

‘You learn to live with all the things that are wrong with you’: gender and the experience of multiple chronic conditions in later life

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ABSTRACT

This article examines how older adults experience the physical and social realities of having multiple chronic conditions in later life. Drawing on data from in-depth interviews with 16 men and 19 women aged 73+ who had between three and 14 chronic conditions, we address the following research questions: (a) What is it like to have multiple chronic conditions in later life? (b) How do older men and women ‘learn to live’ with the physical and social realities of multiple morbidities? (c) How are older adults’ experiences of illness influenced by age and gender norms? Our participants experienced their physical symptoms and the concomitant limitations to their activities to be a source of personal disruption. However, they normalised their illnesses and made social comparisons in order to achieve a sense of biographical flow in distinctly gendered ways. Forthright in their frustration over their loss of autonomy and physicality but resigned and stoic, the men’s stories reflected masculine norms of control, invulnerability, physical prowess, self-reliance and toughness. The women were dismayed by their bodies’ altered appearances and concerned about how their illnesses might affect their significant others, thereby responding to feminine norms of selflessness, sensitivity to others and nurturance. We discuss the findings in relation to the competing concepts of biographical disruption and biographical flow, as well as successful ageing discourses.

KEY WORDS – chronic conditions, biographical flow, gender, health, ageing.

Introduction

Living with chronic conditions is increasingly a reality for the majority of older adults. Statistics Canada (2006) reports that 77 per cent of men and 85 per cent of women aged 65+ have at least one chronic condition and the average number of chronic conditions increases with age. There is a strong sociological tradition of qualitatively analysing the subjective experience of

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single chronic conditions in later life, such as arthritis (Gibbs 2008; Sanders, Donovan and Dieppe 2002), cancer (Hubbard, Kidd and Kearney 2010; Reeve *et al.* 2010; Sinding and Wiernikowski 2008), osteoporosis (Wilkins 2001), Parkinson's disease (Gisquet 2008; Solimeo 2008; Stanley-Hermanns and Engebretson 2010) and stroke (Becker 1993; Faircloth *et al.* 2004a; Pound, Gompertz and Ebrahim 1998). There is also a small but growing body of research concerned with multiple chronic conditions among older adults (Belgrave 1990; Roberto and McCann 2011), although only one study has included older men (Hurd Clarke, Griffin and the Physical Activity and Chronic Conditions (PACC) Research Team 2008). Collectively, this research has yielded important insights into what it means to be in and living through an ageing, frail body in a society that privileges health, youth and autonomy. However, further research is needed to illuminate how gender and age norms shape and constrain older adults' experiences of multiple chronic conditions. Addressing this gap in the literature, the purpose of this article is to examine how older men and women make sense of and learn to live with the physical and social realities of having multiple morbidities in later life. To that end, we draw on data from in-depth interviews with 16 men and 19 women aged 73+ who had a range of three to 14 chronic conditions (average of six) to address the following research questions:

- 1 What is it like to have multiple chronic conditions in later life?
- 2 How do older men and women 'learn to live' with the physical and social realities of multiple morbidities?
- 3 How are older adults' experiences of illness influenced by age and gender norms?

Theoretical and contextual background

In 1982, Bury published his findings from a study of newly diagnosed, predominantly female, rheumatoid arthritis sufferers, aged 24–64. In this oft-cited article, Bury (1982: 167) argued that illness results in a 'biographical disruption' in relation to the individual's 'taken for granted assumptions and behaviours', 'explanatory systems' (1982: 169) and 'mobilisation of resources' (1982: 170). Thus, the person's previously held suppositions about his or her body, self-concept, plans for the future, personal biography and ability to maintain reciprocal, mutually supportive relationships became fractured or challenged by the physical realities of illness.

However, Faircloth *et al.* (2004b: 242) subsequently argued that in later life chronic illnesses are experienced in a 'biographical flow' as they are incorporated into personal accounts of old age as a time when the onset of

increasing numbers and severity of health issues are to be expected. Research with older adults suggests that illnesses such as arthritis (Gibbs 2008; Gignac *et al.* 2006; Sanders, Donovan and Dieppe 2002), cancer (Hubbard, Kidd and Kearney 2010; Sinding and Wiernikowski 2008), prostatitis (Cameron and Bernardes 1998), heart disease (Husser and Roberto 2009) and stroke (Faircloth *et al.* 2004a; Pound, Gompertz and Ebrahim 1998) tend to be perceived as normal aspects of growing older rather than disruptive to one's personal biography. That said, even as they view their health issues as something to be expected with advanced age, some older individuals may also experience the physical symptoms or consequences of their chronic illnesses to be personally disruptive (Bury 1988; Sanders, Donovan and Dieppe 2002).

