‘Exploring Perspectives of Ageing Well: A Mixed Methods Study of Community Dwelling Adults Aged 85 Years and Older’

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ABSTRACT

At the current time, people aged 85 years and over are identified as the fastest growing sector of our ageing population and generally assumed to be the most demanding for care. This thesis challenges this stereotypical assumption and aims to address the gap in current knowledge, bringing a detailed understanding of the influences contributing to 'ageing well' by including the voice of older people themselves.

Applying a convergent parallel mixed methods approach containing two theoretical strands of data: (i) quantitative from 'The Newcastle 85+ Pilot Study', comprising structured interviews with n=116 participants [47 male/69 female]; and (ii) qualitative from additional in-depth interviews with n=17 of these participants [9 male/8 female]. All data collection took place within the participants' usual place of residence [own home/care home; nursing/residential] and analysis was according to the theoretical foundation of each strand. Meta-inferences were led by qualitative themes with quantitative findings providing context. All participants were born in 1918 and permanently registered with a general practice within the City of Newcastle upon Tyne, North East of England.

Findings revealed: (i) past life experiences have relevance as an influencing factor for 'ageing well'; (ii) perspectives of the older individual need to be included when exploring health needs and planning resource allocation; (iii) the contribution of social connectedness and informal support should be considered as influencing factors of 'ageing well'. An overarching discussion concluded that 'ageing well' is a fluid concept, sensitive to the lived context and history of an individual. Examining 'ageing well' in this way not only provides opportunities for future research and practice but also contributes to the development of overall knowledge.

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CHAPTER 1: MAIN INTRODUCTION

1.1 Overview

The purpose of this chapter is to provide the reader with a clear statement of this thesis and a logical rationale to justify the conception and organised reporting of this study.

1.2 Study Rationale

Within the United Kingdom (UK), improving health and social care for older people has been targeted as a priority area by successive governments for over a decade now. This was first highlighted in the National Health Service (NHS) Strategic Review: Ageing and Age-Associated Diseases and Disability (NHS Research and Development (R&D) Strategic Review 1999), then followed by The National Service Framework for Older People (Department of Health (DOH) 2001), until more recently Caring for Our Future: reforming care and support (DOH white paper 2012). The rationale for such a focus is heavily influenced by empirical data demonstrating a worldwide trend towards continuing population ageing, and forming the foundation for the theory of demographic transition (Binstock and George 2001; Murtagh et al 2003). From the late 19th century onwards, this transition within the UK has resulted primarily from increased late life expectancy (Haub 2007), with the additional population 'bulge' from the high post-World War II (WWII) fertility now entering its seventieth year. Such a trend is believed to have vast implications for future resources, which are already under a great amount of pressure and presents challenges to providers of health and social care (Macdonald and Cooper 2007; Office for Budget Responsibility (OBCS) 2012).

At this time, those aged 85 years and older are not only identified as the fastest growing demographic, with mid-2011 census estimates predicting that for the period 2011-2021, when the UK population is projected to rise by 8.6%, the numbers of people aged 85 and over will rise by 39% and by 2030 will rise again by 101% (Office for National Statistics (ONS) 2012 a) but also assumed by society as being the most demanding of care (Wanless 2002). However, aside from empirical data and the existence of key cohort studies focused on

ageing in the UK, such as Medical Research Council Cognitive Function and Ageing Study (MRC CFAS) (Jagger et al 2007), and the English Longitudinal Study of Ageing (ELSA) (Marmot et al 2003), there is relatively little good quality information currently available on the needs of those aged 85 years and older. Therefore, much of what is put forward about the needs of this group and their high use of services is based upon assumption and ageist attitudes.

Undoubtedly, the critical nature of exploring this demographic explosion, and addressing gaps in knowledge about the actual needs and health seeking behaviours of this group, provide exciting opportunities for research. Bury and Holme (1991) identify that ageing does not occur in a neutral environment; therefore, they call for researchers to be creative when examining the complexities of ageing, with others also suggesting the use of approaches which include the experiences and meanings of ageing from the wider context of the individual's lived history (Bowling and Dieppe 2005). More specifically, it is the opinion that research should include the voices of older individuals themselves, and what is more, researchers should listen carefully to their message as currently much of what is known is driven by the desires of the researcher (Phelan et al 2004; Bowling and Dieppe 2005; McNellis Carey 2006; Larsson et al 2009; Moyle et al 2010). Through understanding this, it becomes possible to generate aims such as proposed by this study*: identifying influences that contribute to our ability to 'age well'*, from divergent perspectives. Findings generated from such novel approaches may then go some way to creating innovative ways to address some of the gaps in knowledge already identified within the literature, such as: uncertainties of future resource burden (Phelan et al 2004); developing interventions to increase healthy late life expectancy (Jagger et al 2008); promoting independence (Collerton et al 2009); and simply, the ability to maintain an 'ordinary/everyday' life (Larsson et al 2009).

Therefore, the central statement of the thesis, upon which the aims of the following mixed methods study was constructed, maintains: In a time when those aged 85 years and older are not only identified as the fastest growing sector of an ageing population but also assumed to be the most demanding of care, exploring ageing well from perspectives which include the voices of older people themselves, promotes greater understanding of their health needs and

use of resources. Once generated, such knowledge will drive future policy and practice from a foundation of quality evidence, rather than assumptions and ageist attitudes.

1.3 Telling the Story: Thesis Organisation

Following on from this chapter, narration of the thesis is organised through a further 7 chapters. The following briefly outlines the core of each.

Chapter 2 examines the broad field of literature surrounding ageing, emphasising the vital nature of this topic as a focus for research. In doing so, the chapter considers the determinants and characteristics of population ageing and views healthy ageing and perspectives on ageing through various lenses. From this, discussion is given to concerns around the impact on future resources, bringing into the debate concepts such as the influence of society's ageist attitudes.

