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Research Article

Illness Identity and Its Influence on Self-Management in Older Adults With Multimorbidity: A Hybrid Thematic Analysis

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Abstract

Illness identity refers to the way people integrate health conditions into their sense of self and plays a vital role in managing chronic illness. While most research has examined illness identity in relation to a single diagnosis, this study addressed the added complexity of living with multiple conditions in later life. The aim was to examine how illness identity shapes self-management among older persons with multimorbidity (PwMs) and to refine the relevance of existing illness identity categories by deepening understanding of how evolving identities influence adaptive self-management practices. Semi-structured interviews were conducted with 40 older PwMs in Ireland. Collaborative thematic analysis was used to analyse the data, and a hybrid approach combining inductive and deductive methods was employed. Transcripts were open-coded, discussed collaboratively to deepen interpretation, and then examined in relation to four established dimensions of the illness identity framework: engulfment, rejection, acceptance, and enrichment. In addition to the four established categories, the study identified a further theme linking illness identity with experiences of ageing. Findings showed that older adults with multimorbidity negotiate several, fluid, and context-dependent illness identities rather than a single fixed one. This study extends our understanding of illness identity in the context of multimorbidity and ageing and points to concrete implications for how clinicians communicate with patients, how self-management support can protect autonomy, and how care can be integrated for older adults living with multiple conditions.

Keywords

illness identity, multimorbidity, older adults, self-management, ageing

Introduction

For older adults living with multiple chronic conditions, illness rarely arrives as a single biographical event. Instead, it accumulates across time, layering new challenges onto an already complex sense of self and demanding not just medical management but ongoing identity work (Charmaz, 1995; Kelly, 1992; Kralik, 2002; Mathieson & Barrie, 1998). Early research identified the social and psychological challenges of chronic illness, including managing medical crises, controlling symptoms, maintaining regimens, social isolation, uncertain disease trajectories, and financial strain (Strauss, 1975). Such disruptions hinder personal continuity, and in later life they mark a biographical shift away from an anticipated life course, increasing uncertainty and diminishing the sense of self (Bury, 1982; Corbin, 2003). In response, individuals engage in ongoing narrative work, reconstructing their illness stories to renegotiate identity and restore biographical coherence (Mathieson & Barrie,

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1998). Building on this view of illness as an identity challenge, the illness identity framework defines illness identity as the degree to which a person integrates a chronic condition into their sense of self (Charmaz, 1995, 2002; Oris et al., 2016, 2018). Whereas illness perceptions concern a person's views of the illness and its treatment, illness identity captures the further question of how far the illness has been absorbed into the self-concept (Charmaz, 1995; Corbin, 2003; Van Bulck et al., 2018, 2021). The framework (see Figure 1) comprises four constructs: *engulfment, rejection, acceptance, and enrichment* (Oris et al., 2016). Engulfment is the degree to which illness dominates identity, such that individuals define themselves entirely in terms of their condition(s). Rejection is the degree to which illness is resisted as part of identity and treated as a threat to the self (Adams et al., 1997; Oris et al., 2016); it is often associated with weak self-management and poor adherence (Oris et al., 2016, 2018; Tilden et al., 2005). Acceptance, a more adaptive state, is the extent to which individuals embrace illness as one part of identity alongside other self-defining elements, allowing as normal a life as possible without denial (Adams et al., 1997; Morea et al., 2008; Oris et al., 2016). Enrichment, the fourth dimension, is where illness prompts positive change, with people feeling it has reshaped their values and enabled growth (Bryson-Campbell et al., 2013).

Across age groups and conditions, the severity and complexity of illness have been associated with both engulfment and enrichment (Luyckx et al., 2018; Oris et al., 2018; Rassart et al., 2023; Van Bulck et al., 2019). This pattern, seen in congenital heart disease, refractory epilepsy, and inflammatory bowel disease, suggests that increasing complexity intensifies both the burden of illness and the opportunities for personal growth.

Integrating the different aspects of a person into a coherent identity structure supports psychological well-being (Bryson-Campbell et al., 2013). In multimorbidity,

