’s self-expectations to her functional capacity. Dissonance between ambition and reality can cause an older woman with chronic disabilities to perceive a loss of control when she is unable to perform to her own standards.

Finding 1: An internal coping strategy older women commonly used was reframing beliefs about themselves and meanings they assigned to daily activities and events. (U)

"I do a lot of resting, but at my age I figure I can. That is all I have to do, and that is why I am here [retirement community]." 31 (p.682)

Finding 2: Older women with chronic heart failure had to tailor their expectations, and give priority to less demanding, or more enjoyable activities. (U)

"Well, I used to be more fastidious, but now I just let it [cleaning the house] go." 43 (p. 293)

Finding 3: Older women with multimorbidity sacrificed a variety of daily tasks and pastimes they used to enjoy, so as to manage health-related challenges in their lives. (C)

"For example, Jodi stopped quilting because it upset her when she was not able to achieve the same level of perfection that she had earlier in life. She realized that her need for perfection was emotionally demanding and ultimately would result in stress-related physical detriments." 31 (p.684)

Finding 4: Older women with osteoarthritis lowered their standards of their physical capacity and performance of daily activities. (U)

"You have to change your level of expectations." 45 (p.64)
Finding 5: Older women with Stage II heart failure accepted their physical limitations by allowing unfinished tasks. (U)

"If it doesn't get done today, well, the world doesn't fall apart. I don't drive myself anymore. So it doesn't get done. The world doesn't come to an end."47 (p.445)

Category 3: Financing treatment despite constraints

Some older women with chronic conditions do not enjoy financial security. Nonetheless, these older women strive to maintain their treatment regimen in spite of their financial constraints, underscoring their desire to maintain control over their chronic illnesses.

Finding 1: Older women experience financial strain in their self-management of their chronic conditions. (U)

"It’s been hard to afford them [special food]. They are more expensive than regular food. Anything that is sugar-free is more expensive than others. When you are on a fixed income, and you are just one, you can’t hardly make ends meet. You have to buy the medicine and special diet stuff too."31 (p.681)

Finding 2: Older women with Stage II heart failure may be financially insecure. (C)

"For four, it could be argued that being on the fixed income of retirees, they would be on tight budgets with or without HF. However, the fifth participant had a loss of financial security directly attributable to her disease. She and her husband were forced to sell their Midwest home and to cash in his retirement savings, and were near retirement with no financial reserves."47 (p.445)

Category 4: Seeking alternatives

In striving to control their illnesses, older women with chronic conditions may seek alternative treatments despite cultural differences or barriers. Their action can be construed as being driven by need, but it also reflects their sheer determination to regain control over their illnesses.

Finding 1: It was only when the pain worsened to the extent of restricting movement did older Korean American women sought Western medical treatment, which enlightened them about their pain being a symptom of osteoarthritis, a chronic condition that could be treated. (C)

"I heard about my disease condition and treatment plan from the doctor."46 (p.682)

Finding 2: Older Korean American women with osteoarthritis continued to seek Western medical help in spite of their differences in cultural worldview. In doing so, they encountered language barriers in communicating with English-speaking providers. (U)
“I can make an appointment by myself, but it is still hard for me to express myself about my pain in English. I look like I am deaf and dumb.”\textsuperscript{46} (p.682)

**Finding 3:** Older Korean American women continued to seek Western medical help through Korean-speaking doctors, but they received the same information and regimen for osteoarthritis as they did from previous non-Korean speaking doctors, which were ineffective in alleviating their pain. (C)

“There is no treatment drug or method for osteoarthritis. But I feel pain every day. I have to get self-care for myself. I have to be cared for by myself.”\textsuperscript{46} (p.682)

**Category 5: Receiving the illness**

Receiving the illness involves older women with chronic conditions acknowledging and adapting to their illnesses. It encompasses the concept of ‘going with the flow’ implying the letting go of the need to control, which paradoxically allows these older women to retain their sense of control over their lives.

**Finding 1:** Older women with chronic illnesses overcome their fear of stigmatisation by becoming accustomed to their physical problems. (U)

"I wouldn't wear it [oxygen tank] out, but if I wanted to go any place I had to and that's that. My daughter said, 'Well, Mother, you wore glasses and if necessary you'd wear a hearing aid.' So I go out now. I'm seated in the non-smoking section."\textsuperscript{44} (p.491)

**Finding 2:** Older women with Stage II heart failure practise emotional acceptance of life as it is now with their condition. (U)

"It doesn't bother me emotionally. Either you can do it or you can't, that's just the way it is. No, I don't get depressed over things that I can't do...How do you cope with changes? You just do it...As seniors, we have all learned to live circumstances to a certain degree. And again, I've learned to adjust to this circumstance."\textsuperscript{47} (p.445)

**Finding 3:** Older women's successful living with osteoarthritis involves acceptance of their condition and the changes it has brought and would continue to bring to their lives. (U)

"This is something you live with, but you also learn to live with it."\textsuperscript{45} (p.65)

**Category 6: Excessive support becomes intrusive**

Although many older women with chronic illnesses do receive social support in their self-management, excessive support can invade into their personal space in physical and metaphorical terms. As a metaphor, personal space represents autonomy. When these older women perceive excessive
support as an infringement of their autonomy, it demonstrates their desire to maintain control in spite of their illnesses.

**Finding 1:** Older women received instrumental, informative and emotional support from their families. However, excessive family support that threatened their independence could create conflict and tension in their relationships with families. (U)

"I don’t want them butting in my business. They have a tendency to get carried away …researching things for me and trying to tell me I need to go here and all over these special hospitals that I couldn’t even get into. So, I don’t tell them anything much because I don’t want to hear it from them.” (p.687)

**Finding 2:** Some older women with chronic illnesses did not welcome helpful gestures by others when they found themselves overprotected or unable to convince friends to stop helping them, once help was no longer needed. (C)

"In such cases, women felt ‘hovered over’ as friends continued to respond to them in a way they no longer saw as appropriate.” (p.492)

**Meta-synthesis 3: Developing self-expertise**

Clinicians should foster a collaborative partnership with their patients, which encourages them to effectively self-manage their own chronic conditions. Older women with chronic conditions develop and apply their own knowledge and practices of self-management through personal experience. They learn and apply what works for their illnesses, thus becoming experts in their own self-management (see Figure 4).