Chapter 3 details the methodological approach to the research, along with the methods for sampling, data collection and analysis. Of particular importance is the discussion outlining the theoretical debate of mixed methods, which first considers the position as two opposing, incompatible theoretical dimensions, before putting forward an argument of compatibility when applying a pragmatic approach to the subject under investigation. Recognising the importance of the subject, the chapter concludes with ethical and practical considerations of including older people in research.

Chapter 4 presents key findings from the analysis of quantitative data, pertaining to contextual information of the wider study population [demographic and lifestyle characteristics], whilst offering vignettes from qualitative data as a richer source of description for those participants who consented to in-depth interviews. The theoretical underpinnings of this study consider the researcher to be inextricably linked to the findings of the study; therefore, a researcher vignette is also offered to the reader. As findings from the analysis of qualitative data shaped the overall focus of this thesis, an overview of these themes is provided.

Chapter 5 introduces the first of the three main data chapters, here exploring the relevance of past life events in relation to their contribution to 'ageing well'. Facilitating this, the prevailing domain from participant in-depth interviews is selected: 'experiences of work and transition to retirement'. The debate first considers the nature of work, exploring the potential impact that the 'gains and constraints' of work have upon the lives of participants. Then exploration moves to consider the transition to retirement, in the use of strategies, such as adaptation and acceptance, for those participants who felt loss, contrasted with those participants who felt liberated by the removal of work constraints. Using the data, the chapter also demonstrates that participants may be required to 'manage' these strategies continually in the face of additional transitional challenges, such as changes to health. Throughout, the chapter tackles the gendered nature of the debate, including topics such as defining work solely on the basis that an individual is in receipt of remuneration.

Chapter 6 considers health in the context of ageing. The theme of health dominated many of the participants' in-depth interview conversations, including those described within chapter 5 and therefore links the chapters. However, discussion within this chapter is heavily influenced by dimensionally opposing objective/subjective perspectives of health, where they might converge and perhaps more importantly where they are divergent. Following on from this, questions are presented that enquire about the validity of using standardised self-rated health (SRH) tools in isolation in this population group. The chapter also positions its discussion within the context of larger debates from the literature, including 'disability paradox', and the dominance of 'knowledge' generated from empirical research. Data around use of services, gender and lifestyle choices as a cause of ill health are also considered.

Chapter 7 examines the contribution of social connectedness and informal support as influencing factors of 'ageing well'. Again, links with the previous two chapters are apparent; however, specifically the chapter considers the key characteristics of family dynamics in an attempt not only to define network types but also the levels of support they are perceived to offer. In so doing, questions are raised regarding the usefulness of 'traditional' definitions of family relationships when researching this population group. Challenges are also

posed as to the assumptions made about the type and, more importantly, the direction of support within these relationships.

Lastly, chapter 8 outlines the key findings from the data, drawing them together to provide a detailed overarching discussion that responds directly to the main aim of the study: to explore the influences that contribute to our ability to 'age well'. From this discussion, the chapter is also able to address the two secondary aims: (i) consider the impact of exploring 'ageing well' from the perspective of the older person for policy and practice development; and (ii) explore the gains and limitations to knowledge when widening the methodological approach beyond traditional empirical perspectives to investigate 'ageing well'. Strengths and limitations of the study are also addressed, and possible directions for future research provided, in order to extend the scope of this study. Finally, an overall conclusion to the thesis is given.

1.4 Summary

This chapter has provided the reader with a clear rationale and central statement on which the aims of the study presented within this thesis are based. At the heart of this is an outline of the scope and organisation of the thesis, giving the reader a sense of the overall direction of the work. Following this format, the next chapter examines the broad field of literature surrounding the topic of ageing.

CHAPTER 2: AGEING

> "I mean age it's just a pasture of time it's no big stick having another birthday you just sort of toddle along all the time people make big things out of birthdays --- we make big things out of our marriage and our lives"
>
> (Brenda, p.46, ll.1768-1770)

2.1 Overview

The 'study rationale' of the previous chapter introduced the concept that continuing global trends toward population ageing place very real demands on society and its future resources. None more so, or so it is assumed, than the fastest growing demographic: those aged 85 years and older. The purpose of this chapter is to explore the current literature in order to emphasise the vital need for ageing to be a focus for research, and to determine what the main findings and drivers of existing knowledge are, as it is these principles on which perceptions of demands made by those aged 85 years and older are constructed, and ultimately on which policy and resource allocations are based.

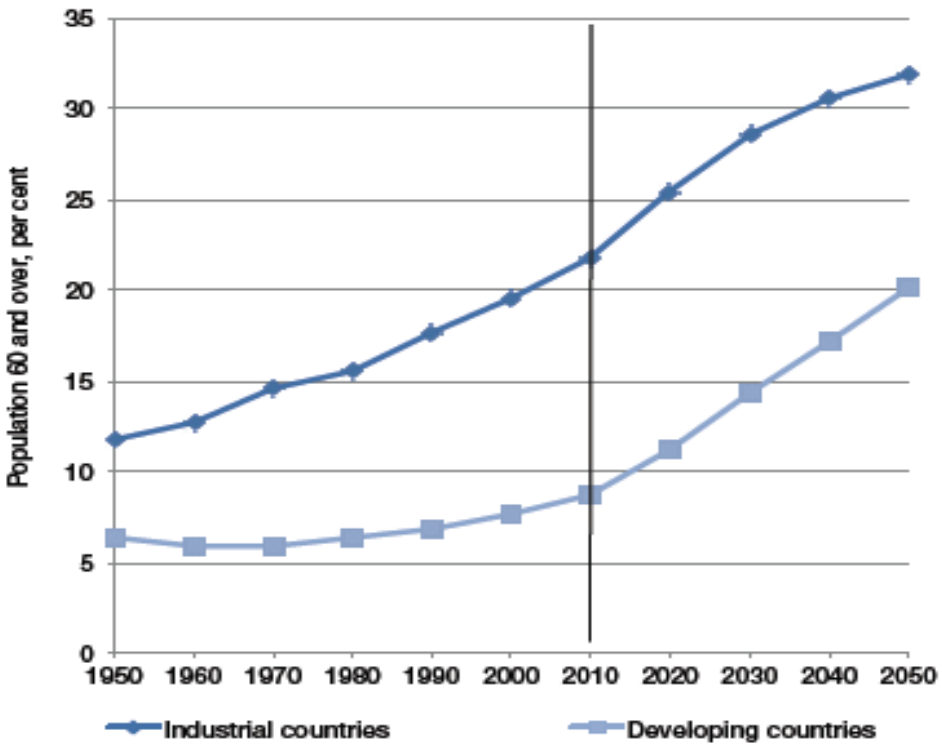
In doing so, focus is first drawn to the characteristics of population ageing, which from a global perspective involves theories of demographic transition, sex differences, and the population explosion of those aged 85 years and older. This is then translated to the UK population where responses from policy and reform are considered. Discussion then moves to the concept of healthy population ageing, with literature attending to concepts such as the compression of morbidity, life expectancy and healthy life expectancy, whilst also introducing a connection to disability paradox. The complex nature of defining ageing itself is then tackled, illustrated through the lenses of alternative perspectives. Finally, the discussion is set against literature examining society's ageist attitudes.