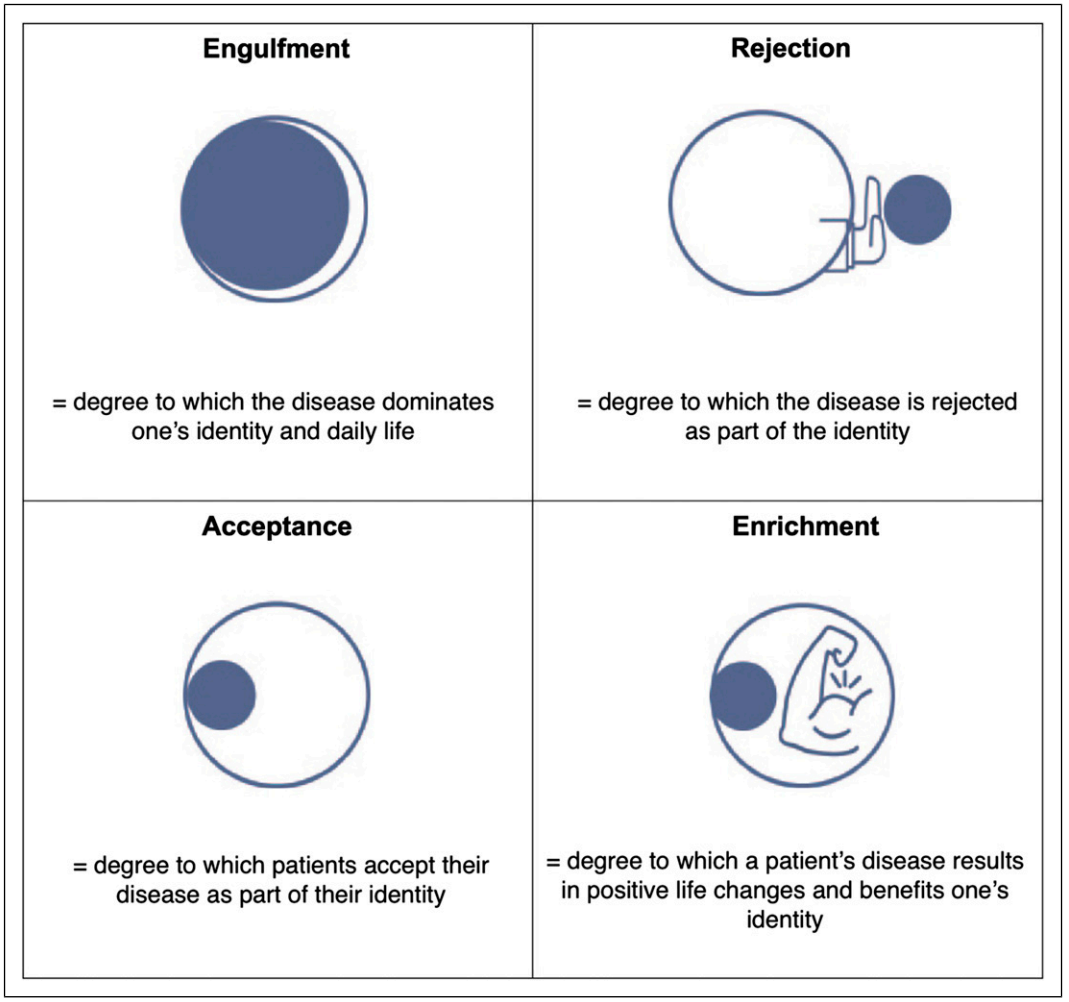

Figure 1. Adapted visualisation of the four identity constructs altering the "heart disease" example (Van Bulck et al., 2019). Reproduced with permission from the author. *The dot represents the disease, and the circle represents the identity

defined as the coexistence of two or more chronic conditions (Skou et al., 2022), this coherence may be harder to sustain. Multimorbidity is a global challenge whose risk increases with age (Atun, 2015; Nartey et al., 2023); it disrupts "normal" life (Sand et al., 2021), affects everyday activities such as eating, working, and managing medication, and complicates healthcare navigation (Signal et al., 2017), and can bring physical and emotional decline while straining social relationships (Sells et al., 2009). As people age, ageing- and multimorbidity-related changes may further disrupt self-continuity by altering competencies, social roles, and values (Lim et al., 2017), leading individuals to reconsider their identities and how others see them (Haslam et al., 2021). Transitions such as retirement or declining physical or cognitive function may also limit access to key psychosocial resources that provide social support and meet the needs of belonging, control, and inclusion. Losing these resources when they are most needed heightens vulnerability and risks poorer health (Haslam et al., 2009; Jetten et al., 2017).

Chronic illness also demands sustained self-management to maintain health and avoid complications (Novak et al., 2013), and multimorbidity makes these routines more complex, spanning symptom monitoring, medication management, coordinating visits to several healthcare providers, and reconciling potentially conflicting advice (Doyle et al., 2019; Markle et al., 2015). How individuals position illness(es) within their identity is therefore central, since it shapes how they approach and sustain self-management of multiple conditions.

To date, most illness identity research is quantitative and focuses on single chronic conditions (Shneider et al., 2024), although some studies include adults aged 65 and over, few have specifically targeted this group (e.g., Campens et al., 2024; Krömeke & Shani, 2025; Luyckx et al., 2018; Oris et al., 2016, 2018; Potter, 2024; Rassart et al., 2023; Van Bulck et al., 2018, 2021), leaving a gap in understanding illness identity among older persons with multimorbidity (PwMs). Whereas a single condition may be integrated into one coherent illness identity, multimorbidity can require individuals to negotiate several, sometimes competing, identities at once, making coherence harder to achieve. Qualitative work shows that people with multimorbidity actively prioritise between valued identities to preserve a coherent sense of self (Sand et al., 2021). A qualitative synthesis similarly shows that living with chronic illness involves an ongoing transformation of the self, and that self-management support focused on disease alone risks neglecting this identity work (Hajdarevic et al., 2025). Yet, few qualitative studies examine how people integrate illness into the self using this framework (Oris et al., 2016). Marín-Chollom and colleagues (2025) applied the four dimensions to interviews with young adults with cancer, showing how acceptance, engulfment, and enrichment shifted across the illness trajectory in ways questionnaires cannot capture, an approach closely aligned with the present study.

Understanding how older adults negotiate illness identity is not only of theoretical interest; it bears directly on how clinicians communicate with patients, how self-management support is designed, and how care systems respond to the coexistence of ageing and multiple chronic conditions. To address this gap, the present qualitative, theory-driven study examines how older PwMs adopt and integrate illness identity states into their self-concept and how these processes shape self-management attitudes and behaviours. Three research questions guided this study: *RQ1*: How do qualitative insights validate or expand the current theoretical framework of illness identity in the context of multimorbidity? *RQ2:* How does illness identity integrate with self and ageing identity? *RQ3:* How does illness identity shape attitudes and behaviours related to self-management in older PwMs?

Methods

Participants and Data Collection

This study is nested within a larger study of self-management among older adults with multimorbidity, conducted across three European countries (Doyle et al., 2025). That study evaluated a digitally supported self-management intervention, and its baseline interviews focused on the self-management practices, routines, and attitudes of older adults with multimorbidity. We analysed the baseline interviews from the Irish site through the lens of illness identity, examining how participants positioned illness within their sense of self and how this shaped their self-management attitudes and practices, within a single health-system and cultural-linguistic context.

Participants were recruited via multiple channels, including healthcare professionals, speciality clinics, formal care organisations, living labs, and community groups for older adults. Eligibility required participants to be aged 65 or older with at least two of four chronic condition categories: diabetes, chronic respiratory disease (chronic obstructive pulmonary disease [COPD], chronic asthma), chronic heart failure, and chronic heart disease (including coronary artery disease and cardiovascular conditions such as hypertension, atherosclerosis, angina, or arrhythmia). Because the respiratory and heart-disease categories each span several diagnoses, a participant qualifying through two categories may live with more than two distinct conditions. These categories were pre-specified in the parent study's registered protocol rather

Table 1. Participants Characteristics

Demographics	*N* (%)
Sex	
Female	25 (62.5)
Male	15 (37.5)
Education level	
Some primary	3 (7.5)
Primary and equivalent	10 (25)
Leaving certificate	8 (20)
Diploma/certificate	5 (12.5)
Primary degree	2 (5)
Postgraduate	10 (25)
Unknown	2 (5)
Living status	
Living alone	10 (25)
Living with others	29 (72.5)
Unknown	1 (2.5)
Employment status	
Retired	33 (82.5)
Employed	1 (2.5)
Unemployed due to long-term illness or disability	1 (2.5)
Self-employed	1 (2.5)
Looking after home or family	1 (2.5)
Other (e.g., retired still working)	1 (2.5)
Unknown	2 (5)
Number of chronic condition categories[a] (including RD, CHD, CHF, Diabetes)	
Two	27 (67.5)
Three	12 (30)
Four	1 (2.5)

[a]Categories rather than individual diagnoses; respiratory and heart-disease categories may each include multiple co-occurring conditions. RD = respiratory disease (including chronic asthma and chronic obstructive pulmonary disease (COPD), a group of progressive lung diseases – including emphysema and chronic bronchitis), CHD = chronic heart disease (including coronary artery disease and cardiovascular disease such as hypertension, atherosclerosis, angina, or arrhythmia), CHF = chronic heart failure.

than selected for this analysis; they form a clinically coherent cluster of prevalent, frequently co-occurring cardiometabolic and respiratory conditions (Barnett et al., 2012), each carrying substantial self-management demands, making the sample well suited to a focus on illness identity and self-management. The sample comprised 40 older PwMs (M_{age} 72.7 ± 5.6, range 65–85; 25 women). Table 1 provides further demographic and health detail.