At the same time, experiences of chronic conditions have been found to be gendered and influenced by masculinity and femininity norms. Men are socialised to view their bodies as tools for social and physical action such that functional abilities are more highly esteemed than appearance (Franzoi 1995). Because they often involve fatigue, pain and a loss of strength, chronic illnesses can undermine a man's ability to achieve and adhere to hegemonic masculinity, which is typically associated with ambition, autonomy, competitiveness, control, invulnerability and physical and social power and prowess (Bernardes and Lima 2010; Chapple and Ziebland 2002; Charmaz 1994; Connell 2005; Gibbs 2005, 2008; Gray *et al.* 2002; Oliffe 2006; Prentice and Carranza 2002; Robertson, Sheikh and Moore 2010; Solimeo 2008). For these reasons as well as the masculine ideals of stoicism and self-reliance, expressions of pain or despair in the face of physical symptoms or concomitant social losses contravene masculine norms of emotional reserve and toughness (Cameron and Bernardes 1998; Chapple and Ziebland 2002; O'Brien, Hart and Hunt 2007). In their study of the relationship between body image and multiple chronic conditions, Hurd Clarke, Griffin and the PACC Research Team (2008) found that while the older men in the study were displeased with their failing physical abilities and increasing dependence, they were resigned and stoic about their health issues.

Taught to view the body 'as an object of discrete parts that others aesthetically evaluate' (Franzoi 1995: 417), women learn from an early age to be concerned with appearances and the achievement of idealised feminine beauty. Therefore, chronic conditions or their associated treatments that result in alterations to a woman's appearance, especially her body shape or weight, may negatively influence her body image and self-concept (Cornwall and Schmidt 1990; Helms, O'Hea and Corso 2008; Hurd Clarke, Griffin and the PACC Research Team 2008; Roberto and McGraw 1991; Wilkins 2001). For example, Hurd Clarke, Griffin and the PACC Research

Team (2008) found that the majority of the women in their study were dissatisfied with the weight gain that had resulted from the medications they were taking to treat their multiple chronic conditions or their corresponding inability to engage in physical activity. Those female participants who had osteoporosis and Parkinson's disease also conveyed displeasure with the visibility of their illnesses such as the development of rounded shoulders, stooped backs or readily apparent bodily tremors.

Women's experiences of chronic illnesses are also firmly embedded in and influenced by their various social roles and responsibilities. Socialised to be nurturing, cheerful, family-oriented, selfless and sensitive to the needs of others (Prentice and Carranza 2002), women frequently downplay their own suffering relative to the experiences of their friends and family members. As a result, women tend to construct their illnesses as less biographically disruptive and physically harrowing (Pound, Gompertz and Ebrahim 1998; Sanders, Donovan and Dieppe 2002; Sinding and Wiernikowski 2008). Reflecting cultural, gender and generational discourses about appropriate responses to adversity and like the participants in the study by Pound, Gompertz and Ebrahim (1998), the women in the study by Sinding and Wiernikowski (2008) stressed the importance of not dwelling on their physical problems as well as of keeping busy and maintaining a positive outlook irrespective of their bodily suffering.

Although the majority of the research concerned with chronic conditions has focused on single conditions, there is a growing awareness of and attention to the fact that the majority of older adults have multiple morbidities. The extant research in this area reveals that older adults experience multiple chronic conditions both physically and socially. Roberto and McCann (2011) interviewed 36 women aged 69–89 (mean age of 78) and found that the participants experienced their health as problematic when their physical symptoms curtailed their ability to engage in valued social activities. Similarly, in her interviews with 29 older women (mean age of 74), Belgrave (1990) found that the study participants experienced their illnesses in three interrelated ways, namely in relation to specific symptoms, as a result of negative impacts on their activities and lifestyles and finally, with respect to influences on their self-concepts. Interestingly, the older participants (aged 60+) in the focus groups conducted by Lindsay (2009) tended to be more accepting of their multiple health issues and the accompanying physical and social consequences and to demonstrate stronger coping skills. As previously noted, in their pilot study with ten men and ten women aged 68–88, Hurd Clarke, Griffin and the PACC Research Team (2008) found that while older women were dissatisfied with their bodies because of appearance changes stemming from chronic conditions, older men were displeased with their loss of physical strength and functional autonomy.