Ultimately, the discussion of literature reviewed within this chapter intends to provide a sound theoretical foundation for the ensuing study.

2.2 Population Ageing

The world's population is ageing, with estimates predicting that by the year 2050, total populations will grow by about 28 million per year and older population growth will reach 33 million per year (United Nations 2004). Where previously there was believed to be a great 'demographic divide' with very little population growth in the more developed countries against a continually increasing population in less developed countries (Haub 2007), it is now understood that ageing is occurring faster in the less developed world (Beard et al 2011) [Figure 1], although perhaps with the exception of those countries where the Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) are widely prevalent (de Walque and Filmer 2011).

Figure 1: Global Population Ageing



(Source: UN World Population prospectus: the 2010 revision IN Beard et al 2011, p.6)

2.2.1 Determinants

Determinants of an ageing population are attributed to the combination of two primary factors:

(i) Increased Life Expectancy

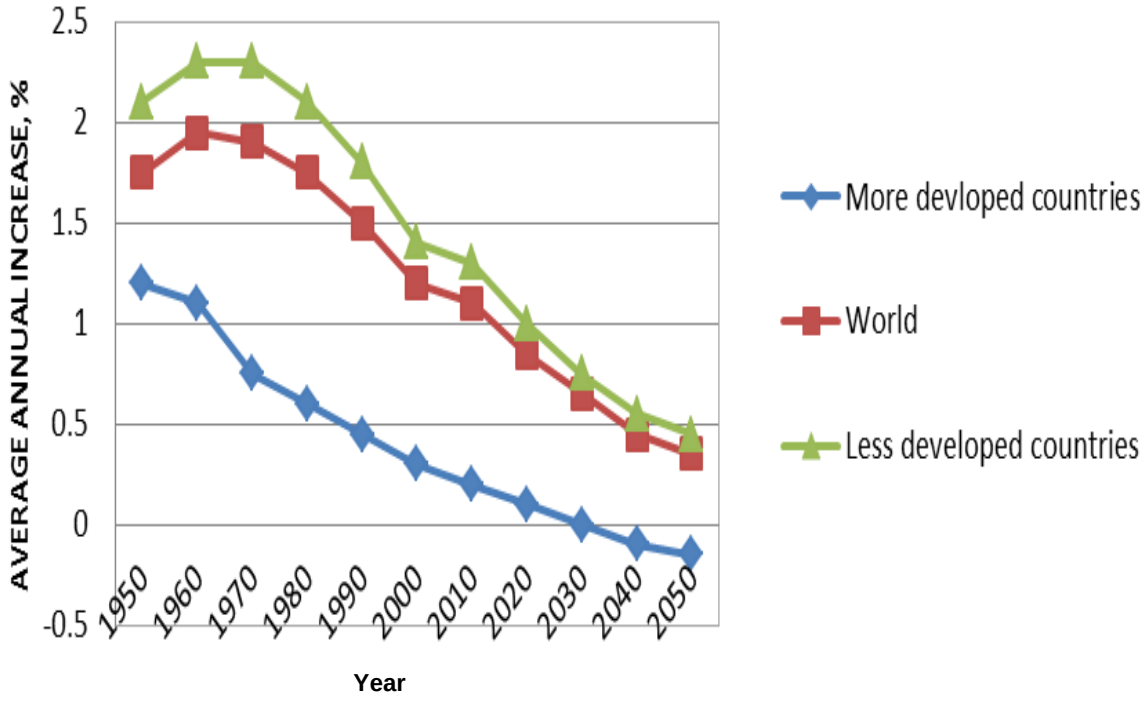
Most individuals in several European countries can now expect to live to 'old age' (Tallis and Fillit 2003), with predictions suggesting that by the year 2020 approximately 25% of the population in these countries will be aged 65 (Walker and Maltby 1997; Binstock and George 2001; Grundy 2003; Murtagh et al 2003; Abbott 2004), rising to 32% by 2050 (Beard et al 2011). What is more, contrary to numerous claims from the United Nations that life expectancy will eventually plateau off, to date empirical evidence shows that life expectancy is still increasing at a rate of approximately 44 days per year:

> "As a result, more than 11 million people alive today [17.6% of the population] can expect to live to more than 100 years old. This is 200,000 more than estimates last year".
>
> (Prince 2011 online).

(ii) Reduced Fertility

Fertility rates refer to the number of children a woman will produce over her lifetime. Figure 2 below illustrates that total world growth in 2008, when these figures were updated, was at around 1.15%, approximately half of what it was at its peak in 1963. In less developed countries, the decline in fertility rates is shown to be more marked. This trend is predicted to continue for some time, taking the global total fertility rate close to global replacement levels of 2.23 children, the number of children a woman would need to produce for the long-term replacement of the population (Espenshade et al 2003).