Ethical approval was obtained from two academic institutional review boards and a regional health service ethics committee. Data were collected between February 2023 and June 2024, primarily through individual face-to-face semi-structured interviews, with a smaller proportion (N = 5) conducted via telephone. Participants provided written consent both to take part in the study and to have the interviews audio recorded. All personally identifying information was removed during transcription to protect privacy, and audio files were deleted once transcripts were finalised. Data were securely stored using an encrypted cloud storage system with access restrictions and compliance with data protection requirements.

Interview Protocol

A semi-structured interview guide was developed by the research team and piloted before use to elicit participants' experiences of living with multiple conditions and managing their health. Participants reflected on how they perceive having multiple conditions, how their health issues affect daily life and sense of self, and how they approach self-management tasks such as medication, diet, exercise, and symptom monitoring. Although the guide was open rather than framework-driven, its focus on self-management and on how illness affected participants' sense of self yielded material well suited to analysing illness identity. Interviews were conducted in English,

lasted approximately 60–90 minutes, and were carried out by three doctoral-level researchers with prior training and experience in qualitative interviewing. All used the same guide of core questions, with probes to explore responses in depth, which, together with the interviewers' common methodological training, supported consistency while preserving the flexibility appropriate to semi-structured interviewing.

Data Analysis

A hybrid thematic analysis (Fereday & Muir-Cochrane, 2006) combining inductive open coding with deductive theoretical mapping was used to enable both data-driven theme generation and theory-informed interpretation. This study employed a hybrid rather than a reflexive thematic analysis, and we draw on Braun and Clarke (2006) for the foundational conceptualisation of thematic analysis and for reflexivity as an analytic sensibility. In reporting our analysis, we were guided by current recommendations for transparent thematic analysis reporting (Braun & Clarke, 2024), making explicit our epistemological position, the rationale for a hybrid approach, the role of the framework as an interpretive organising device, the composition of the analytic team, and how reflexivity was practised.

This study employed a constructivist-interpretivist epistemological framework, which holds that meaning is socially constructed and derives from lived experience and narrative interpretation (Crotty, 1998; Schwandt, 1999). Within this framework, themes are understood as interpretive patterns produced by researchers rather than as objective entities inherent in the data.

Aligned with this epistemological stance, inductive coding was completed first to capture aspects of participants' lived experiences, including how illness affected their sense of self and their self-management strategies. In the following phase, inductively derived themes were examined against the four established dimensions of illness identity, namely engulfment, rejection, acceptance, and enrichment (Oris et al., 2016), as an analytic lens rather than a predetermined coding template (Fife & Gossner, 2024). The deductive phase was interrogative rather than confirmatory: the team examined the content of each established dimension against the data, treating the constructs as provisional and open to question. This interrogation was most pronounced in developing the fifth theme, where material concerning the intersection of ageing and illness identity could not be adequately accommodated within the existing four dimensions and was therefore retained as an inductively derived theme rather than subsumed into them.

A collaborative qualitative analysis approach was employed (Richards & Hemphill, 2018). Multiple researchers independently coded transcripts and met regularly to compare and discuss interpretations and refine themes through discussion, using differing interpretations as a resource to deepen the analysis rather than treating them as errors to be eliminated (Olson et al., 2016; Zreik et al., 2022). These discussions also served as a space for reflexivity, as researchers whose backgrounds span social psychology, health psychology, exercise psychology, and human-computer interaction critically examined how their disciplinary perspectives may have shaped data interpretation (Malterud, 2001). Reflexivity was maintained throughout the analytic and writing process as a core component of qualitative rigour (Pillow, 2003). The three researchers who conducted the interviews were also involved in the analytic phase, providing continuity between data collection and interpretation, with collective discussion enabling assumptions to be challenged and themes examined from multiple perspectives (Barry et al., 1999; Rankl et al., 2021). The remaining two members of the five-person team, who had supervised the development of the interview guide and the conduct of data collection, contributed to the analysis and to the interpretation and framing of findings, further strengthening the reflexive process. Rather than applying data saturation as a stopping criterion, the adequacy of the sample was judged by the richness and depth of the data in relation to the research questions, consistent with the interpretative nature of the analytic approach (Braun & Clarke, 2019).

Trustworthiness was addressed using Lincoln and Guba's criteria (Lincoln & Guba, 1985), interpreted in line with our constructivist-interpretivist stance. Credibility was supported by drawing multiple researchers' perspectives into dialogue (investigator triangulation) and by verbatim participant quotations grounding each theme. Transferability is supported by thick description of participants (Table 1), setting, and recruitment, alongside explicit acknowledgement of the sample's boundaries. Dependability was supported by an auditable analytic process, using an established hybrid method and systematic data management in NVivo (Lumivero, n.d). Confirmability was approached not as the elimination of researcher influence but as a reflexive, traceable account of how interpretations were reached.

Results

We identified four primary themes aligned with the classic illness identity dimensions (engulfment, rejection, enrichment, and acceptance), each with several subthemes, and one additional theme capturing the intersection of illness identity with ageing. Figure 2 represents all related themes and subthemes.