![Figure 4: Developing self-expertise](image-url)
Category 1: Changing ways of doing things

Older women with chronic conditions accommodate their physical limitations by adopting new approaches to performing tasks. They also avoid tasks which they can no longer perform.

Finding 1: Older women with chronic heart failure had to perform activities at a slower pace due to their feeling lack of energy. (U)

“Heavy work, such as vacuum-cleaning, had to be interrupted for several rest breaks.” (p.293)

Finding 2: Older women with multi-morbidity modified activities and daily routines to accommodate changes in their capacity to participate at the same level or perform tasks as they had done in their past. (U)

“Well, I get potted plants, and I have them on the patio, just all kinds, but I don’t have them out in the yard like I used to.” (p.685)

Finding 3: Older women with osteoarthritis gave up doing things that they used to do but could no longer perform due to their condition, in order to make their lives as normal as possible. (U)

“I just eliminate a lot of things that I used to do that I can’t do now. Like one of the things I cherished was watching my granddaughter. It’s hard for me to hold her and get up and out of a chair while I’m holding her. I also can’t lift a lot of groceries. Stairs are the worse thing. I have to go one then both feet on the stairs. It takes me twice as long to go down and even longer to go up the stairs.” (p.62)

Finding 4: Older women with Stage II heart failure paced themselves in their daily activities. (U)

“I pace myself. After all, I have all day to get it done! I only do a little bit every day.” (p.446)

Finding 5: To cope with their physical limitations, older women with Stage II heart failure adopted new, less energy-demanding ways to complete daily tasks. (U)

“There’s a few things I can’t do, but I try to substitute things I can do.” (p.446)

Category 2: Infusing tradition

Besides using modern medicine, some older women also turn to traditional medicine to control their chronic conditions. In addition, they may incorporate traditional beliefs and practices into their own self-management regimens.

Finding 1: In striving to reduce pain, older Korean American women turned to traditional folk remedies from their native cultural background. (U)
"When I felt pain I wore a magnetic brace on my knee, then I felt less pain. I thought that the magnet was working to accumulate my energy in my body so I felt less pain." (p.683)

Finding 2: Managing and tolerating pain involved older Korean American women with OA constantly exploring and applying methods of pain reduction, which were culturally related to their Korean traditional beliefs. (C)

"One participant, for example, takes a hot bath every day after washing dishes in the late morning, whereas another regularly uses acupuncture, which she finds helpful." (p.683)

Category 3: Adhering to treatment regimen

Older women with chronic illnesses believe in adherence to their treatment regimens to control their conditions. Even though some of them may face challenges in adherence, they appreciate the importance of their treatment regimens in regulating their bodies. In order to adhere to their treatment regimens, these women have to adopt new practices which are consistent with their health goals as well as their lifestyles.

Finding 1: Older women with multi-morbidity added new activities to their daily life, so as to maintain their current status of health and prevent further decline. (U)

"I lived in a neighbourhood that was ideal for walking, and I did real well with my exercise. I also changed my diet a lot. I was careful about what I ate, so I could keep my weight at a good place." (p.686)

Finding 2: Some older women experienced their chronic illnesses as treatment regimens. (U)

"The diabetes doesn't bother me except that I have to be particular about what I eat." (p.486)

Finding 3: Some older women with diabetes experienced difficulty in adherence to their treatment regimens. (U)

"They frequently commented on the difficulty of reducing their sugar intake, buying special foods, and eating at prescribed times during the day. Holidays and other special occasions were particularly challenging times." (p.681)

Finding 4: Some older women with multimorbidity understood the connections between their chronic conditions and treatment regimens. (U)

"If I watch my diet for diabetes, that is taking care of the heart problem too...Of course you are not supposed to gain a lot of weight with neither one." (p.681)
Meta-synthesis 4: Redefining health

A collaborative clinician-patient relationship should be developed to facilitate older women to adopt a more positive attitude towards their illness experiences. Older women with chronic conditions have to redefine their meaning of health in the context of illness, in order to protect their emotional wellbeing. They change their perspectives to accommodate their chronic conditions in their lives. The paradigm shift allows them to experience health in illness (see Figure 5).

![Figure 5: Redefining Health](image)

Category 1: Chronic illness as a consequence of ageing

One way older women redefine their meaning of health is accepting their chronic conditions as part and parcel of the ageing process. This can be seen as normalization, which enables the older women to make sense of their chronic illnesses more positively.

**Finding 1:** Older Korean American women viewed their chronic osteoarthritic pain as a sign of ageing. (U)

“They did not understand my pain, but someday they will be getting old, then they also will have the same pain, I know that.” (p.682)

**Finding 2:** Older women tended to attribute fatigue to old age, even though they did acknowledge that their chronic conditions also influenced their energy levels. (U)
"It's just a combination of everything. I am eighty-four, so you do get slower . . . a combination [of age and health problems], but mostly years."31 (p.680)

Finding 3: Older women with osteoarthritis associated their chronic condition with the ageing process and feeling old. (U)

"I blame it on old age."45 (p.54)

Finding 4: Older women with osteoarthritis created a sense of normalcy in their lives by viewing their condition as an inevitable event in their lives. (U)

"It's just an ageing process and I'm getting up there. It's the least of my worries. You know it could be a lot worse."45 (p.65)

Finding 5: One factor contributing to older women's acceptance of having osteoarthritis was their belief that their chronic illness was part of the ageing process. (U)

"I look at arthritis as part of the ageing process, and I'm getting up there. It's the least of my worries, and I can't do anything about it. It could be a lot worse."45 (p.65)

Finding 6: Some older women did not see their chronic illnesses as stigmatising because they thought that many people had similar or worse problems, and it was usual for elderly women like themselves. (U)

"Well, you have to expect that some things happen with advancing age. A number of people around here are stronger in some ways and weaker in others."44 (p.492)

Finding 7: Some older women did not see themselves as ill in spite of having chronic conditions, because they saw their conditions as problems that they could deal with. (U)