Methods

Design

The data for this article were drawn from in-depth interviews with 35 older individuals (16 men and 19 women). Ethical approval was granted by the University of British Columbia Behavioural Research Ethics Board. Participants were recruited through advertisements in local newspapers and posters in public facilities. Additionally, we sent invitational letters of recruitment to potential participants using a database of individuals who had participated in a previous study concerned with chronic conditions in which the first author had been a co-investigator. None of our sample had been previously interviewed in the pilot study (Hurd Clarke, Griffin and the PACC Research Team 2008). We only included individuals aged 70+ who had a minimum of three chronic conditions, at least one of which was arthritis, cataracts/glaucoma, back problems, heart disease or diabetes. These conditions were deliberately selected and utilised as inclusion criteria because they are the most prevalent chronic illnesses reported by older adults in Canada and are frequently linked to increased rates of disability and dependency (Statistics Canada 2006). Each participant was interviewed twice by either the first author or one of two female graduate student research assistants (with participants being paired with the same interviewer for both sessions) for an average of 2.4 hours and a total of 97 hours. Although participants were encouraged to speak freely and our interviews were semi-structured, we used a topic guide to ensure that there was consistency across all the interviews. The men and women were asked about their health histories, current health status, daily experiences of having multiple chronic conditions and attitudes towards and experiences in their bodies. Rigour across multiple interviewers was further maintained by holding regular team meetings, reviewing transcripts together and having the first author (who was the principal investigator) provide on-going feedback and mentorship to the two graduate student interviewers.

Sample

While our participants ranged in age from 73 to 91 years, the average age of the men was 78.6 years and the average age of the women was 80.3 years. Study members had between three and 14 chronic conditions, with individuals reporting an average of six health problems. Reflecting our recruitment strategy, the most commonly reported chronic conditions included: arthritis (28), back problems (26), heart disease (24), cataracts/glaucoma (14) and cancer (12). All of the participants resided either in their own homes or retirement communities within the greater Vancouver

regional district, a large urban centre in western Canada. They were diverse with respect to their marital status, incomes, educational attainment, work histories and countries of origin (even as the majority of our study members were of European descent). There was a noticeable difference between the men's and women's levels of education and income. Whereas the majority of the women reported having a high school or technical school education and had lower to middle-class incomes, the men were equally as likely to have a high school or university education and most had middle- to upper-class incomes.

Data analysis

All interviews were digitally recorded and transcribed verbatim by trained research assistants. Following transcription and with the aid of NVivo 8 software, we conducted a thematic analysis (Patton 2002), drawing on the extant literature and theorising as well as examining patterns that emerged in the data. We began by reading and rereading the transcripts to generate an initial codebook that included three broad thematic categories, namely the physical, social and emotional consequences of multiple chronic conditions. Additional analysis resulted in the physical consequences theme being sub-divided into the following sub-themes: decreased balance, erectile dysfunction, fatigue, incontinence, insomnia, loss of hearing/vision/memory, mobility difficulties and resultant use of assistive technology, pain and weight changes. Similarly, the social consequences category was broken down into the following sub-themes: decreased or altered activities, reliance on others and social isolation. Finally, the emotional consequences thematic category included the following sub-themes: acceptance, anger/disappointment/frustration, complaining, feeling old, personal control and social comparisons. Within each broad category, we further examined how men's and women's experiences, behaviours and emotional reactions were both similar and divergent. Although we coded emotional consequences as an independent theme, we found that elements of this category spanned and logically fit with the physical and social consequences of multiple chronic conditions. Thus, we have rolled some of the emotional responses data into our presentation of the first two themes.

Findings

In the three sub-sections that follow, we elucidate the physical, social and gendered realities of having multiple chronic conditions as well as the emotional strategies that our participants employed in their efforts to 'live with' their numerous health issues.

'My body is breaking down like an old car': the physical realities of illness

When asked what it was like to live with their various illnesses, our participants often began by describing the physical symptoms and/or effects associated with each chronic condition. Specifically, 30 (13 men and 17 women) participants reported that they experienced pain, 22 (12 men and ten women) described fatigue, 18 (four men and 14 women) had experienced weight changes, 14 (six men and eight women) indicated that they had difficulty walking and had, therefore, begun to use assistive technologies, ten (two men and eight women) reported decreased balance, ten (five men and five women) noted that they had had losses of hearing, vision and/or memory, ten (eight men and two women) suffered from insomnia, seven (three men and four women) had developed incontinence and five men had erectile dysfunction. The men's accounts of their physical suffering were akin to those of a 75-year-old man who had arthritis, back problems, chronic fatigue syndrome, sleep apnoea and heart disease:

At the moment my back is alright . . . but when your back goes out, you're just totally useless. I use the cane to take the pressure off my back . . . I have arthritis in my joints and in my hips. I can't lay on my back or my stomach in bed. I lay on my side so I'm flip-flopping back and forth. When it gets too sore on the right hip I flip over to the left . . . With Alzheimer's they say you remember things a 100 years ago but you can't remember what happened a minute ago . . . And I have flashes of that too. That makes me think that I might be on my way to that . . . I have also got high blood pressure and I take a vertigo pill and just half a dozen different things . . . but what I'm really concerned about is this chronic fatigue . . . That's the one that's just driving me nuts . . . It doesn't matter whether I have eight or ten hours sleep, I'm just constantly tired. I wake up tired. I go to bed tired. I'm basically fighting off the tiredness all day long . . . I'd say in the last three, four years I have not woken up and felt 'Oh man, hello world I'm here again!' . . . It's so annoying . . . My quality of life is zilch.