Figure 2: Population Growth Rate 1950-2050



(Source: United Nations (2009) World Population Prospects: *The 2008 Revision*. New York: United Nations, p.3*)*

Demographic Transition

Collectively, these two primary factors are encapsulated within the theory of 'demographic transition', characterised through four distinct phases (Caldwell et al 2006) [Table 1]. Within the developed countries of Western Europe, transition from phase 1 to 2 is said to have come about from the late 19th to early 20th century with, amongst other historical factors, the introduction of improved housing and sanitation. This trend continued with advances in medical technology first with the introduction of vaccines and then antibiotics to prevent/treat infectious disease (Fries 1980). However, from the late 20th century onwards much of the increase in life expectancy was due to an entirely new phenomenon, that of a reduction in late-life mortality (Westendorp and Kirkwood 2007).

Table 1: The Four Phases of Demographic Transition

Phase 1	• High birth and mortality rates. • Fluctuations in rates are dependent upon outbreaks of transmittable disease. • Modern medicine and standards of hygiene are comparatively low.
Phase 2	• Knowledge growth in standards of hygiene and modern medicine. • Mortality rates drop. • Birth rate remains high. • Upward trend in population size.
Phase 3	• Economy based upon agriculture decreases whilst urbanisation increases. • Economic incentive for larger family falls. • Birth rate drops.
Phase 4	• Birth rates and mortality rates remain relatively low.

(Source: tabulated from Caldwell et al 2006)

Implications

The swelling ratio of older to younger individuals is claimed to have far reaching implications, including a deterioration in standards of living brought about by an increasingly top-heavy financial burden placing too great a demand on a decreasing workforce (Jeavans 2004). Additionally, increased demands on future care because of fewer children who, after spouse, currently provide a significant, although as yet not fully determined, amount of informal care to their older relatives (Connidis 2001). With regards to this last point, in China the implications of this, along with data emerging from their sixth national census in 2010, form the backdrop of calls to relax the one-child policy (China Development Research Foundation (CDRF) (2012). Recognising the implications of a decreasing workforce and the birth of fewer children, both of these important points are returned to respectively in chapters 5 and 7 of this thesis.

2.2.2 Sex Differences

Further review of empirical evidence on population ageing in developed countries illustrates differences between the sexes, with females living longer than males (Jeffreys and Thane 1989) [Table 2]. Despite emerging data indicating that sex differences will eventually be cancelled out due to life expectancy rates increasing more rapidly for males than females (ONS 2012b), implications for demands placed on current and 'near' future resources remain. The rationale being, females generally experience more of the chronic diseases and therefore live for a longer period of time but in poorer health, thus making greater demands on society and resources (Olshansky et al 1991). There is also a body of evidence suggesting that females are less likely than males to remarry after the death of their spouse, therefore spending a greater time living alone and at increased risk of loneliness, a factor commonly associated with poor self-rated health (Theeke and Theeke 2009; Nummela et al 2011), declining cognitive health (Bowling et al 1989; Victor 2005), and increased physical disability (Aartsen and Jylhä 2011; Bowling et al 1989; Theeke and Theeke 2009; Wenger et al 2004).

2.2.3 Population Aged 85 Years and Older

As set out in the previous chapter, the rationale for this study includes the remarkable statistical evidence that the population aged 85 years and older continues to be the most rapidly growing demographic of an ageing population. With regard to this, there is an assertion that growth of this population group will place a great strain on already fragile health and social care services within the UK (Royal College of Physicians RCP 2012), which is then ramped up by the media reporting that 'services will be pushed to the brink of collapse' (Peev 2013). Others, however, point toward a much greater intrinsic malleability in the mechanisms of ageing than previously appreciated (Kirkwood and Austad 2000; Kirkwood 2005). Both of these viewpoints generate great scientific interest to carry out a detailed study into what is happening to the health of this group.

2.2.4 Policy and Reform within the United Kingdom

For over a decade, successive British governments have attempted to respond to an ageing population and address the concerns of increased demand,

including an increase to pensionable age, along with two independent commission', three public consultations and three white papers outlining reforms aimed to improve health and social care for older people: NHS R&D Strategic Review 1999 (DOH 2006); The National Service Framework for Older People (DOH 2001). In the latest UK Government white paper 'caring for our future' (DOH 2012), two primary targets for care and support reorganisation are identified: (i) 'promoting independence and wellbeing' and (ii) 'putting individuals in charge of their own care'. Strategies put forward to support these include: standardisation and improvements to the quality of resource information provided to individuals; valuing the contribution of carers and raising training standards and opportunities to promote dignity and respect; encouragement and support of community projects to encourage social connectedness and tackle social isolation; and better housing to enable individuals to regain independence at home. However, responses to this paper accuse the government of failing to acknowledge exactly how such reforms will be funded, particularly in times of cuts, fiscal austerity, and ever-increasing demands. As a result, the need for solutions remains as urgent as ever (Humphries 2012). Recently concurring with this viewpoint, a House of Lords report (2013) stated that Britain is not ready for an ageing population, drawing particular attention to those aged 85 years and older, and setting the UK government a challenge to:

> "Produce a further White Paper which addresses the implications of an ageing society with a vision for living well and independently"
>
> (Filkin 2013. Online).

2.3 Healthy Population Ageing

From the previous [primary target (i)], it appears that the concept of promoting wellbeing has increasingly become a central political goal for the government's social and public policy, replacing welfare, to drive healthy population ageing (Barnes et al 2013). However, according to Hagberg (2006) the concept of wellbeing, along with the commonly interchangeable terminology of quality of life, healthy ageing, active ageing, successful ageing, and indeed 'ageing well', is ambiguous and seldom clarified with distinct definition. The point made here

is that very often this depends upon the preferred focus of the researcher (Lawton 2000 cited IN Rott et al 2006, p.120), where within the UK it is argued that 'preference' is dominated by empiricism (Hammersley 2012). Therefore, determining that policy on such matters of wellbeing and healthy population ageing are driven by concerns of 'physical' measurements from which to inform outcomes.