"I think arthritis sets in when you are older...As you get older, most people have some form of arthritis. You know you have these things and you don't dwell on them. You know you have to take your medication...If you are able to live with your problems, they are not really problems."44 (p.493)

Category 2: Focusing on the positive

To redefine their meaning of health, older women focus on positive aspects of their experiences of chronic illness. Failing to do so can cause them to experience disempowerment from their chronic illnesses.
Finding 1: Older women with chronic heart failure appreciated their remaining physical and mental abilities. (U)
“...I do boil the potatoes myself...I am glad that I can take care of that.” (p.293)

Finding 2: Older women with Stage II heart failure experienced loss of emotional control, leading to difficulty in achieving happiness. (U)
“I don’t think I’m as happy as I was. You have to work on being content, and before this, I didn’t have to do that.” (p.445)

Finding 3: Older women with Stage II heart failure made a conscious choice to be happy despite their illness. (U)
“You can choose to be unhappy. You can choose to be miserable, and you can choose to try to make people miserable. But nobody can make you miserable if you won't let ’em. Right?” (p.446)

Finding 4: Older women with Stage II heart failure used positive self-talk to focus on what they could do in spite of their illness. (C)
"...I’m a survivor, and I live with it. I don’t have to go down with the ship.” (p.446)

Finding 5: Some older women strove to maintain a positive self-concept by focusing on things they could do despite their illnesses. (U)
"...I just don’t think too much about things unless they are something that can be done something about, and then I go and do it.” (p.682)

Finding 6: Some older women with chronic conditions saw but accepted themselves being ill, and described themselves as doing their best in spite of their physical problems. (U)
"...I don’t let no sickness get me down...When I get determined I want to do something, I go ahead and do it regardless...I think I am pretty active myself with my condition.” (p.493)

Finding 7: Some older women with multi-morbidity used social comparisons as an internal strategy to maintain their self-concepts. (C)
“They often compared themselves with friends and relatives who they described as ‘more unfortunate others’ who were faced with fates perceived as much worse than their own (e.g., Alzheimer’s disease).” (p.684)
Finding 8: Through striving to reduce their chronic osteoarthritic pain, the older Korean American women also sought to restore their self-esteem. (C)

“I have the ability to work in a standing position, and I am proud that I can manage my house chores by myself.”46 (p.683)

Category 3: Distraction from illness

Older women with chronic conditions engage in various activities to distract themselves from their illnesses. They focus themselves on leading meaningful and productive lives, in spite of their chronic conditions.

Finding 1: Some older women with multi-morbidity kept themselves busy instead of focusing on their illnesses. (U)

“All the ladies want to do is talk about their illness, and I think that is bad. I think they ought to get their mind on [other things].”431 (p.683)

Finding 2: Older women with Stage II heart failure redirected their mental focus on what they could do in spite of their illness through participating in meaningful activities. (U)

“I just stopped thinking about me, and I just went out there and helped other people [through volunteer work].”47 (p.446)

Finding 3: The older women with osteoarthritis strove to maintain a sense of normalcy in their lives by using diversional activities. (U)

“I try not to let it get me down that's why I do so much handwork. When you're working, I'm counting, you can't be thinking about how bad you feel or what you can't do. So that's why I keep myself busy.”45 (p.61)

Category 4: Religion

Older women with chronic illnesses also rely on religion as a coping resource. They entrust themselves in their religious faith, thus buffering their emotional wellbeing against the challenges of living with chronic illnesses.

Finding 1: Older women with osteoarthritis relied on religion to re-establish some degree of normalcy in their lives. (C)

“I ask God to give me strength and endurance to keep going.”45 (p.64)
Finding 2: Older women with Stage II heart failure strengthened their relationships with religion. (U)

"HF has only firmed my belief that God's in charge. I put it into Your hands, Lord, and that's just about what it amounts to."47 (p.446)

Finding 3: Some older women with multimorbidity relied on religion to cope with their illnesses. (U)

“You know if something is wrong with you, you take it to the Lord and He takes care of it.”31 (p.683)

Meta-synthesis 5: Relying on social support

As the clinician-patient relationship is an important source of social support, clinicians should practise therapeutic communication to convey care and concern to their older female patients. Social support is critical to self-management by older women with chronic illnesses. They seek informational, instrumental and emotional support from their social networks, which include their families, close friends, healthcare providers and animals. A lack of social support can undermine effective self-management in these older women (see Figure 6).

Figure 6: Relying of social support
Category 1: Relying on social networks

Older women with chronic illnesses rely on their social networks for support. Very salient is the emotional support that they derive from their relationships with others, including animals.

Finding 1: Life course changes in older women’s social networks could affect social support they received in their management of chronic conditions. (C)

“Fatima used to talk to her neighbour frequently and reported great emotional satisfaction from the relationship, but said she lost her neighbour to Alzheimer’s disease.”

Finding 2: Older women with Stage II heart failure strengthened their existing relationships with family and friends. (C)

“Sometimes they reached out more indirectly than in the past, using letters, e-mail and phone calls.”

Finding 3: Animals could be an important source of support for older women with Stage II heart failure. (U)

“Besides my husband, my dog is my best friend and companion. We exercise together every day by walking. After bypass surgery, I believe they should pass out dogs instead of mended heart pillows. A dog will give you back so much more.”

Finding 4: Support networks of older women with osteoarthritis positively influenced their experiences of living with their illness. (U)

“My friends come over, and I like to be social. I think that’s what is helping me. If I was a loner, I think I would feel it more.”

Finding 5: Older women with Stage II heart failure depended on others, both socially and in their support systems. (C)

“When you're in the company of others, you have a tendency to forget about yourself. I think having friends that care about you is the best medicine in the world.”

Category 2: Necessity of functional assistance

The necessity of functional assistance is evident in instrumental support that older women with chronic illnesses frequently require from other people to cope with their daily lives.