In this way, the men frequently described pain, fatigue, loss of memory and decreased mobility as physical realities that constrained their everyday life. The men experienced their various symptoms as a source of exasperation, decreased quality of life and growing perception of themselves as ineffectual.

The female participants recounted stories similar to those of an 80-year-old woman who had back problems, cataracts/glaucoma, chronic obstructive pulmonary disease, osteoarthritis and stomach ulcers, and who had had a hip replacement. She described the physical consequences of her chronic conditions in the following way:

I don't try to do anything too much first thing in the morning until my muscles get going. I'm quite stiff when I get out of bed . . . It hurts my back and my legs to walk and I get short of breath. It's an effort . . . I even bought a walker for when it was really bad – when it was hurting so much. I felt like a real old lady with the walker and it was a nuisance trying to get in and out of a store with it . . . Just walking is a struggle because

I have to be careful . . . because I don't want to lose my balance. I've fallen a few times – tripped on the curb . . . and that was very frustrating because it was embarrassing . . . because usually young women would come up to help and they were tiny and I'm heavy now and you know, I'd say, 'Don't try to lift me, you'll hurt yourself' . . . It's mainly the weight I think that is bothering me because I can't look nice and I can't do all the things I want to do with this weight . . . I've sort of accepted my limitations . . . It bothered me at first but I think I've accepted it.

Therefore, the women experienced their failing bodies as a source of frustration and embarrassment, both in terms of their altered physical abilities but also with respect to their changing appearances. Despite their obvious and stated dismay, the women described how they had achieved a sense of acceptance, if not serenity, a theme we will more fully explicate in a subsequent section.

Notably, approximately half of the men and women (eight men and eight women) directly stated that their changed bodies made them feel old, which further augmented their sense of frustration and/or embarrassment. The men's sense of themselves as old stemmed primarily from a decrease in their stamina and strength. A 75-year-old man who had abdominal aneurysms, arthritis, cancer, cataracts/glaucoma, chronic obstructive pulmonary disorder, erectile dysfunction, gout, heart disease and memory loss stated:

I find it very irritating because I used to be fairly active. For example, I was going to walk up here for the interview. I only live four blocks away. And I started to walk up and then I says 'God damn it!' You know, I was out of breath so I went back and drove my car up here. And it made me feel old.

In contrast, the women's sense of themselves as old was described predominantly in relation to their changing appearances and how they assumed others perceived them. A 77-year-old woman who had arthritis, asthma and fibromyalgia and who indicated that she had gained a substantial amount of weight as a result of the medicines she had to take for her various illnesses summarised her sense of being old in this way:

I am horrified when I look in the mirror . . . It's hard to accept the fact that you don't look anything like you used to look. At one time, I wasn't bad looking actually . . . I hate being perceived as old and I know I'm old. But I don't want to be the poor little old lady that lives in [her apartment number].

Not wanting to be pitied, to be identified with her failing health or to draw negative attention to herself and her growing frailty, this woman went on to describe how she frequently told herself to 'stand up and don't droop. Don't moan and groan.'

Irrespective of their stated feelings of dismay with their bodies and sense that their physical realities were rendering them socially and physically old, many of the men and women (11 men and nine women) discounted the extent to which they were truly disturbed by their infirmities and

changing bodies. The previously referred to 75-year-old man who had nine chronic conditions maintained that his physical losses were annoying but not worthy of prolonged comment and attention: 'It bothers me but not to the extent I'm going to harp on it . . . It bothers me but it doesn't bother me. You know what I mean?' Similarly, a 77-year-old woman who had arthritis, back problems, cataracts and heart disease discussed the impact of her changing appearance on her felt age: 'I break out in these blood spots, which is quite common for seniors [who take blood thinners]. I just don't like them . . . I feel old when I look at my blood spots . . . but I'm not going to worry about it.' In this way, there was sometimes an uneasy tension within many of the men's and women's accounts between expressions of negative emotions and the minimisation of those same feelings of exasperation and discontent.