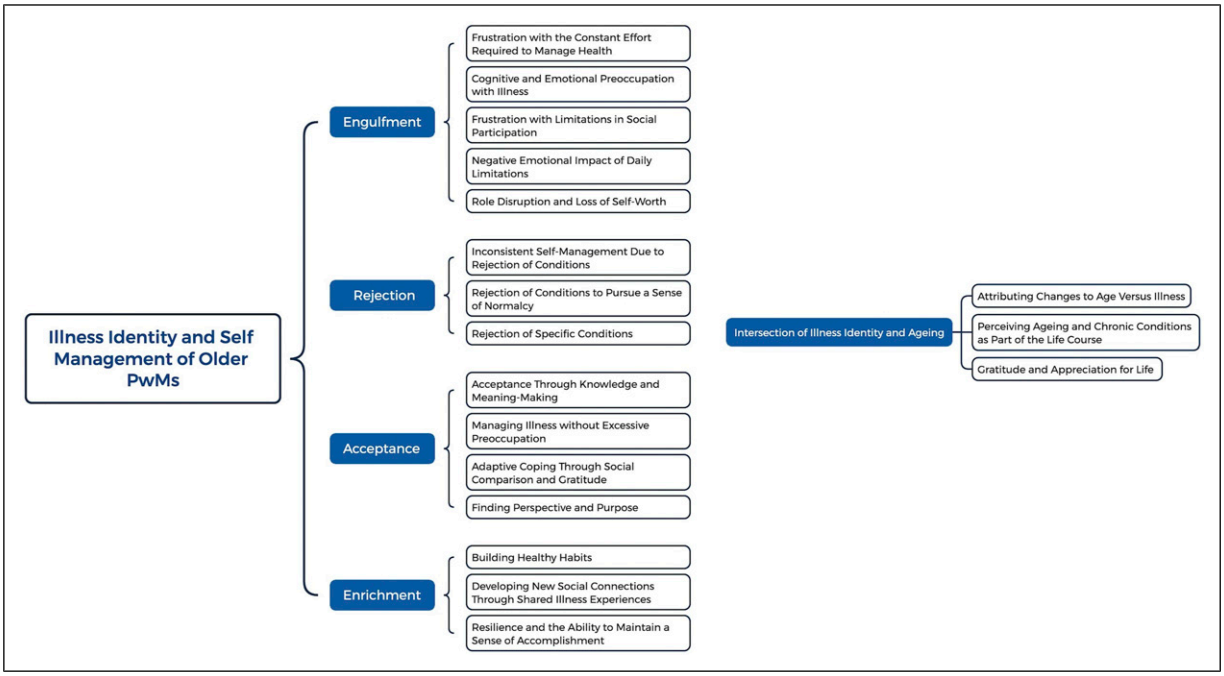

Figure 2. Themes and subthemes

In terms of the study's aims, Themes 1–4 primarily address RQ1, concerning whether qualitative insights validate or expand the illness identity framework, and RQ3, concerning how illness identity shapes self-management; Theme 5 principally addresses RQ2, concerning how illness identity integrates with self and ageing identity.

Each theme is presented with illustrative quotations. To protect confidentiality, quotes carry anonymised codes for sex (F = female, M = male), age group (65–74, 75–85), and conditions (CHD = chronic heart disease, CHF = chronic heart failure, RD = respiratory disease, and Diabetes).

Theme 1: Engulfment

The accounts in this theme are read as expressions of engulfment, the dimension in which illness comes to dominate identity and to invade most domains of life (Oris et al., 2016).

Engulfment involves not just distress but a preoccupation with illness and a sense that it limits valued activities. The frustration and restriction participants described are therefore read as signs that illness had come to occupy a central place in how they saw themselves rather than as symptom burden alone.

Subtheme 1.1: Frustration With the Constant Effort Required to Manage Health. Some participants felt exhausted and overwhelmed by the treatment, monitoring, and lifestyle changes required for multiple conditions. Yet, despite this frustration, most continued to manage their conditions out of fear of the consequences of stopping, so that engulfment, although burdensome, still compelled action for their health.

> I get tired sometimes of it. Then say if you don't do it, then you can just see how you're going to deteriorate yourself, you know. So yeah, you do get tired of it sometimes … Oh for God sake I am sick of this and then actually when they mentioned diabetes, it's not, Oh my God's sake. I thought I was escaping that one. (F, 75–85, RD, CHD)

Subtheme 1.2: Cognitive and Emotional Preoccupation With Illness. For some individuals, illness became a central focus of thoughts and emotions and started to dominate other aspects of life. Some participants shared how their conditions were "constantly on their mind," with daily symptoms or exacerbations repeatedly reminding them of their illnesses. A participant described how this continuous awareness impacted their mood:

> If I'm waking up and I'm coughing and I'm doing it, I'm not in good form. So it does affect your mood and the opposite occurs too when you don't have the symptoms or that you're in great form because you don't have them sort if things … you're not not happy then you know, I just want to get rid of the bloody thing and back to normal. (M, 65–74, RD, CHD)

For some, long-term demands and the inability to achieve health goals became burdensome, and concerns

about weight and diet began to shape how they saw themselves, linking illness closely to identity. One participant described how constant monitoring of food and weight, and dissatisfaction with her appearance, led them to withdraw from social relationships.

> Yeah, but you're you're all the time, you start to watch, you're trying to watch your food, you're watching your weight, then the weight is … you know that that that annoys me and … (started crying) … That's like. I don't like myself … No, I don't want to, I don't want to really want to go out… Maybe that's why I don't see people that I used to see. (F, 65–74, RD, CHD)

This reluctance did not extend to an illness-based community group joined after diagnosis. The difficulty seemed to lie less in the illness itself than in being seen by people who had known an earlier self, and this eased in a group built around shared illness.

Subtheme 1.3: Frustration With Limitations in Social Participation. Some participants felt frustrated, disappointed, and at times overwhelmed because the complex, interacting symptoms of multiple conditions imposed physical and social limitations that prevented them from fully engaging in activities.

> … the combination breathing and arthritis because it limits me and I can't, it has put me off going. I used to be found at the cinema in the theatre. I really can't sit there for hours. Without getting very, very stiff, even out for a meal, at least you can move or stand up … (F, 75–85, RD, CHD, CHF)

Subtheme 1.4: Negative Emotional Impact of Daily Limitations. For some participants, the impact of several conditions on daily activities led to frustration, with physical and psychological issues reinforcing each other and leaving them overwhelmed.

> Well, the COPD means I can't walk, so I can't lose the weight, and the anxiety then, when I try walk, I get panicky and it just stops me. So, it really, it's one is fighting against the other. (F, 65–74, RD, CHD)

Some also explained how mobility limitations negatively impact their mood and psychological well-being.

> And you get very depressed sometimes when you be sitting around … (F, 65–74, RD, Diabetes)

Here, the restriction itself, rather than any single symptom, is what feeds low mood, showing how physical limits and emotional state reinforce one another in how participants experienced their conditions. For some participants, the limitations their illness(es) placed on daily activities overshadowed their sense of identity, leaving them feeling restricted and unable to engage in activities that once brought them a sense of purpose.