Finding 1: Homemaker services allowed older women to better manage their daily lives but their accessibility was affected by their socioeconomic status. (C)
"Those women who had access to homemaker services (the well-to-do and those poor enough to qualify for free services) did have someone to perform basic tasks they could no longer accomplish alone."^{44} (p.489)

**Finding 2:** Not having enough energy to perform the necessary activities of daily life made older women with chronic heart failure vulnerable and in need of help from others. (C)

"...for example with heavy household tasks, shopping, hair-washing, or travelling."^{43} (p.293)

**Finding 3:** Some older women welcomed help others volunteer to them because of the visibility of their chronic conditions. (U)

"It’s so maddening to have to walk through the parking lot and the buildings and open the doors and move your cane and take your coat off and all that stuff...In the shopping centres people are always very nice to me with me with my cane, especially Black people. Any age, they always help you."^{44} (p.491)

**Finding 4:** When other people did not volunteer assistance to chronically ill older women despite the visibility of their physical disabilities, they may perceive the lack of it as neglect. (U)

"Other people around me forget to be careful...If they don't offer, I find it very difficult to ask. I have a funny feeling that if I have to ask them, somebody that knows me very well, then it's just too bad. So, there's a lot of that."^{44} (p.492)

**Category 3: Family members undermining effective self-management**

Family members can inadvertently thwart older women's efforts to adhere to their treatment regimens, thus undermining effective self-management of their chronic conditions.

**Finding 1:** Even though families appeared to understand the older women's conditions, they might inadvertently encourage noncompliant behaviours in the older women. (U)

"I laugh because he [son] loves everything [food] just like I do. No, he would never say, "Mom, you shouldn't eat that." But if he would come home and I was out mowing the yard, he would get angry there. But now he doesn't care what I fix to eat."^{31} (p.688)

**Finding 2:** Family's failure to understand older women's chronic conditions could undermine their self-management. (U)

"The oldest one [daughter] doesn't understand that you have to eat at a regular time...The one that lives here with me, she knows what is going to happen if you don't, but the others are just kind of blank. I went to visit and [dinner] was like 9:00 p.m. one night, but that was too late...I had to eat me a snack about 5:00 p.m...but it [sugar] was up, you know, because I ate two dinners just about."^{31} (p.687)
Category 4: Unable to socialise

Chronic conditions can significantly impair older women’s ability to socialise with other people. Therefore, older women with chronic conditions risk losing support from their social networks, which in turn impacts on their experiences of self-management.

Finding 1: Fatigue affected the social lives of older women with chronic heart failure. (C)
“Instead of the grandmother helping her grandchildren, the grandchildren had to help their grandmother. Living a long distance away from friends and relatives made it difficult to meet up in person since travelling had become strenuous, giving rise to feelings of loneliness.” (p.292)

Finding 2: Older women with chronic illnesses decreased their social interaction because they were unable to participate in social activities due to their physical limitations. (U)
“I no longer go to my sister’s to play bridge because she doesn’t have lavatory on the first floor. I would have difficulty waiting until I was dummy and rushing up the stairs.” (p.487)

Finding 3: Older women with chronic illnesses reduced their participation in social activities, because their physical symptoms affected their satisfaction with these activities. (U)
“...when you are tired and you are hurting, you don’t enjoy things as much.” (p.680)

Finding 4: Older women with osteoarthritis had reduced ability to socialise. (U)
“I just don’t visit anymore. It’s very hard when you’re in pain, to enjoy it.” (p.65)

Finding 5: Older women with osteoarthritis had to curtail their social activities. (U)
“The only thing I know is I don’t think I can dance anymore and we used to go dancing all the time.” (p.49)

Category 5: Support by provider

Healthcare providers are an important source of informational support to older women with chronic conditions, providing them guidance in their self-management. Therefore, their relationships with healthcare providers affect their experiences of chronic illnesses.
Finding 1: Relationships with healthcare providers could negatively impact on the experiences of older women living with osteoarthritis and their self-management of the condition. (U)

“The doctors told me it was arthritis and learn to live with it. They just say everybody is going to get it. A lot of times they ignore you completely. Take two aspirins and call me in the morning. I think doctors should be a little more forward with you and explain what to expect and how you can treat yourself.”45 (p.55)

Finding 2: Financial issues could affect relationships between older women with osteoarthritis and their healthcare providers. (U)

“The medications I take for my arthritis are very expensive. I don’t have insurance that covers my medications. I found myself using herbal preparations to treat my symptoms. Now, they say some of the herbs are not safe.”45 (p.56)

Discussion

Findings from this systematic review confirm some important challenges community-dwelling older women with chronic illnesses face in their experiences of self-management. Coping with physical disability is a major theme in these women’s experiences in self-management of their chronic conditions.31,43-47 Physical disability invariably affects their functional capacity, and their compromised physical independence is a major factor contributing to their perceived loss of control over their bodies and lives. Older women in all the reviewed studies discussed how their physical disabilities impact on their daily functioning, especially in terms of domestic activities like doing household chores31,43-47 and caring for young children.44-45,47 This suggests that many older women continue to identify themselves with their lifelong social roles within the domestic sphere, in spite of their illnesses and old age. Such domestic activities frequently involve manual work, thus challenging their physical limitations. Consequently, older women with chronic illnesses may experience role loss resulting from their inability to perform the domestic work that is physically demanding, thus exacerbating their perceived loss of control.

Financial security can influence the ability of older women to self-manage their chronic illnesses. Two studies31,45 illustrated how older women’s financial constraints can undermine their adherence to treatment regimens prescribed by their physicians. In another study, Rhodes and Bowles47 noted that some older women struggled with living on a tight budget because of their illness. This finding, however, should be viewed with caution as there was no data to substantiate it in the manuscript. In contrast, Belgrave44 demonstrated that for those who were financially secure, money provided access to homemaking services, thus alleviating their difficulty in daily functioning. However, these women were an exception as the majority of the participants in her study were considered financially insecure. All of these studies highlighted the economic vulnerability of older women, which can undermine their self-management of chronic illnesses.
This systematic review also provides a useful insight into older women’s experiences of self-management, particularly how they redefine their meaning of health in the context of illness. Besides developing their self-expertise in managing their chronic conditions, older women also adopt a new perspective towards their illnesses to maintain their emotional well-being. Specifically, they accept their chronic conditions as “part and parcel” of old age, which allows them to appraise their health more positively. Through normalisation of their chronic conditions, the older women better appreciate their remaining capacities, and become more accepting towards their illnesses. Older women also redefine their meaning of health through their religion, focusing on positive aspects of their lives and engaging in meaningful activities to distract themselves from illness. The concept of redefining health is not dissimilar to that of health within illness\(^{39}\), in which an individual experiences meaningfulness of life despite living with a chronic illness that can be physically debilitating.