'I wish I could be more active': the social consequences of multiple chronic conditions

As a result of the debilitating physical symptoms associated with their multiple chronic conditions and like the findings of Belgrave (1990), many of our participants reported that their physical and social activities had been profoundly affected by their failing health. Indeed, 12 men and 13 women stated that they were no longer able to engage in previously valued sports (ten men and eight women), physical activities such as biking, running, swimming and walking (eight men and ten women) as well as a variety of other hobbies, including travel and dance (three men and two women). Additionally, and although the men invariably experienced similar problems even though they did not discuss them, the women reported that their ability to socialise with friends (four women) and/or clean and cook for themselves (three women) had been severely reduced or eliminated altogether, much to their dismay.

For more than half of the men, the decreased ability to be involved in physical pursuits, particularly sports-related activities, and remain functionally independent challenged their sense of identity as masculine, autonomous individuals. For example, a 75-year-old man who had arthritis, back problems, cancer, cataracts and irritated bladder syndrome described his decreased sports participation, growing isolation and increased dependence on his wife in this way:

I wish I could be more physically active . . . I wish I had more physical energy . . . I force myself to go walking but I still cannot play tennis because of my limited movement . . . In my younger days, I hiked, I played badminton, I played tennis, I biked. I was a good active athlete . . . Playing tennis for two, three hours was nothing . . . Now my balance is not very good . . . so my bicycling is limited. And of course my tennis is gone . . . I'm less interested in social conversations. I mean we

get invited to dinners but I don't participate as much . . . The conversation revolves around tennis and I have no part in that anymore. My interest level has changed . . . I've become more interested in my health and my body function . . . I mean you are not going to sit and talk to your guests about your health problems – about not sleeping, about your gut problem, your urine problem and so on . . . Without my wife I would have perished. She cooks for me. She feeds me. She keeps my appointments. She drives me everywhere . . . I've become more dependent on her . . . I have difficulty dealing with [my loss of abilities] but I deal with it the best way I can. It's not pleasant.

Faced with increasing social isolation and reliance on his wife, this man was readily aware of his corporeal and social fragility. For the majority of the men, this growing dependence on others was a source of personal frustration, as expressed by a 91-year-old man who had back problems, cancer, cataracts, chemical sensitivities, chronic fatigue syndrome and heart disease:

One feels sorry for oneself, in the sense that one loses one's independence and you become dependent on others. My daughter has to drive me. I have to phone her and she has to adjust her schedule if she can. If she can't, I have to adjust my schedule . . . I do feel unduly restricted. The truth of the matter is, I get a little impatient sometimes because I can't go out. I can't go where I want to go, when I want to go – even the short distances . . . I'd say that's one of my biggest frustrations.

Contravening masculine norms of autonomy, control and invulnerability (Prentice and Carranza 2002), the men's decreased physicality provoked feelings of aggravation with the body and the men's limited social realities. These feelings of frustration were further augmented by their growing dependence on the women in their lives.

In contrast, the women experienced their multiple morbidities in two distinct ways. On the one hand, and like the findings of Hurd Clarke, Griffin and the PACC Research Team (2008), half of the women commented on how their decreased physical activity had culminated in changes to their body weight and shape, much to their displeasure. A 76-year-old woman who had arthritis, back problems, cancer, cataracts, heart disease and urinary incontinence recounted:

I was always very physical . . . I swam all the time . . . I used to be a great walker . . . Because of the pain, I was walking less . . . I was finding it was getting harder and harder to play golf without a cart . . . I gradually had to decrease the things that I did on foot . . . I gave up skiing and I'd always skied and so on . . . Now I'm packing around 20 or 30 pounds more than I should . . . And I know my osteoarthritis would be better if I didn't have that weight. I think I eat fairly carefully but obviously I don't get enough exercise . . . to burn it off . . . And I can't exercise a lot because of my arthritis so . . . it's a vicious circle.

Similar to the existing body image research (Hurd Clarke 2002; Hurd Clarke, Griffin and the PACC Research Team 2008), the women's perceptions of their increased weight had both health and appearance

implications and were fraught with moral undertones regarding personal responsibility for disciplining one's body.

At the same time, half of the women discussed the consequences of their illnesses in terms of how they negatively affected the lives of others or might do so in the future. Making comments like 'I'd hate to have to pester someone' and 'I just don't want to be a nuisance', some of these women were particularly concerned by their decreased ability to cook and clean for themselves and saddened by their loss of ability to socialise with others. Moreover, the women frequently indicated that they were fearful of becoming a further burden on their loved ones. For example, an 87-year-old woman who had Crohn's disease, diabetes, effects of stroke, heart disease and urinary incontinence stated: 'My daughter having to look after me – that's a big worry to me. If something happens that my daughter has to look after me – I just don't want that at all.' This concern for others was even more magnified in the comments of four women who were dismayed by their inability to care for others, let alone themselves, as a result of their multiple morbidities and their corresponding loss of functional abilities. For example, an 81-year-old woman who had back problems, bowel disorder, cancer, chemical sensitivities, cataracts/glaucoma, chronic obstructive pulmonary disorder, depression, emphysema, fibromyalgia, osteoarthritis, osteoporosis and post-polio syndrome articulated her experience in this way:

It's very depressing at times . . . Because you know you sit there and you think, 'Okay I want to do this, this and this today.' Intellectually I can do those things, physically no . . . One of the hardest things about being disabled is that you can't do as much for other people as you've always done. You become dependent on other people instead of helping other people and it's an awful hard blow to take. It's really hard.