> … you get a bit, it's, it's a frustration that you want to do things and you're not able to continue … I used to paint my house myself, all of that … now I find I wouldn't be able to do that, and it's a combination, I suppose, of my age and my conditions that … I would be so exhausted after that, it's, it's just not worth the effort … it would take from the rest of everything I was doing, and so, it would have a huge effect. (F, 75–85, RD, CHD)

Subtheme 1.5: Role Disruption and Loss of Self-Worth. Some participants described how illness gradually disrupted valued roles within their families and social lives, eroding their self-confidence and subtly altering how they saw themselves. Since their health changed, some felt unhappier and withdrawn, comparing their current situation with previous active roles such as work and caregiving.

> Yeah, so, I find I'm more depressed … compared to what I used to be … I was out working until I was 66 like, and then I was minding the grandchildren … some days I'm down and depressed a bit … but just have to get up and get on .. yeah, and then you see the daughter's saying, "oh no, you can't do this, and you can't do that," and I say, "for God's sake [daughter's name], you're making me old before my time" [laughing]. (F, 65–74, CHD, Diabetes)

Theme 2: Rejection

These accounts are interpreted as instances of rejection, the dimension in which illness is resisted as part of the self and treated as a threat to, or as incompatible with, one's identity (Oris et al., 2016). Participants' distancing from particular diagnoses and their efforts to keep illness from defining them are read as identity work rather than as simple non-adherence or lack of awareness.

Subtheme 2.1: Inconsistent Self-Management Due to Rejection of Conditions. Some PwMs downplayed the seriousness of their conditions and resisted the need for strict management, questioning healthcare providers' decisions and justifying departures from dietary guidance.

> I don't probably take it serious enough, the diabetes … and I think that comes back to being a bit of a rebel, as in. Well, if the doctor doesn't think it's serious enough to refer me to a diabetic clinic or, you know, why should I be worrying about it … Do what I'm told as much you know, but maybe food wise, I don't always eat perfectly healthy every day … I feel OK, I'm getting by. (M, 65–74, RD, CHD, Diabetes)

Subtheme 2.2: Rejection of Conditions to Pursue a Sense of Normalcy. Some participants avoided engaging with their illness, distancing themselves from its emotional and cognitive weight to preserve a sense of normalcy. Adopting a "take every day as it comes" approach, they avoided seeking information or worrying about symptoms.

> Well, do you see, I'm afraid I'm one of these people who would say, "take every day as it comes," and, you know what I mean … I wouldn't be stressing over it like … I'm afraid I'm the opposite like, where I've a sister-in-law that would be reading up on everything and anything on every ache and pain. No, no, I'm not like that … I just plod along, you know … (F, 65–74, CHD, Diabetes)

Subtheme 2.3: Rejection of Specific Conditions. Some participants described initial difficulty accepting certain diagnoses, often because of stigma or because the condition did not fit their self-image or their sense of who typically develops it. This mismatch led them to misjudge its seriousness and to struggle to integrate the diagnosis into their identity.

> I couldn't accept that I was diabetic in the beginning … when I was told I was diabetic, it was like telling me I was going to die next week, you know that kind of a way. Because I wasn't heavy … I was about the same weight I am still, you know, and I assumed that anyone that had diabetes were very heavy people … So, I couldn't understand why I could be diabetic. That took me a long time. And it took me a long time to control it even. (F, 65–74, RD, CHD, Diabetes)

Theme 3: Acceptance

This theme reflects acceptance, in which illness is integrated into identity alongside other roles without overwhelming the self, allowing a relatively normal life to be sustained (Oris et al., 2016). The accounts below are positioned as ways of incorporating illness into the self, not merely as effective symptom management.

Subtheme 3.1: Acceptance Through Knowledge and Meaning Making. Gaining knowledge about their illness helped PwMs embrace it as part of their reality rather than rejecting it or feeling overwhelmed. Coupled with a collaborative relationship with healthcare professionals, this provided a sense of control. One participant with diabetes described their care as a team effort.

> It affects your lifestyle in as much that you have to learn to spend the time doing what you're supposed to be doing … taking a reading, taking the medication, checking with the medication … as my GP always said, diabetes, the diabetes basically is, is a teamwork … you got nurses, you got consultants, you've got the GP and so on and so forth, but the head of the team is you, and you know, without you, the team can't do any work. (M, 75–85, RD, CHD, Diabetes)

Subtheme 3.2: Managing Illness Without Excessive Preoccupation. Most participants acknowledged their conditions but did not let them define daily life, taking their medication and monitoring their health without allowing illness to dominate.

> It's no different, and that's being honest with you. Because I take my medication in the morning … and, that's it. I actually, I never think about them … It doesn't affect my lifestyle or the things I do, or anything like that you know. I don't factor it in and say "I can't do that because I have heart failure or high blood pressure." None of that. No, no. (F, 65–74, RD, CHD, CHF)

Others followed medical advice but deliberately avoided dwelling on details that might cause distress.

> Basically, I don't want to know because if I went into it in depth I'd start might start getting depressed about it and she said I'm doing well and as long as she says I'm doing well and that I obey all the instructions, then I don't want to know much about.(F, 75–85, CHD, CHF)

This perspective is distinct from rejection: participants had accepted their diagnosis and adhered to care but intentionally limited their engagement to what felt manageable, doing "enough" to avoid becoming overwhelmed without letting illness dominate their identity or daily life.

Subtheme 3.3: Adaptive Coping Through Social Comparison and Gratitude. Some participants described a shift from initial struggles with mood to managing and accepting their illness, learning to cope so that the conditions no longer dominated their lives. Some expressed gratitude, viewing their illness as manageable compared with more severe conditions seen in family members and acquaintances; this downward social comparison fostered acceptance and a proactive approach to managing symptoms and preventing flare-ups.

> I've learned to I suppose I want to use the word "cope" … I just accept that is something that I have. I could have been diagnosed with something 10 times worse … So that's how I kind of looked like just put it into perspective, I just have to be aware of it and manage it the best way I could and know that if I felt like coming on … I had family with, you know who died suddenly at a young age from heart failure, and there's some people in the family that had cancer. So I kind

> of accepted it was just "that's life" kind of I was lucky that's all it is, you know. Not something much worse, and I was able to manage it. (F, 65–74, RD, CHD)

Subtheme 3.4: Finding Perspective and Purpose. Some described acceptance as viewing physical decline as a natural part of ageing, focusing instead on what they could still do for themselves and contribute to others.