In addition, this systematic review demonstrates the importance of social support to older women’s experiences of self-management. Social support is derived from their social networks comprised of their families, friends, members of their immediate community, as well as their healthcare providers. Forms of social support include instrumental\(^{31, 43-45}\), informational\(^{31, 46}\) and emotional\(^{31, 43-45, 47}\) In particular, emotional support emerges as the most prominent aspect from the findings, suggesting that older women with chronic illnesses highly value their social connection with others. This is underscored by our finding that older women in all the reviewed studies suffered a sense of loss from their inability to socialise with other people due to their physical disabilities. Older women’s need for social connection is also evident in their relationships with healthcare providers. In one study\(^{45}\) on older women with OA, participants expressed a sense of frustration and abandonment with their physicians’ seeming lack of empathy towards their illness.

In contrast, two studies suggested that excessive social support can be perceived as invasive and restricting. Roberto, Gigliotti and Husser\(^{31}\) found that overprotective family members can cause older women to experience an unwanted infringement of their privacy and autonomy. Similarly, some older women in Belgrave’s study\(^{44}\) reported that they felt ‘hovered over’ by surrounding people who were overzealous about volunteering help. These findings show that social support, however well-meaning it is, needs to be sensitive and respectful towards the older women’s need for independence. Therefore, social support has to maintain a delicate balance between developing dependence or independence of the recipient.

Family members undermining effective self-management is another important finding that demonstrates the insidious social influences on older women’s experiences of self-management. Older women’s adherence can be sabotaged by their family members’ ignorance or carelessness towards their treatment regimens, in spite of overt family support in other areas.\(^{31}\) This indicates the importance of family being well-informed of and committed to their family members’ treatment regimens, suggesting that patient education needs to closely involve these older women’s families as well.
In summary, the chronic illness experience of older women was characterised by a constant struggle between losing and gaining control. Many older women perceived a loss of control over their bodies, due to their inability to control physical symptoms from interfering with their daily functioning. These symptoms were frequently described as unpredictable or resistant to interventions. When chronic illness involved physical disability, the loss of independence and freedom also contributed to the perceived loss of control over the body.

To reclaim their sense of control over their lives, these women had to mitigate the impact of their illnesses on their lives, in physical and psychological terms. They strove to overcome their physical symptoms to keep their bodies as active as possible and prevent further decline. They also sought treatments which may be considered unusual in their cultural background. For those who were financially strapped, they persevered in financing their medical treatments in spite of their monetary problems. The reclamation of control also involved psychological adjustment, which constituted the older women adjusting self-expectations of their functional capacity and allowing themselves to live with their illnesses.

Self-management encapsulated the essence of regaining and maintaining a sense of control over the chronic illness. For the older women in the reviewed studies, self-management involved developing their self-expertise, redefining their meaning of health and relying on social support. They developed self-expertise by learning and applying their own knowledge and practices of self-management through personal experience. They also redefined their meaning of health in the context of chronic illness, as well as relied on people in their own social networks to cope with the challenges of their illnesses.

Limitations

An important limitation concerns the cultural representation of older women in the reviewed studies. An overwhelming majority of participants in these studies were Caucasian from either the United States\(^{31, 44-45, 47}\) or Sweden\(^{43}\). Only one study\(^{44}\) included African Americans or Hispanics, while another\(^{46}\) included Korean American older women from the United States who had migrated from their native country. It is, therefore, highly likely that there is a cultural bias in the findings due to underrepresentation of other cultures.

Conclusions

The systematic review shows that community-dwelling older women with chronic illnesses experience a loss of control over their bodies due to the physical symptoms and other disabilities their conditions produce, thus affecting their well-being. They strive to regain and maintain their sense of control by mitigating their physical limitations through psychological and practical mechanisms. In the process of doing so, they develop their own self-expertise in managing their conditions, as well as redefine their meaning of health to maintain their emotional well-being in spite of their illnesses. However, financial
security is crucial to effective self-management as it significantly affects how older women adhere to their treatment regimens. Also pivotal to their self-management is the social support that these women receive from their social networks, particularly emotional support which they experience as a social connection with others.

**Implications for practice**

The following recommendations are based on findings from the best available qualitative studies, which represent level 1 evidence.

Healthcare providers should not focus on just symptom management, but also provide practical guidance in reducing patients' risk of experiencing role loss through physical and emotional adjustments to their illnesses. This may be achieved by well-thought educational programmes for these patients. (Level 1)

Healthcare providers should recognise that financial insecurity appears to be a common issue in older women, which can undermine effective self-management of their chronic illnesses, particularly their adherence to treatment regimens. Whenever possible, healthcare providers should direct economically vulnerable patients to sources of financial assistance. Moreover, healthcare providers need to be sensitive to their patients' socioeconomic backgrounds when planning their treatment regimens, providing alternatives which are compatible with their incomes. (Level 1)

Healthcare providers should foster a collaborative partnership with their older female patients, which encourages them to develop self-expertise in managing their chronic conditions in daily life. (Level 1)

The provider-patient relationship is an important source of social support for older women with chronic illnesses. Therefore, healthcare providers should practise therapeutic communication to convey care and concern to their older female patients. They should also be mindful and respectful of older women's personal autonomy, and engage them in shared decision-making regarding their health. (Level 1)

Wherever relevant, healthcare providers should also include the family in patient education, so that family members are well-informed of the older woman’s treatment regimen. (Level 1)
Implications for research

Further qualitative research should be conducted to explore self-management experiences of older women living with chronic illnesses. The systematic review has identified a severe lack of cultural diversity in the reviewed studies, with an overrepresentation of Caucasian females and underrepresentation of other cultural groups. Therefore, there is a need to expand the focus on older females to include those from other cultural backgrounds, so as to identify issues and challenges in self-management which may differ across cultural groups.

Acknowledgements

The primary reviewer would like to acknowledge both her supervisors, Associate Professor Edward Poon and Professor Desley Hegney, for their support and guidance throughout the systematic review which was conducted as part of the school curriculum.