2.3.1 Compression of Morbidity

One such example of this is the measurement of 'compression of morbidity', denoted by the observed postponement of ill health to the fewest number of years towards the end of an individual's lifetime (Fries 1980). This phenomenon is believed to have resulted from advances in medical technology connected to age-related disease and disability such as dementia, arthritis, diabetes and hypertension (Rowe and Kahn 1998). Whilst criticised by those who look beyond empiricism for overplaying the importance of medical advance and overlooking changes to the physical and social environment (Bond 1993), the theory gains support in opposing the belief that extended life automatically equates to extended ill health (Olshansky et al 1991), achieved by presenting evidence that shows many individuals are not only living longer but staying healthier (Coleman and Bond 1993).

2.3.2 Life Expectancy Versus Healthy Life Expectancy

Nonetheless, growing debate questions the value of 'compression of morbidity' in understanding healthy population ageing, if it does not parallel that of increased life expectancy (Jagger et al 2008). In this regard, recommendations are made to design measurements to differentiate between Life Expectancy (LE) and Healthy Life Expectancy (HLE) (Victor 2005). As:

> "…While there is no possibility of error in determining when life begins and ends, good and bad health are far from being absolutes. They are often a matter of impression, and the line between the two is not a sharp one."
>
> (House Of Lords 2005, p.17)

In 2013 the Office for National Statistics (ONS) produced data for the UK, using information from 2 core questions relating to perceived health status from the Integrated Household Survey (IHS). Abridged here as: (i) “How is your health in general …? (with 5 closed incremental responses); and (ii) “Do you have any longstanding illness, disability or infirmity …?” [With 2 closed dichotomous responses and filter question to determine the presence of limited activity]. Findings from this data demonstrated that in the same period between 2001 and 2010 when LE at birth increased for both sexes, the proportion of HLE at birth decreased [Table 2].

Table 2: UK Trends in Life Expectancy and Healthy Life Expectancy at Birth 2001- 2010

	Females		Males	
Year	2001	2010	2001	2010
LE	80.4	82.1	75.7	78.1
General HLE -5	68.8	65.7	67.0	63.5

(Source: ONS 2013)

The value of differentiating LE from HLE is clear, if we consider that currently policy and reforms draw from LE data. An example of this is the already briefly mentioned reforms to increase pensionable age, however, in using LE data, the targets set for the increased participation of older people in the labour force may be unrealistic and prove difficult to meet (Jagger et al 2008).

However, population health measures such as those used in the IHS [and previously the General Household Survey], although quick and easy to administer, are accused of lacking validation in terms of sensitivity to capture variances in self-rated health, particularly influences from individual expectations and socio-demographic factors such as age, gender and economic position (Parliamentary Office of Science and Technology 2011; ONS 2013).

Furthermore, The Organisation for Economic Co-operation and Development (2007) indicate limitations in the use of measures such as LE and HLE due to the lack of consistency within European Union (EU) countries. To explore the reality of this, researchers conducted a meta-analysis of data from 25 EU countries and standardised a structural indicator for health as 'Healthy Life Years' (HLY) (Jagger et al 2008 [Table 3; Figures 3 and 4]).

Table 3: Life Expectancy (LE) and Healthy Life Years (HLYs) at 50 Years of Age by Sex for all EU countries 2005; Figure 3: Male HLYs; Figure 4: Female HLYs).