> I inquired about some voluntary work and it was actually the receptionist in the GP surgery gave me the number. And I started going up on a Tuesday and I just found it so rewarding … maybe that's one of the reasons why I have an appreciation for not having really severe problems that will confined to the house or make me dependent on other people because I see so much of them and these are all people in their 80s. Some would be 90, 91, 92 and you can imagine they have different ailments. So yeah, it kind of it gives me a sense of giving back, you know, and doing something kind of worthwhile for a few hours a week. (F, 65–74, RD, CHD)

Theme 4: Enrichment

These accounts are read as enrichment, the dimension in which illness is experienced as producing positive change and personal growth that benefits identity (Oris et al., 2016). Participants' descriptions of new habits, relationships, and resilience are analysed as changes to the sense of self, rather than as lifestyle adjustments alone.

Subtheme 4.1: Building Healthy Habits. For some participants, a diagnosis acted as a catalyst for positive lifestyle changes, prompting new routines such as regular walking that became embedded in daily life. These activities were valued not only as self-management but as sources of enjoyment and well-being, reflecting a deeper appreciation for physical activity.

> Probably from 2003, as a result of being diagnosed with osteoporosis, I started walking. And I would have walked, I do normally walk at least five times a week and I do big long walks now … and since I retired six years ago, I sometimes in the summertime get up at six o'clock in the morning, do a big block of 10 kilometres, and come back then and have my breakfast. And it just sets you up for the day. (F, 65–74, RD, CHD, Diabetes)

Subtheme 4.2: Developing New Social Connections Through Shared Illness Experiences. Some participants joined condition-based community groups. They described finding comfort in the company of others with the same conditions, through activities such as "singing exercises" for COPD or "physical exercises" for heart conditions. Events run by these groups, supported by healthcare professionals, also helped improve their health literacy.

> I made lots of new friends, done a few different things. You know that's good because I believe in going to different phases in your life … You enter a new phase in your life and you meet new people and do different things you know that I'm happy with that. We do a sing choir as well. We are part of the Sing Strong on Monday and yeah, that that's really good because I find that's good for a bit of meditation relaxation. The sounds we do and we have a laugh, people laugh, you know, and it's not always singing, it's funny. (F, 65–74, RD, CHD, Diabetes)

Subtheme 4.3: Resilience and the Ability to Maintain a Sense of Accomplishment. Some participants demonstrated resilience, maintaining a positive sense of self despite living with multiple conditions. Rather than letting illness define or diminish their identity, they integrated it into their lives while continuing to value their abilities and achievements, expressing pride in their capacity to endure and to stay engaged in meaningful activities, and viewing illness as part of personal growth rather than as a limitation.

> … I felt at times teetered on the tip of the needle, and there there were times "I wanted to go down the other side and just rest and not feel the pain." But I didn't, I kept. I kept the … and I seen the day came and I seen the grass was green. So that is my barometer. Whenever any hard things happen now. I know the pain I walk through and I know, but I'm not at that, I will never be at that. That was the worst thing. I'm a "great little woman." (F, 65–74, RD, CHD, CHF)

Theme 5: Intersection of Illness Identity and Ageing

This theme extends beyond the four established dimensions. It captures how participants positioned illness in relation to ageing identity, integrating, distinguishing, or blurring the two, and thus concerns identity construction at the intersection of being older and being ill rather than perceptions of illness in isolation. Participants often framed illness in the context of getting older, and this interplay shaped how they saw themselves and managed their conditions: some viewed certain declines as inevitable with age rather than illness, which could reduce the emotional weight of the change, while others compared their current and younger selves with sadness or irony.

Subtheme 5.1: Attributing Changes to Age Versus Illness. Many older adults were uncertain whether certain physical limitations were caused by their health conditions or were just "normal for my age." This ambiguity shaped illness identity, and blaming age sometimes helped them to accept changes more readily.

> … you know that you're not doing what you thought you would be able to do. And you know, right why am I unable to do as well? I'm blaming that. But they blame everything on cigarettes now. But I mean, OK, it's old age as well. (M, 65–74, RD, CHD, CHF)

This attribution was itself a form of identity work, and was often done across conditions rather than for illness in general, suggesting that within multimorbidity illness identity is negotiated condition by condition rather than as a single undifferentiated state. One participant distinguished between age and their individual conditions, attributing some change to simply getting older while locating more of their changed life in one condition than another:

> Yeah, I guess, well, with age, I'm 80 years of age now, so you expect to slow down a bit. And yeah, I think the COPD more, has affected my life. So, the diabetes you learn to live with, basically, and treat with medication … but the COPD, I think you can do less about. (M, 75–85, RD, Diabetes)

However, attributing some conditions to age, and at first, not being willing to accept them, led to weaker self-management for some participants:

> I'm a little bit disrespectful of diabetes and Type 2 Diabetes, which is kind of, for most people, a later life experience, so maybe I'm a little bit disrespectful of it. And if those were, if that reading was a fairly kind of regular occurrence, well I would need to sharpen up on that, you know? So, yeah. (M, 65–74, RD, CHD, Diabetes)

Subtheme 5.2: Perceiving Ageing and Chronic Conditions as Part of the Life Course. Some participants moved beyond the dichotomy of "age vs. illness" by integrating both into their evolving self-concept. This allowed them to adapt and accept limitations without self-blame, often embracing change with a sense of resilience, wisdom, and long-term perspective. This integrative mindset supported emotional stability and self-management.

> My attitude towards it … I think I just accept my conditions as a fact of life, and … my attitude is that, yes, this is a fact of life, and I don't panic about it, I don't worry unduly about it, because I know I've done what I need to do, and get, and I'm having medications that, although it's daily and I hate taking it, I do, I never forget to take it. So, it's just, yeah, go with the territory, I think at this age. (F, 75–85, RD, CHD)

When participants integrated ageing and illness into a coherent understanding of their changing selves, they appeared better able to accommodate emerging limitations while maintaining a sense of agency and looking ahead.

> I can't do heavy stuff like that anymore … and I've had to make choices, not just because of medical conditions, but just because I'm older, you know. I've had to make choices where there's some things I'm not going to be able to achieve in my lifetime, but well, yes, I still hope I will (laughing). (M, 65–74, RD, CHD, Diabetes)

This stance reflects neither rejection nor engulfment. Instead, decline is seen as an expected part of getting older rather than a break in life, so new limits can be taken on without threatening the person's sense of who they are.

Subtheme 5.3: Gratitude and Appreciation for Life. Some participants expressed deep gratitude for life, emphasising the value of each day in later years. They focused on the positive, such as reaching an age that others may not, reflecting a shift from dwelling on limitations or losses to appreciating life itself.