Conflict of interest

No conflict of interests noted.
References


Appendix I: Search strategies

<table>
<thead>
<tr>
<th>Database</th>
<th>Search strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>CINAHL</td>
<td>1. (MM &quot;Chronic Disease&quot;) and (MH &quot;Aged+&quot;) and (MH &quot;Women+&quot;) and (MH &quot;Self Care+&quot;) (2)</td>
</tr>
<tr>
<td></td>
<td>2. (MM &quot;Chronic Disease&quot;) and (MH &quot;Aged+&quot;) and (MH &quot;Women+&quot;) (15)</td>
</tr>
<tr>
<td></td>
<td>3. (MH &quot;Aged+&quot;) and (MH &quot;Women+&quot;) and (MH &quot;Self Care+&quot;) (43)</td>
</tr>
<tr>
<td>MEDLINE</td>
<td>1. (<em>Aged</em>[Mesh]) AND (<em>Women</em>[Mesh]) AND (<em>Chronic Disease</em>[Mesh]) (4)</td>
</tr>
<tr>
<td></td>
<td>2. (<em>Aged</em> [Mesh]) AND (<em>Women</em> [Mesh]) AND (<em>Self Care</em>[Mesh]) (105)</td>
</tr>
<tr>
<td></td>
<td>3. (<em>Aged</em> [Mesh]) AND (<em>Women</em> [Mesh]) AND (<em>Chronic Disease</em> [Mesh]) AND (<em>Self Care</em>[Mesh]) (8)</td>
</tr>
<tr>
<td>Embase</td>
<td>1. (Experience) AND (Chronic disease OR chronic illness OR chronic condition) AND (Older OR aged OR elderly) AND (Women OR female) AND (Self care OR self management) (55)</td>
</tr>
<tr>
<td></td>
<td>2. (Experience) AND (Chronic disease OR chronic illness OR chronic condition) AND (Older OR aged OR elderly) AND (Women OR female) (434)</td>
</tr>
<tr>
<td></td>
<td>3. (Experience) AND (Older OR aged OR elderly) AND (Women OR female) AND (Self care OR self management) (4)</td>
</tr>
<tr>
<td></td>
<td>4. (Chronic disease OR chronic illness OR chronic condition) AND (Older OR aged OR elderly) AND (Women OR female) AND (Self care OR self management) (6)</td>
</tr>
<tr>
<td>PsycINFO</td>
<td>1. Older AND women AND self care.mp. [mp=title, abstract, heading word, table of contents, key concepts] (104)</td>
</tr>
<tr>
<td></td>
<td>2. Elderly AND women AND self care.mp. (43)</td>
</tr>
<tr>
<td></td>
<td>3. Aged AND women AND self care.mp. (139)</td>
</tr>
<tr>
<td></td>
<td>4. Older AND women AND self management.mp. (43)</td>
</tr>
<tr>
<td></td>
<td>5. Elderly AND women AND self management.mp. (13)</td>
</tr>
<tr>
<td></td>
<td>6. Aged AND women AND self management.mp. (46)</td>
</tr>
<tr>
<td></td>
<td>7. Older AND women AND chronic illness AND self care.mp. (10)</td>
</tr>
<tr>
<td></td>
<td>8. Older AND women AND chronic condition AND self care.mp. (0)</td>
</tr>
<tr>
<td></td>
<td>9. Older AND women AND chronic disease AND self care.mp. (3)</td>
</tr>
<tr>
<td></td>
<td>10. Older AND women AND chronic illness AND self management.mp. (6)</td>
</tr>
<tr>
<td></td>
<td>11. Older AND women AND chronic condition AND self management.mp. (1)</td>
</tr>
<tr>
<td></td>
<td>12. Older AND women AND chronic disease AND self management.mp. (1)</td>
</tr>
</tbody>
</table>

Legend:
- MM – major concept
- MH – MeSH term
- + – expand search
| 13. | Elderly AND women AND chronic illness AND self care.mp. (2) |
| 14. | Elderly AND women AND chronic condition AND self care.mp. (0) |
| 15. | Elderly AND women AND chronic disease AND self care.mp. (1) |
| 16. | Elderly AND women AND chronic illness AND self management.mp. (1) |
| 17. | Elderly AND women AND chronic condition AND self management.mp. (0) |
| 18. | Elderly AND women AND chronic disease AND self management.mp. (1) |
| 19. | Aged AND women AND chronic illness AND self care.mp. (5) |
| 20. | Aged AND women AND chronic condition AND self care.mp. (0) |
| 21. | Aged AND women AND chronic disease AND self care.mp. (1) |
| 22. | Aged AND women AND chronic illness AND self management.mp. (3) |
| 23. | Aged AND women AND chronic condition AND self management.mp. (0) |
| 24. | Aged AND women AND chronic disease AND self management.mp. (0) |

| Scopus |
| 1. | TITLE-ABS-KEY(older OR aged OR elderly) AND TITLE-ABS-KEY(women OR female) AND TITLE-ABS-KEY(self care OR self management) AND TITLE-ABS-KEY(chronic illness OR chronic disease OR chronic condition) (457) |
| 2. | TITLE-ABS-KEY(older OR aged OR elderly) AND TITLE-ABS-KEY(women OR female) AND TITLE-ABS-KEY(self care OR self management) AND TITLE-ABS-KEY(experience) (1625) |
| 3. | TITLE-ABS-KEY(older OR aged OR elderly) AND TITLE-ABS-KEY(women OR female) AND TITLE-ABS-KEY(self care OR self management) AND TITLE-ABS-KEY(chronic illness OR chronic disease OR chronic condition) AND TITLE-ABS-KEY(experience) (86) |

| ScienceDirect |
| 1. | TITLE-ABSTR-KEY((chronic illness OR chronic disease OR chronic condition) AND (self-management OR self-care) AND (older OR elderly OR aged) AND (women OR female) AND (experience)) (1269) |
| 2. | TITLE-ABSTR-KEY((chronic illness OR chronic disease OR chronic condition) AND (self-management OR self-care) AND (older OR elderly OR aged) AND (women OR female) AND (experience)) [All Sources[Nursing and Health Professions]] (266) |
| 3. | TITLE-ABSTR-KEY((chronic illness OR chronic disease OR chronic condition) AND (self-management OR self-care) AND (older OR elderly OR aged) AND (women OR female) AND (experience)) [All Sources[Medicine and Dentistry]] (1132) |
| 4. | TITLE-ABSTR-KEY((chronic illness OR chronic disease OR chronic condition) AND (self-management OR self-care) AND (older OR elderly OR aged) AND (women OR female) AND (experience)) [All Sources[Social Sciences]] (214) |