Figure 3

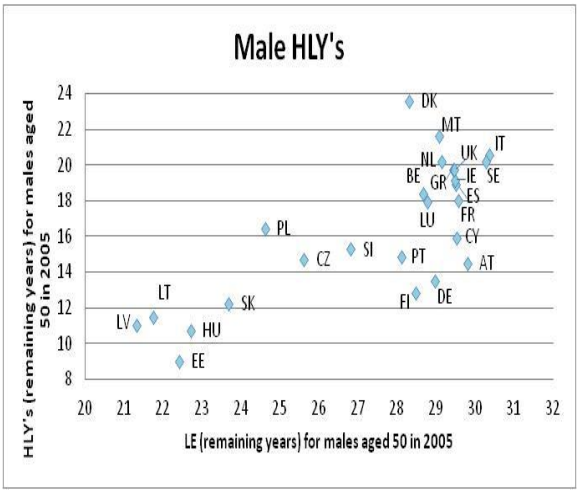


Figure 4

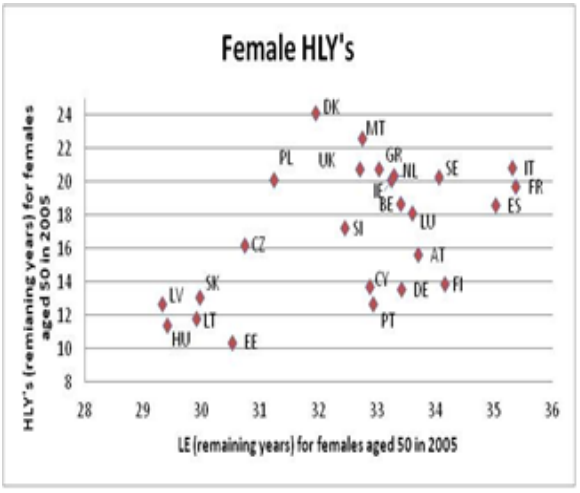


Table 3		Male		Female	
		LE	HLYs	LE	HLYs
Austria	(AT)	29.8	14.53	33.7	15.66
Belgium	(BE)	28.67	18.42	33.39	18.66
Cyprus	(CY)	29.52	15.92	32.86	13.71
Czech Republic	(CZ)	25.61	14.77	30.72	16.26
Denmark	(DK)	28.3	23.64	31.94	24.12
Estonia	(EE)	22.42	9.05	30.52	10.42
Finland	(FI)	28.48	12.86	34.15	13.87
France	(FR)	29.57	18.01	35.37	19.74
Germany	(DE)	28.96	13.56	33.41	13.55
Greece	(GR)	29.43	19.78	33.02	20.81
Hungary	(HU)	22.72	10.78	29.4	11.39
Ireland	(IE)	29.5	18.91	33.24	20.17
Italy	(IT)	30.37	20.63	35.31	20.86
Latvia	(LV)	21.31	11.02	29.32	12.74
Lithuania	(LT)	21.74	11.49	29.9	11.86
Luxembourg	(LU)	28.78	17.99	33.6	18.16
Malta	(MT)	29.07	21.68	32.74	22.58
Netherlands	(NL)	29.14	20.21	33.28	20.4
Poland	(PL)	24.62	16.48	31.23	20.16
Portugal	(PT)	28.12	14.9	32.92	12.67
Slovakia	(SK)	23.68	12.28	29.96	13.07
Slovenia	(SI)	26.81	15.32	32.44	17.25
Spain	(ES)	29.48	19.16	35.02	18.62
Sweden	(SE)	30.28	20.22	34.05	20.31
United Kingdom	(UK)	29.46	19.74	32.69	20.78

(Source: Jagger et al 2008, p.4)

Results clearly point toward a great deal of variation among the 25 European countries for HLY in both sexes at 50 years of age in the year 2005, and overall suggest a mean average of 67.3 HLY for males, and 68.1 HLY for females. Evidence also strongly illustrates that countries with low HLY [Estonia] were those with greater social, economic and environmental disadvantage. Tending to support those who criticise the lack of sensitivity in 'quick and easy methods' and the need for some agreed standardisation of measurement before any true comparisons can be made.

Challenges are also set for future research to consider that the pursuit of knowledge with regard to the effects of the wider environment on an ageing society may require investigation beyond empirical measurement, to include those more aligned to the social sciences, which have the potential to capture the diverse experiences of older individuals themselves (Glass 2003). However, all too often:

> "Social science research is perceived as economically unproductive in times of limited resources and knowledge for its own sake"
>
> (Grimley Evans and Bond 1997, p.44).

2.3.3 Disability Paradox

At this point it is appropriate to introduce a further dimension to the debate, the concept of a 'disability paradox', which suggests that objective measures of health do not routinely correspond to people's perceptions of it. Put into context, despite the presence of disease and disability, individuals may still consider themselves healthy (Bootsma-van der Wiel et al 2001; von Faber 2001; Rowe and Kahn 1998; Von Heideken Wagert et al 2005). Again this tends to support the challenge to move beyond the reliance on measures that lack the capacity to consider individual sensitivities, as in all probability health lies within a fluctuating continuum between the absence of disease and an individual's self-perception of this (Walsh 1989; Glass 2003). This important point is returned to in chapter 5 of this thesis.

2.4 Perspectives on Ageing

What much of the previous discussion highlights is that ageing has far-reaching consequences, setting very real challenges for researchers, policy makers and the providers of health and social care. However, what exactly is meant by ageing? Perhaps it is easier to start by acknowledging that age and ageing are not the same. The principle of counting passing years from one fixed point to another is largely accepted as the means of defining age, with the added benefit of providing clear-cut classification of population groups based upon chronological shared age in years (Hayflick 1994). Ageing, however resists such universal harmony:

> "…As it is not merely the passage of time. It is the manifestation of biological events that occur over the span of time. With time itself producing no biological effects"
>
> (Hayflick 1994, p.12)

Despite this, the author accepts that "we all recognise an old person when we see one". Even though such recognition is relative, depending largely upon an individual's context, such as their own age, their experiences and worldviews. Attempting to locate this 'recognition' within UK thinking, the rule of thumb generally applied is that ageing becomes apparent:

> "… Around 60 or 65 years of age, as at about this time declines in many physical and psychological processes, which have been taking place for most of the adult lifespan, first become readily apparent"
>
> (Stuart-Hamilton 2006, p.47).

However, the problems with this arbitrary benchmark are threefold. Firstly, is its overreliance on medicine in determining 'declines'. As this chapter has already gone some way in considering, there appears to be a much greater interplay between disease, individual and environment. Secondly, its correlation with retirement age, as this is an arbitrarily set social construct, which, as already

suggested, has recently been revised upwards to fit current thinking. Thirdly, the matter of its convenience and supposition that all individuals over the stipulated age follow a similar trajectory, failing entirely to acknowledge the complexity and diversity of ageing (Aiken 1989). The result, many academic papers refer to calendar age, which does not necessarily coincide with biological age or the age at which an individual's body or mind ages (Bengston et al 2005).

Models of Ageing

Such a failure to recognise diversity very much links to criticisms of gross oversimplification of ageing when attempting to describe the concepts through two very distinct models: (i) the 'deficit model' which links back to some of the previous literature systematically viewing old age as a chronic period of loss, decline or social withdrawal, ultimately denying any triumph of ageing itself ; and (ii) the 'heroic model', which considers active or 'successful' ageing in terms of being fit, healthy, happy and engaged with life (Rowe and Kahn 1998), implying that loss of fitness, health and so forth is to age badly. In short:

> "…To age well would mean not to age at all, or at least to minimise the extent to which it is apparent that one is ageing, both internally and externally"
>
> (Andrews 1999 cited IN Godfrey et al 2004, p.305).

Given this, and in view of this chapter already implying that the preferred focus of a researcher can determine what and how something is explored, and ultimately frame a definition, it therefore seems appropriate at this point of the discussion to give a brief account of the key points from the four main theoretical approaches used by researchers to 'define' ageing: (i) biomedical; (ii) psychological; (iii) sociological and (iv) social gerontology. However, the reader should note that such separation is used here as a tool for description and, as will be illustrated, should in no way be interpreted as accepting their independence from each other.

2.4.1 Biomedical

Biomedicine considers ageing from a scientific knowledge base, which according to Bengston et al (2005) approaches the concept from organism, molecular, and cellular levels. It describes ageing as a process of accumulated random changes occurring over time within the organs, tissues, cells and molecules (Kirkwood and Austad 2000; Holliday 2010). Consequences of these changes:

> "… Eventually interfere with normal functions and with homeostasis"
>
> (Kirkwood and Ritter 1997, p.26).