Thus, and in sharp contrast to the men, the women's experiences of decreased physical abilities were strongly influenced by expected and esteemed feminine qualities that privileged nurturing, care-giving and selflessness (Prentice and Carranza 2002).

'Go with the flow': learning to live with chronic illness

Despite the painful and frustrating physical and social realities of having multiple chronic conditions, our participants employed various strategies by which they achieved 'biographical flow' (Faircloth *et al.* 2004b: 242) and learned to live with their health problems. Similar to the research that has explored the relationship between masculinity and health (Cameron and Bernardes 1998; Chapple and Ziebland 2002; O'Brien, Hart and Hunt 2007) and like the extant research concerning single chronic illnesses (Faircloth *et al.* 2004b), the men viewed their multiple chronic conditions as a normal aspect of ageing and approached their expected infirm destinies

with resignation and stoicism. For example, a 77-year-old man who had arthritis, back problems, diabetes, heart disease, kidney disease and a thyroid condition expressed his resignation in this way: 'That's life . . . I'm not happy with it but if it has to be that way, it has to be. That's all there is to it. You just accept it and move on.' Therefore, even while they were openly dissatisfied with their health and social situations, the men argued that since nothing could be done to change the inevitability of chronic conditions in old age, one must simply concede to one's reality. However, a few men also maintained that it was important to exercise whatever remaining control one had, as articulated by a 79-year-old man who had arthritis, back problems, bowel disorder, cancer, Dupuytren's disease (also known as morbus Dupuytren, Dupuytren's contracture or palmar fibromatosis) and urinary incontinence:

You don't feel happy about your health problems but there's nothing much you can do about it except for try to accommodate to it . . . and you cannot let your health problems take over your life. You have to stay in charge; you have to be in control.

In this way, the words the men used to describe their personal experiences reflected masculine ideals of self-reliance, control and emotional and physical toughness in the face of adversity (Cameron and Bernardes 1998).

In contrast, the women's strategy for maintaining biographical flow stemmed from their unfailingly cheerful and upbeat endorsements of the need for acceptance. While also embracing the assumption that chronic conditions were an unavoidable part of ageing (Faircloth *et al.* 2004b), the women subscribed to the perspective that 'attitude gives you altitude'. Thus, the women made comments similar to those of an 82-year-old woman who had arthritis, a bowel disorder, cancer, heart disease and visual impairment: 'I have a very positive attitude . . . I'm healthier because of it . . . whatever comes along I have to handle so, you know, that's half the battle.' Some women further maintained that older adults should 'concentrate on and enjoy the things you can do' and be thankful for one's remaining physical abilities. An 87-year-old woman who had Crohn's disease, diabetes, effects of stroke, heart disease and urinary incontinence asserted: 'Your body naturally deteriorates gradually and everyone knows it . . . so you expect things not to work in your body as well . . . and whatever comes along you have to roll along with it and just be thankful.' Repeatedly emphasising the power of positive thinking, some women even contended that a failure to maintain an optimistic attitude would only serve to augment one's physical misery. For example, a 75-year-old woman who had back problems, bursitis, fibromyalgia, lupus, osteoporosis, rheumatoid arthritis and Tourette's syndrome stated:

If you don't have a good attitude, that's it. You know? If you're feeling sorry for yourself and you're sitting there thinking, 'Oh this is awful today. My knee hurts.

I can't walk. I can't do this.' Then sure you're going to sit there and you're going to feel worse.

Disparaging those who 'mope' or 'complain too much', many of the women actively distanced themselves from those who were perceived to be lacking in the requisite positive attitude as they recounted stories similar to those of a 77-year-old woman who had arthritis, back problems, glaucoma and heart disease who maintained:

I try to hang out with people who are positive and uplifting. It sounds terrible but I just have nothing to do with two friends I've known all my life because all they do is moan. We've all got problems. I don't want hear about them. They're just too downer. And I mean we're all going die very soon so let's have a good time while we're here.

While the women were certainly like the men in their pragmatic assessments about their looming mortality and the inevitability of chronic conditions, they nonetheless endeavoured to remain hopeful and positive.