> You kind of think, more about you know, the finite situation and the whole thing about a bucket list and so on. But also, simple things like … just to hear nature and to see nature … more an appreciation now than before … I'm retired now. Probably when I was working and I was, you know, working pretty long days and that, you really didn't have much time to kind of surface for air like that, you know? So, you have the advantage when you're retired. (M, 65–74, RD, CHD, Diabetes)

For some, a sharp awareness that time was short, and seemed to pass faster with age, lay behind this gratitude, turning attention towards the present and towards valuing what was left.

> The last 10 years of your life went at such a pace … The next 10 years of your life will go by in seven years, and the following ten years will go by in five. Time absolutely disappears. (M, 65–74, RD, CHD, CHF)

For this participant, the sense that time was speeding up was not just a loss but a reason to value the present, and this awareness fed a more appreciative sense of self in later life.

Taken together, this theme indicates that illness identity in later life cannot be fully understood in isolation from ageing identity. Participants drew on age, on illness, or on both to explain change and located illness within a longer life course. This shaping of illness and ageing identities together is not captured by the four established dimensions, and represents the principal way in which our

findings extend the illness identity framework for older adults with multimorbidity.

Cross-Cutting Patterns

Participants' illness identities were not fixed: they shifted over time and could differ across the conditions a person managed at once. Several described moving from an initial refusal of a diagnosis towards a more integrated, managed stance. One participant, quoted earlier (Subtheme 2.3) about her diabetes, shows this movement. At first she could not accept the diagnosis but over time she came to terms with it, marking the change herself: "I couldn't accept that I was diabetic in the beginning … That took me a long time. And it took me a long time to control it even" (F, 65–74, RD, CHD, Diabetes).

Alongside this movement over time, participants often held different identity positions for different conditions at once. Rather than relating to their multimorbidity as a single undifferentiated state, they foregrounded some conditions and backgrounded others:

> I think diabetes is the main one to manage. The other one, you can't really do that much … the diabetes is the main one … the other one subsumes into it. (F, 65–74, CHD, Diabetes)

This is an example of prioritisation: diabetes was the main focus while the other condition stayed in the background. A similar pattern was evident for others, who focused more on the conditions they found constant or serious and less on those they saw as minor:

> No. Heart is the most difficult one and which I don't notice really. It is the diabetes. It's there. I'm on stuff for it. And yeah, it's relatively under control … The heart is as good as it's going to be … So no, I don't really think about it. I try not to think about it. (M, 65–74, CHF, Diabetes)

Together, these accounts indicate that illness identity in multimorbidity both shifts over time and differs between conditions: a person may reject one diagnosis while accepting another, and may move between positions as their circumstances and understanding change.

Discussion

This study used narratives from older PwMs to examine how illness identity develops and how it influences attitudes and behaviours related to self-management in the context of multimorbidity. Our findings both confirmed the established illness identity framework and extended it, showing that in multimorbidity illness identity shifts over time, changes with context, and works differently across coexisting conditions. Consistent with previous research (Oris et al., 2016, 2018), we observed clear instances of engulfment, rejection, acceptance, and enrichment in our sample. However, these states were not static traits: participants often moved between them or occupied several at once for different conditions. This fluidity corresponds with the notion that identity is multidimensional and context-dependent (Brubaker & Cooper, 2000; Markle et al., 2015), and with models that frame chronic illness as a dynamically shifting perspective rather than a fixed trajectory (Paterson, 2001).

Age and illness often arose together in participants' stories, with changes in abilities and roles linked to both "getting older" and "having these illnesses," so that illness and ageing identities tended to blend. Accepting mobility problems as a normal part of ageing, for instance, could make struggles feel more normal and reduce stigma (Corbin, 2003; Gilbride et al., 2023). However, it can also mean that treatable symptoms are overlooked if they are seen as "just age." This complicates the concept of biographical disruption (Bury, 1982), which was developed for younger adults, where part of what made illness disruptive was the early arrival of conditions culturally associated with old age (Bury, 2002). For older adults with multimorbidity, these conditions fit what people expect of old age, so they may be anticipated as part of normal ageing rather than felt as a break in the life story, and decline is absorbed into the expected life course. Later scholarship has similarly recognised that illness can be woven into biography rather than only disrupting it (Carricaburu & Pierret, 1995; Williams, 2000). Our findings extend this debate by suggesting that in later life, illness identity is shaped not by a disrupted life story but within the ordinary process of ageing. Clinically, this raises the risk that older patients discount treatable symptoms as normal ageing (see the Implications for Practice and Policy section).

Participants also compared their current and younger, healthier selves, eliciting pride, sadness, or irony over lost abilities, and gratitude for still being alive (Corbin, 2003; Rassart et al., 2021). For some, this brought overwhelm and disappointment, but more often they used downward social comparison, a common coping strategy (Festinger, 1954; Wills, 1987), expressing gratitude for being "better off" than others.

Beyond identity and ageing, our findings revealed clear links between illness identity states and self-management behaviours. Consistent with earlier quantitative studies, positive illness identities such as acceptance and enrichment were associated with self-management (Peters & Brown, 2022). People with an acceptance identity usually kept up routines such as taking medication and attending appointments, supporting earlier findings that acceptance aids adherence and quality of life (Kralik, 2002; Maas et al., 2024).

Enrichment, on the other hand, went further than just maintaining routines. Participants described using self-management to grow and connect with others, such as by starting new exercise routines or volunteering in health-related activities. Seeing these tasks as meaningful helped them stay motivated and strengthened their sense of being capable health managers, findings similar to those of previous research on proactive health behaviours (Maietta, 2021; Tang & Lin, 2024).

Conversely, participants who showed rejection patterns reported insufficient or inconsistent self-care, as noted in previous research (Tilden et al., 2005). For some participants, denying the "sick role" was a way to preserve their ideal self-image and independence. For these participants, the emotional payoff of not being a patient outweighed the perceived benefits of strict adherence. Recognising this matters, since simply instructing people on self-care does not address their need to feel "not defined" by illness. For older PwMs, presenting treatment as choices and fostering control beliefs can align self-management with their self-perception, reinforcing autonomy and adherence (Aujoulat et al., 2007). Such integration succeeds most when management is something people do actively rather than something done to them (Maietta, 2021). This resonates with qualitative work on chronic illness and the self, which argues that encouraging people to revise daily habits is itself work on the boundaries of their self-concept, so that self-management support attentive only to the disease risks neglecting the self (Hajdarevic et al., 2025).