Clear examples of such 'interference' within the human body are often expressed in medical conditions commonly associated with ageing, one being cardiovascular degeneration or heart failure. This condition, recently found to be more common in community dwelling 87-89 year olds than previously suggested in other studies (Yousaf et al 2012), occurs as heart strength decreases and arterial elasticity is lost, thus compromising the system and placing it under a greater stress (Forman 2003 cited IN Yousaf et al 2012, p.1418). Interference with sensory function such as sight and hearing can also occur. Loss of elasticity in the eye lens increases risk of presbyopia, the inability to focus upon nearby objects. Stiffening of the malleus, incus and stapes bones within the middle ear and loss of auditory 'hair cells' slowly degrade hearing, particularly at a higher frequency (Totora and Grabowski 2003). In combination, changes such as these are often used to characterise age-related frailty which is linked to increased risk of disability, institutionalisation and death (Fried et al 2001 cited IN Collerton et al 2012, p.456).

Biomedical understanding, primarily in the expansion of knowledge of genetic factors has also provided a major breakthrough in the exploration of why ageing occurs (Kirkwood 2005). Where previous theories saw ageing as a programmed unavoidable decay, resulting in death to make way for the younger generations (Warner 2003), others now point toward scant supporting evidence for such a 'built-in age-related death programme'. They propose instead that it is the

absence of evolutionary advantage in long-term survival which makes us "disposable" (Kirkwood 2005 & 2008; Westendorp and Kirkwood 2007). Put simply, a high use of the body's resources to sustain mechanisms of maintenance and repair from internal and environmental damage at a level that might prevent ageing makes little evolutionary sense. Rather, some of this resource is used for growth and reproduction (Kirkwood 2005).

Due to the interplay of environmental factors, there is a growing acceptance from research, including that on monozygotic twins, that genetic factors only contribute to 25% of human lifespan variance. Therefore, the ageing process is susceptible to a wide range of non-genetic or life-course factors (Westendorp and Kirkwood 2007; Kirkwood and Ritter 1997; Abbott 2004; Rowe and Kahn 1998; McGue and Christensei 2002: Skythe et al 2003 cited IN Abbott 2004, p.117). Findings therefore place great importance on gaining understanding of the ageing process and its amenability to positive intervention. Literature here emphasises the benefit at any age of adopting good nutrition, regular exercise, the cessation of smoking and reducing alcohol consumption. For some this information is about empowering individuals and allowing them to take control:

> "We can and should take some responsibility for the way in which we grow older"
>
> (Rowe and Kahn 1998 p17).

However, as we will see through sociological approaches to ageing, not all individuals are equally empowered.

2.4.2 Psychological

As with the biomedical approach, psychological literature recognises ageing as multifaceted and markedly different for each individual, dependent upon a number of complex and inter-related factors (Rabbitt 2005). As such, no one definition of ageing is put forward.

Additional parallels exist in that psychological theories of ageing are also grounded in the scientific, particularly that which draws upon cellular and molecular changes. For ease, the examples of cardiovascular degeneration or heart failure and sensory loss are again used to illustrate this point: loss of cardiovascular function can result in cerebral hypoxia, reduced oxygen supply to the brain, in turn psychological performance is adversely affected and may manifest in inability to concentrate and in loss of memory. Compounding this, sensory loss as previously described also starves the brain of vital information to enable engagement with the environment (Birren et al 1980 cited IN Stuart-Hamilton 2006, p.32; Gross 1992). The slowing down of neural transmission can also result in longer reaction time to stimuli (Rabbitt 2005). An additional point to note is that many of the changes described are misconstrued as a decline in intelligence.

What psychological knowledge does bring to the table is an attempt to unravel the effects of ageing upon intellect, memory and personality, particularly in trying to understand changes in behaviour or lifestyle (Aiken 1989). The latter includes investigation of individual experiences of managing gains and losses over the life-course. Focus here centres on capacity for adaptation or transition, in making sense of and adjusting to biological, psychological and social changes. Psychological theorists put forward three main processes for this: (i) selection; (ii) compensation; and (iii) optimism (Baltes and Baltes 1990; Baltes et al 2005), illustrated in the following:

> “The passionate gardener may maintain his interest into old age by reducing the size of the borders, concentrating on low maintenance shrubs (selection), constructing raised beds for ease (compensation) and placing emphasis on creating painterly schemes within a small space (optimism)”
>
> (Godfrey et al 2004, p.3)

However, these authors warn that the capacity to adapt to, or the potential to balance gains over loss, becomes increasingly difficult with advancing age.

2.4.3 Sociological

It is argued that sociological progress in exploring and explaining ageing has been more difficult than biological and psychological approaches. The main causes of this are given as the complexity and fluidity of social phenomena and the many epistemological starting points of social theorists (Bengston et al 2005).

Historical attempts made by Cummings and Henry in 1961 (cited IN Stuart-Hamilton 2006, p.188), to posit a grand sociological theory of 'disengagement' in ageing have been, over time, widely rejected by sociologists, with key criticism surrounding the theory's derogatory depiction of older people as:

> "Shedding off social links to prepare for death and passively waiting for the Grim Reaper"
>
> (Stuart-Hamilton 2006, p.188).

Critics go on to argue that deterioration and increased dependency in old age is not inevitable, with the majority of these individuals remaining independent and healthy (Bond 1992). Claims such as this can often be linked to the social model of disability (Clapton and Fitzgerald 1997) which suggests that where older people are dependent this is often due to society and the barriers it places upon the environment, rather than the individuals themselves. Here, the condition of pavements (Wennburg et al 2009) and the built environment of our homes and community dwellings (Burton et al 2011) are cited as culpable.