The third and related strategy for limiting the disruption of chronic conditions and maintaining biographical flow had to do with the ongoing social comparisons in which our participants engaged. Close to half of the participants (six men and eight women) contextualised their own experiences relative to the suffering of others. Reminiscent of Hochschild's (1973: 58–63) 'poor dear hierarchy' and the social comparisons made by participants in Laz's (2003) study, the men and women we spoke with tended to compare their physical issues to those of others, thereby positioning their own health situations as less onerous and distressing. A 75-year-old man who had arthritis, bladder cancer, cataracts/glaucoma, chronic obstructive pulmonary disease, erectile dysfunction, gout, heart disease and memory loss asserted the following:

Sure a lot of people are a lot healthier than me at 75 but a lot of them are a lot sicker than me . . . I'm not in a wheel chair. I don't need a cane to walk. I haven't had a stroke, and so on . . . Of course I don't want my chronic conditions. I wish I didn't have bladder cancer. I wish I didn't have high blood pressure. I wish my breathing was better . . . I wish my legs didn't hurt. I wish I didn't have to take Viagra, but so what? . . . I got 'em and there's nothing I can do – just accept them . . . It's just a part of getting old . . . All my friends who are not 75, they're dead. Obviously they don't have any health issues anymore (laughingly). So given the choice, I'll take the health issues.

Although the men, like the previously cited individual, were forthright about their dissatisfaction with their health status, the women tended to be less negative in their descriptions of their own suffering relative to others. The women made comments like those of a 74-year-old woman who had asthma, back problems, cataracts, diabetes and osteoarthritis:

I've learned to live with these things. My husband had cancer and that's a whole lot worse . . . and I have a friend who's been diagnosed with ALS [Amyotrophic Lateral

Sclerosis, also known as Lou Gehrig's Disease] and that's horrible . . . Life could be a whole lot worse.

Like the findings of Duay and Bryan (2006) and underscoring the social comparisons with others, our participants rejected the right to complain about their physical suffering because it was deemed to be an expected, albeit unpleasant, part of growing old. The men's comparisons of their own health relative to others were laced with pragmatism, stoicism and emotional reserve. Suggesting that there was 'no point in complaining', the men made comments similar to those of a 75-year-old man who had back problems, bowel disorder, glaucoma, haemorrhoids, heart disease and pre-onset diabetes: 'Everyone has adversity . . . There's no sense crying about it. You can't change it . . . It's just a matter of how you handle it . . . Just do the best you can with what you've got.' While the women's sentiments were similar, they tended to stress that the suffering of others was far greater than their own. Moreover, both the men and women noted that complaining about one's health rendered one a pariah and ultimately led to social isolation. A 78-year-old woman who had Crohn's disease, diabetes, heart disease and osteoporosis put it simply: 'You know, if you start talking about all your ailments, then everybody's going to run when they see you coming.' In this way, the participants endorsed the importance of remaining self-controlled and long-suffering as well as of keeping one's physical misery largely to oneself.

Discussion

In this paper, we have examined what it is like to live with multiple morbidities in later life. Our results suggest that the experience of multiple chronic conditions in old age is characterised by often profound bodily suffering and concomitant losses in one's ability to participate in valued physical and social activities. Both the symptoms and their resultant social and physical limitations were experienced as a source of personal disruption (Bury 1988; Sanders, Donovan and Dieppe 2002). However, this personal disruption was gendered as the men and women responded to their limitations differently and expressed displeasure over the loss of disparate abilities. The men were more likely than the women to convey strong feelings of frustration and to be displeased with the loss of ability to engage in sports or lead autonomous lives. Their sense of personal disruption clearly reflected how their altered bodies, decreased physicality and social realities contravened masculine norms of control, invulnerability, physical prowess, self-reliance and toughness (Bernardes and Lima 2010; Chapple and Ziebland 2002; Charmaz 1994; Connell 2005; Gibbs 2005, 2008;

Gray *et al.* 2002; Oliffe 2006; Prentice and Carranza 2002; Robertson, Sheikh and Moore 2010; Solimeo 2008).

In contrast, the women's personal disruption was expressed in less forthright admissions of frustration. However, the women were clearly dismayed over and embarrassed by their bodies' altered appearances, which delimited their ability to achieve and maintain idealised feminine beauty (Cornwall and Schmidt 1990; Helms, O'Hea and Corso 2008; Hurd Clarke, Griffin and the PACC Research Team 2008; Roberto and McGraw 1991; Wilkins 2001). Additionally, the women conveyed sadness and loss regarding their decreased ability to fulfil traditional female domestic duties and/or adhere to the expected feminine qualities of selflessness, sensitivity to others and nurturance (Prentice and Carranza 2002) as they increasingly became a burden to their friends and loved ones. In this way, both the men's and women's experiences of their health issues, the resultant body changes and the accompanying personal disruption undermined their sense of identity as masculine and feminine individuals.