Moreover, the overwhelming sense of engulfment among some participants often carried feelings of helplessness and led to resignation and disengagement. Previous research demonstrated that feelings of engulfment correlate with poorer psychosocial outcomes and lower self-efficacy in self-care practices (Konsztowicz & Lepage, 2019). Interestingly, our study found that despite their emotional struggles, most participants adhered to treatment regimens driven by fear or a belief in the necessity of self-management. Adherence driven by fear or necessity, however, has a different basis than adherence rooted in acceptance, and may be harder to sustain as frustration with the demands of self-management grows. Therefore, helping these individuals move from engulfment towards a more neutral acceptance is critical for sustaining effective self-management. Professional help or peer support could be instrumental in assisting PwMs to navigate their identities beyond their illness, fostering a broader recognition of the possibilities and meanings that life with illness can hold (Kennedy et al., 2005).

The complexity of managing multiple conditions highlights the importance of integrated care. This holistic approach can help patients understand how their conditions interrelate, promoting more comprehensive health management (Beaudin et al., 2022; McCabe et al., 2025). Given the complexity of self-management in multimorbidity, celebrating small wins in one area could foster a broader sense of capability across health activities by reinforcing control (LeBlanc & Jacelon, 2022) and self-efficacy (Bandura, 1997), which is in turn linked to more effective health behaviours.

Including illness identity as a key part of self-management interventions may also increase the effectiveness of these programmes. Adding educational and persuasive features to help transform identity-related beliefs may help people accept their conditions and stay motivated to manage them (Peters & Brown, 2022). Additionally, peer-led activities and opportunities for reflection can build social connections and help people integrate their illness into their sense of self. Narrating one's illness experience can itself serve as identity work: constructing and sharing an illness story supports biographical renegotiation and a coherent sense of self (Mathieson & Barrie, 1998). Structured opportunities for such reflection within self-management programmes may therefore offer value beyond the informational, helping older PwMs make meaning from their experiences and situate illness within a broader life narrative. While these suggestions apply to all self-management programmes, digital interventions may be especially suited to them, being flexible, personalised, and scalable (Beaudin et al., 2022), helping older adults stay engaged, feel more independent, and sustain self-management over time.

Implications for Practice and Policy

Although this study is qualitative and exploratory, several practical implications follow. Because illness identity may shift over time and differ between conditions, clinicians may find it useful to explore how each condition is positioned within an older patient's sense of self. The analysis indicated that fear-based compliance supported self-management even among participants who had not adopted an accepting attitude towards their condition(s). Because this kind of compliance is less durable, as noted above, helping patients move towards acceptance is a clinical goal in itself. Attributing treatable symptoms to ageing rather than to a medical condition is a recognised barrier to seeking care in older adults (Kobus et al., 2026; Prohaska et al., 1987), since framing a symptom as part of ageing positions it as external and beyond the individual's ability to influence or control, which can reduce the perceived value of reporting or acting on it. This points to a concrete communication task: by asking older patients how they explain their symptoms and offering alternative explanations where appropriate, clinicians can help ensure that treatable problems are not dismissed as inevitable decline. The value participants placed on condition-

based groups suggests that commissioning and funding for peer support and social prescribing should be considered a complement to clinical care, rather than an optional add-on. More broadly, because participants experienced their conditions as interrelated, these findings reinforce calls for service models built around integrated, person-centred care for multimorbidity rather than single-condition pathways.

Limitations and Strengths

This study's qualitative, cross-sectional design limits generalisability and cannot capture changes in illness identity over time. The purposive sample, drawn mainly from healthcare and community networks, consisted of people already engaged with formal self-management support, and so may under-represent more socially isolated or disengaged individuals. Relatedly, eligibility was confined to four condition categories, two of which each span several diagnoses. While these represent a prevalent and frequently co-occurring grouping of cardiometabolic and respiratory conditions, the symptom burdens described here are specific to this grouping. Our central focus, however, is on how individuals manage multiple coexisting illness identities, a defining feature of multimorbidity itself, so while the particular content will differ across condition types, these underlying processes offer a basis for future exploration in other clusters. Recall bias, current health status, and social desirability may also have influenced these self-reported narratives. Finally, framing the analysis within the illness identity framework may have emphasised certain constructs while overlooking other psychosocial factors; and although the guide centred on self-management rather than illness identity as such, framework dimensions less tied to self-management, particularly the intersection with ageing, were developed inductively rather than through targeted probing.

Despite these limitations, the study has important strengths. In-depth interviews provided detailed accounts grounded in participants' own circumstances, which not only validated the theoretical framework but also extended its application for the first time to multimorbidity, self-management, and ageing. The findings highlighted how illness identity both shapes and is shaped by attitudes towards self-management, demonstrating that these constructs are dynamic and fluid. This perspective offers valuable insights for designing person-centred interventions and care for older PwMs.

Recommendations for Future Research

Longitudinal studies could examine how illness identity evolves with age and changing health, and how social support shapes it. Recruiting more diverse samples may also surface perspectives relevant to healthcare inequalities and the influence of socio-economic and cultural factors.

Conclusion

This study confirmed the four illness identity states and expanded the current framework by showing how illness identity is built and maintained, and how it overlaps with ageing identity. The findings show that identity states affect control beliefs and self-management, with acceptance and enrichment leading to more adaptive behaviours. These results point to the value of including age-related perspectives in self-management support, and of targeted interventions that improve health literacy to reduce rejection of illness, with potential benefits for the quality of life and well-being of older PwMs. Ultimately, understanding how older PwMs construct and negotiate illness identity is not merely a theoretical concern but a practical imperative for designing healthcare and self-management support that is responsive to the whole person rather than each diagnosis in isolation.

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Ethical Considerations

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Consent to Participate

All participants provided written informed consent.

Author Contributions

ICO: Conceptualisation, methodology, formal analysis, investigation, data curation, writing – original draft, writing – review and editing, and visualisation. SH: Methodology, formal analysis, investigation, data curation, and writing – review and editing. JuD: Supervision, methodology, formal analysis, investigation, data curation, and writing – review and editing. FT: Investigation, data curation, and writing – review and editing. JoD: Supervision, methodology, formal analysis, investigation, data curation, and writing – review and editing.

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Declaration of Conflicting Interests

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

Data Availability Statement

The data analysed in this study are not publicly available due to ethical and privacy considerations but are available from the corresponding author upon reasonable request if approval is obtained from the relevant ethics committee and data sharing complies with institutional and legal guidelines.

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Appendix

Abbreviations

H2020	Horizon 2020
PwMs	Persons with multimorbidity
SEURO	Scaling EUROpean citizen-driven transferable and transformative digital health