<p>| Sociological Abstracts |
| 1. | KW = (older or elderly or aged) and KW = women and KW = (chronic illness or chronic disease or chronic condition) and KW = (self care or self management) (8) |
| 2. | KW = (older or elderly or aged) and KW = women and KW = (self care or self management) (40) |
| 3. | (older or elderly or aged) and (women) and (self care or self management) (198) |
| 4. | (older or elderly or aged) and (women) and (self care or self management) and (experience or meaning) (86) |</p>
<table>
<thead>
<tr>
<th>Social Sciences Citation Index</th>
<th>Proquest</th>
<th>GoogleScholar</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. (Older OR elderly OR aged) AND (women) AND ((chronic illness) OR (chronic condition) OR (chronic disease)) AND ((self management) OR (self care))</td>
<td>Experience AND (older OR elderly OR aged) AND (women OR female) AND (chronic illness OR chronic disease OR chronic condition) AND (self care OR self management)</td>
<td>allintitle: experience chronic elderly women</td>
</tr>
<tr>
<td>2. (Experience) AND (Older OR elderly OR aged) AND (women) AND ((chronic illness) OR (chronic condition) OR (chronic disease)) AND ((self management) OR (self care))</td>
<td>Experience AND (older OR elderly OR aged) AND (women OR female) AND (self care OR self management)</td>
<td>allintitle: experience chronic older women</td>
</tr>
<tr>
<td>3. (Older OR elderly OR aged) AND (women) AND ((self management) OR (self care))</td>
<td>(Older OR elderly OR aged) AND (women OR female) AND (chronic illness OR chronic disease OR chronic condition) AND (self care OR self management)</td>
<td>allintitle: experience chronic aged women</td>
</tr>
<tr>
<td>4.</td>
<td>(Older OR elderly OR aged) AND (women OR female) AND (chronic illness OR chronic disease OR chronic condition)</td>
<td>allintitle: chronic older women</td>
</tr>
<tr>
<td>5.</td>
<td>(Experience) AND (older OR elderly OR aged) AND (women OR female) AND (chronic illness OR chronic disease OR chronic condition)</td>
<td>allintitle: chronic aged women</td>
</tr>
<tr>
<td>6.</td>
<td>allintitle: chronic aged women</td>
<td>allintitle: chronic older women</td>
</tr>
<tr>
<td>7.</td>
<td>allintitle: chronic aged women</td>
<td>allintitle: chronic older female</td>
</tr>
<tr>
<td>8.</td>
<td>allintitle: chronic aged women</td>
<td>allintitle: chronic aged female</td>
</tr>
<tr>
<td>9.</td>
<td>allintitle: chronic aged women</td>
<td>allintitle: chronic aged female</td>
</tr>
<tr>
<td>10.</td>
<td>allintitle: chronic older women self care</td>
<td>allintitle: chronic older women self care</td>
</tr>
<tr>
<td>11.</td>
<td>allintitle: chronic older women self management</td>
<td>allintitle: chronic older women self management</td>
</tr>
<tr>
<td>12.</td>
<td>allintitle: chronic older women self care</td>
<td>allintitle: chronic aged women self care</td>
</tr>
<tr>
<td>13.</td>
<td>allintitle: chronic older women self management</td>
<td>allintitle: chronic aged women self care</td>
</tr>
<tr>
<td>14.</td>
<td>allintitle: chronic aged women self care</td>
<td>allintitle: chronic aged women self management</td>
</tr>
<tr>
<td>15.</td>
<td>allintitle: chronic aged women self care</td>
<td>allintitle: chronic aged women self management</td>
</tr>
<tr>
<td>16.</td>
<td>allintitle: chronic older female self care</td>
<td>allintitle: chronic older female self care</td>
</tr>
<tr>
<td>17.</td>
<td>allintitle: chronic older female self management</td>
<td>allintitle: chronic older female self management</td>
</tr>
<tr>
<td>18.</td>
<td>allintitle: chronic older female self care</td>
<td>allintitle: chronic older female self management</td>
</tr>
<tr>
<td>19.</td>
<td>allintitle: chronic older female self management</td>
<td>allintitle: chronic older female self management</td>
</tr>
</tbody>
</table>
20. allintitle: chronic aged female self care (0)
21. allintitle: chronic aged female self management (0)
Appendix II: JBI Critical Appraisal Checklist for Interpretive and Critical Research

User: Craig Lockwood

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Yes</th>
<th>No</th>
<th>Unclear</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) There is congruity between the stated philosophical perspective and the research methodology.</td>
<td>☑️</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>2) There is congruity between the research methodology and the research question or objectives.</td>
<td>☑️</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>3) There is congruity between the research methodology and the methods used to collect data.</td>
<td>☑️</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>4) There is congruity between the research methodology and the representation and analysis of data.</td>
<td>☑️</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>5) There is congruity between the research methodology and the interpretation of results.</td>
<td>☑️</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>6) There is a statement locating the researcher culturally or theoretically.</td>
<td>☑️</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>7) The influence of the researcher on the research, and vice-versa, is addressed.</td>
<td>☑️</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>8) Participants, and their voices, are adequately represented.</td>
<td>☑️</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>9) The research is ethical according to current criteria or, for recent studies, there is evidence of ethical approval by an appropriate body.</td>
<td>☑️</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>10) Conclusions drawn in the research report do appear to flow from the analysis, or interpretation, of the data.</td>
<td>☑️</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>
Appendix III: JBI QARI Data Extraction Form for Interpretive & Critical Research