Our participants constructed accounts of health and ageing that reframed the negative physical and social consequences of illness and facilitated the achievement of biographical flow (Faircloth *et al.* 2004a). Like much of the extant research on single chronic illnesses in later life (Cameron and Bernardes 1998; Faircloth *et al.* 2004a; Gibbs 2008; Gignac *et al.* 2006; Hubbard, Kidd and Kearney 2010; Husser and Roberto 2009; Pound, Gompertz and Ebrahim 1998; Sanders, Donovan and Dieppe 2002; Sinding and Wiernikowski 2008), our participants positioned their multiple morbidities as a normal aspect of growing older. As such, physical suffering and restrictions to activity were framed as realities of ageing that must be accepted and faced with dignity. The men's expressions of stoicism and resignation once again reflected their socialisation into the masculine culture of toughness, autonomy and invulnerability. In contrast, the women's stronger emphasis on preserving a positive attitude and showing concern for others revealed the influence of the feminine privileging of selflessness and cheerfulness.

At the same time, complaining about one's social and bodily limitations and losses was strongly disavowed. The denunciation of expressed discontent was further solidified through ongoing comparisons between our participants' physical travails and those of their friends and family who were living with what were perceived to be worse physical problems. By evaluating their own physical failings relative to those who were in more dire health, the participants minimised their suffering and the legitimacy of any complaints they might have as well as reconstructing their corporeal realities in a positive light such that they warranted gratitude, if not optimism. However, even as the men and women disparaged those who were perceived to be irritable and

overly forthcoming about their symptoms and suffering, their own stated negative feelings created an uneasy tension with the emphasis on acceptance. By constructing and subscribing to the belief that negative emotionality regarding their physical and social losses was improper, if not insupportable, our participants effectively silenced themselves and gave up the right to articulate feelings of anger, sadness and dismay with their increasingly frail bodies.

Our findings point to the social perils of ageing with multiple morbidities. In a neoliberal culture in which individuals are held personally responsible for their health (Crawford 1980), being frail and infirm not only culminates in social isolation and decreased quality of life but also puts one at risk of moral aspersions of one's character and previous lifestyle. Despite their acceptance of their physical and social changes, our participants were clearly unsuccessful relative to Rowe and Kahn's (1997) model of successful ageing with respect to their health status, physical functioning and social engagement. To that end, their emphasis on positivity and acceptance may have been an attempt to obfuscate their physical realities and shore up their identities and social currency in their own eyes as well as those of their peers and younger individuals. Furthermore, our participants may have been actively managing the perceptions of others in an effort to not appear to have capitulated to or conformed with ageist assumptions about later life as a time of decline and decay or older adults as invariably grumpy or bad tempered.

Our paper adds to the theorising on chronic illness in later life by demonstrating how personal disruption (Bury 1988; Sanders, Donovan and Dieppe 2002) and biographical flow (Faircloth *et al.* 2004a) are gendered and shaped by age as well as hegemonic masculinity and femininity norms. That said, our study is limited by its small, convenience sample as well as by the relatively homogeneous nature of our participants. Although they were diverse with respect to age, income and education, none of our participants identified as homosexual and the majority were of European descent. The fact that none of the interviewees were male may have inhibited some of our male participants from fully disclosing their thoughts and feelings, although none of the men we spoke to conveyed any related sense of discomfort. Further research needs to explore how biographical flow in later life is also influenced by culture, sexual preference and social class to tease out additional strategies by which older adults make sense of and learn to live with multiple morbidities. It would also be beneficial to investigate the experiences of rural older adults for whom living with multiple chronic conditions may be further complicated by a lack of health-care resources. Finally, there is a need to research the experiences of adults in advanced old age when health issues tend to accumulate and become ever more profoundly limiting.

In conclusion, our findings illuminate what it is like to be an older man or woman suffering from multiple morbidities and faced with a bleak health future. Despite the societal tendency to silence older, frail adults regarding their physical and social distress, it is imperative that researchers and health-care providers alike find ways to give voice to their pain as well as their resilience so that we may better understand and respond to the needs of those living with multiple chronic conditions in old age.

Acknowledgements

This research was supported by a Social Sciences and Humanities Research Council of Canada Standard Research Grant, a Canadian Institutes of Health Research Catalyst Grant and a Michael Smith Foundation for Health Research Career Investigator Award, all of which were awarded to the first author. The authors wish to thank all of the individuals who took part in the study and shared with us their time, personal stories and important insights. We would also like to thank Ayli Berson, Lauren Courtice and Chris Liu for their invaluable assistance with data transcription and data management.

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Accepted 28 November 2011; first published online 12 January 2012

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