**Extraction Details: Bousfield C - Journal of Advanced Nursing (1997)**

<table>
<thead>
<tr>
<th>Methodology:</th>
<th>Phenomenology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Method:</td>
<td>Interview</td>
</tr>
<tr>
<td>Phenomena of Interest:</td>
<td>Characteristics of good leadership</td>
</tr>
<tr>
<td>Setting:</td>
<td>Acute Care</td>
</tr>
<tr>
<td>Geographical:</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>Cultural:</td>
<td>Anglo Saxon</td>
</tr>
<tr>
<td>Participants:</td>
<td>Nursing staff in senior clinical positions</td>
</tr>
<tr>
<td>Data Analysis:</td>
<td>thematic analysis</td>
</tr>
<tr>
<td>Authors Conclusion:</td>
<td>Leadership must be proven in practice</td>
</tr>
<tr>
<td>Reviewers Comments:</td>
<td>conclusions appear congruent with textual reporting</td>
</tr>
<tr>
<td>Complete</td>
<td>Yes</td>
</tr>
</tbody>
</table>
## Appendix IV: Characteristics of included studies

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Country Culture</th>
<th>Research purpose (or questions if the former was unstated)</th>
<th>Methodology</th>
<th>Methods</th>
<th>Context of chronic condition/s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgrave et al., 1990</td>
<td>1990</td>
<td>Country unstated</td>
<td>What is the experience of chronic illness in the everyday lives of non-institutionalized elderly women? In what ways is stigmatization a part of the experience? How is the chronic illness related to self-concept? How is the relationship (between chronic illness and self-concept) affected by the experience of specific ailments?</td>
<td>Unstated</td>
<td>Data collection: Face-to-face interviews, Observation of a self-help group, Examination of publications available to lay public</td>
<td>Diabetes or arthritis, but not strictly limited to these two conditions</td>
</tr>
<tr>
<td>Dickson &amp; Kim, 2003</td>
<td>2003</td>
<td>United States</td>
<td>To gain a deeper understanding of older Korean American women’s experiences of chronic osteoarthritic pain</td>
<td>Grounded theory</td>
<td>Data collection: Two face-to-face, unstructured interviews, One follow-up telephone interview</td>
<td>Osteoarthritis</td>
</tr>
<tr>
<td>Grabowski et al., 2002</td>
<td>2002</td>
<td>United States</td>
<td>To explore the day-to-day experiences of older women with osteoarthritis</td>
<td>Grounded theory</td>
<td>Data collection: Face-to-face semi-structured interviews</td>
<td>Osteoarthritis</td>
</tr>
<tr>
<td>Hagglund et al., 2008</td>
<td>2008</td>
<td>Sweden</td>
<td>To illuminate the lived experience of fatigue among elderly women with chronic heart failure</td>
<td>Qualitative explorative, descriptive study</td>
<td>Data collection: Face-to-face narrative interviews</td>
<td>Chronic heart failure</td>
</tr>
<tr>
<td>Authors</td>
<td>Country</td>
<td>Participants</td>
<td>Research Question</td>
<td>Methodology</td>
<td>Data Collection</td>
<td>Data Analysis</td>
</tr>
<tr>
<td>---------</td>
<td>---------</td>
<td>--------------</td>
<td>-------------------</td>
<td>-------------</td>
<td>----------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Rhodes &amp; Bowles</td>
<td>United States</td>
<td>Caucasians</td>
<td>To examine and describe the experience of living with HF from the perspective of the women who live with this health problem</td>
<td>Phenomenology</td>
<td>Face-to-face, semi-structured interviews</td>
<td>Colaizzi’s (1978) seven-step method</td>
</tr>
</tbody>
</table>
| Roberto, Gigliotti & Husser | United States | Caucasians | • What problems and symptoms do older women associate with their health conditions?  
• What specific management strategies do older women use to cope with their health conditions?  
• How does living with multiple health conditions affect older women’s relationship and reliance on members of informal network? | Mixed quantitative and qualitative methodology belonging to a bigger-scale study | Telephone interviews  
Face-to-face semi-structured interviews | Open coding |

Zhi Ru et al.  Experiences of older women living with chronic illnesses © the authors 2011  page 2825
Appendix V: Excluded studies

Reason for exclusion: Although the phenomenon of interest was the experience of older women with osteoarthritis, a chronic condition listed in our inclusion criteria, the study focused their physical symptoms and limitations, and did not explore their experiences of self-management.

Reason for exclusion: The phenomenon of interest was “inner strength”, which the study sought to describe and explicate as instead of the experiences of self-management in older women with chronic illnesses. As a result, self-management was not discussed in detail.

Reason for exclusion: The study focused on the psychological aspects of the experience of the older woman living with chronic heart failure, from living in her own home to being transferred to a nursing home. The latter experience in the nursing home also did not satisfy our inclusion criterion of participants being community-dwelling.

Reason for exclusion: The phenomena of interest were these older women’s perceptions of their initial experiences of an acute cardiovascular event leading to their diagnosis, and the long-term influences of their conditions on their daily lives. Experiences of self-management were not discussed.

Reason for exclusion: The focus of the paper was on chronic leg ulcers rather than the chronic vascular conditions which caused them.

Reason for exclusion: The phenomenon of interest was how older women with RA experience their health. The findings did not cover the aspect of self-management, even though the topic appeared relevant.


Reason for exclusion: The phenomenon of interest was how older women with congestive heart failure conceived their life situation, focusing on how their perspectives towards their illness. The study did not cover self-management in its findings.


Reason for exclusion: This was a quantitative study.


Reason for exclusion: Participants included women younger than sixty-five years, even though the average age of participants was sixty-one years. Self-management was not explored, instead the study focused on how RA impacted on the participants' daily lives.


Reason for exclusion: Chronic pain in the participants was caused by chronic conditions which included those not stated in the inclusion criteria. In addition, strategies of self-management formed a small part of the study's findings.


Reason for exclusion: The phenomenon of interest was the meaning of health to older women with chronic illnesses. Although the study's topic appeared relevant to the systematic review, its findings did not include self-management.

Reason for exclusion: Despite its title, the study focused on the relationships between self-concept and the meanings of ageing and chronic illness, and the implications on how the older women managed their daily lives. The phenomenon of interest was thus irrelevant to our systematic review.