As previously indicated, the sociological approach argues against those who suggest that individuals are able to take control in determining how they age by modifying behavioural risk factors. Here, claims of empowerment are said to absolve professionals should individuals 'choose' to continue leading a 'risky' lifestyle, as in reality, individuals may be constrained by limited opportunities, socioeconomic status or the attitudes and expectations of others and their wider societies (Bernard 1993; Rowe and Khan 1998). Within sociological approaches, ageing is often observed from the perspective of the individual,

and includes the notion that to understand the present circumstances of an older population, exploration must take into account major events that have already taken place, through a life-course perspective (George 2010).

Perhaps, then, the most significant development in sociological exploration of ageing is that it considers the individual within their wider context, taking into account organising factors such as race, class, education, ethnicity, gender and status in society determined by income, and tackles inequalities within these (Bengston et al 2005).

2.4.4 Social Gerontology

During the post-war years of Britain, a shift toward combining knowledge from the three disciplines described above with that from demographers and economists, amongst others, began to emerge in an attempt to provide a new and rich understanding and to respond to implications of an ageing population (Phillipson 1998 cited IN Powell 2001 online), which, according to Achenbaum (1987 cited IN Putney et al 2005, p.90) had been largely ignored until that time. This diverse multi-disciplinary approach aimed at improving the health and well-being of older people is framed as social gerontology, engaging not only with social structures such as class and gender but also an individual's connectivity within their social constructs (Aiken 1989). To elaborate, this involves exploring individual perspectives on the purpose, quality, and history of their social surroundings and their interactions with them (Hepburn 2003). Essentially, social gerontology is concerned with the experience of ageing and as such, takes many forms:

> "It is always in a state of evolution and what counts as gerontological knowledge changes over time."
>
> (Victor et al 2007, p. 85)

Critical Gerontology

After an early embrace of social gerontology, criticism levelled at the neglect of theory over the collection of data began to emerge (Birren and Begston 1988

cited IN Katz 2003, p.17; Baars et al 2006), resulting in a lack of any meaningful interpretation being drawn from the data (Ray 2003). To overcome this, recommendations are made that social gerontology aim to achieve a greater balance between researchers who amass data and those who connect data with meanings, achievable, some argue, by realising the importance of including 'narrative' approaches to understand ageing (Baars et al 2006). Nevertheless, potential barriers first require address, in that social gerontology's claims of a 'multi-disciplinary', and more recently 'inter-disciplinary' approach, are in reality steered by the dominance of positivism and biomedicine (Achenbaum 1987 cited IN Putney et al 1995, p.90; Estes 1992 cited IN Katz 2003, p. 27). The outcome of which draws parallels with those earlier criticisms of a reliance on 'measures' which are divorced from any context or sensitivities.

2.5 Ageism

There is a further pervading element of the ageing debate which, although implied at various points throughout this chapter, is of a level of importance that it requires specific attention, that of ageism, or society's discrimination of individuals based on no reason other than their age (Peace et al 2007). According to Cuddy et al (2005), no group within society is exempt from discrimination or prejudice; however some, including older people, face a more complex form of this.

Drain on resources

Already we have noted the viewpoint predicting the overburdening of resources as a result of an ageing population. Commonly, these views are express through alarmist language:

> "…The increase in percentages of older people particularly those aged 85 years and older will generate tremendous demands upon services and resources, enough to swamp all economies, unless we begin to get ready very soon".
>
> (Alvarez 1993, p.7)

This approach is accused of fuelling society's ageism, presenting older people as a problem associated with decrepitude, senility, and death, with old age itself as a time of poverty, illness, disability and social disengagement (Patterson 1998; Sousa and Figueriedo 2002; Grundy 2003; Abbott 2004). Alternate claims contend that old age is a socially produced 'problem', with ageism being reinforced by all of the social stratifications such as class, gender and ethnicity (MacIntyre 1977). Arguably, the current climate of fiscal austerity does little to alleviate this 'problem' when looking to find motivations to explain economic cuts. As a result, the need is highlighted to challenge society's negative view of the elderly as being:

> '… Sick, demented, frail, weak, disabled, powerless, sexless, passive, alone, unhappy and unable to learn…'
>
> (Rowe and Kahn 1998, p.12).

Indeed findings from a study undertaken by Langer and Benevento (1978) concluded that the most common emotion felt toward older people was that of pity, as they were believed to be helpless. Moreover, Cohen (1990) argues such emotions are very often reinforced to older people, resulting in the 'message' being internalised and creating a self-fulfilling prophecy through self-induced dependence. All this despite predictions of an impending drain on resources being bound with the already-discredited assumption that an ageing population is one that becomes sicker.

Stereotyping

Undoubtedly, such constant negative generalisations have resulted in older people becoming stereotyped, devalued and marginalised by Western society (Sousa and Figueriedo 2002), despite evidence to show that, far from being an unproductive burden, older people form the greatest proportion of unpaid caregivers, saving the government more than £15 billion in care per annum (Age UK 2010). Also, through lifelong learning, there is considerable potential

for society to gain from older people's mental capital, which as yet remains untapped (Kirkwood et al 2008). Therefore, it might be assumed that the label of non-productivity is applied as a means of justifying resource prioritisation away from the needs of the older population (Jeffreys and Thane 1989). Similar to a self-fulfilling prophecy, older people are said to advance this situation in downplaying ailments, attributing them merely to the onset of old age rather than taking up medical time that is believed to be better spent elsewhere (Bond 1992).

The Media

Modern culture is heavily influenced by the media, as seen already through some of the reported headlines, the medias portrayal of older people and ageing has done little to dispel negative stereotypes and ageist views. More commonly, focus constantly references the avoidance of ageing using advertisement headlines toward 'looking younger' and 'staying young' and whilst more recently there has been a shift towards presenting the 'youthful elder', criticism remains in that this new frame of reference merely polarises stereotypes to negative and positive formats, once again marginalising those individuals who fall outside of them (Rowe and Kahn 1998; Featherstone and Werwick 1995 cited IN Sousa and Figueriedo 2002, p.270).

2.6 Summary

Time after time, empirical evidence demonstrates a continuing global trend towards population ageing, attributed to declining rates of fertility and ever increasing LE as conceptualised within the theory of demographic transition. With this trend comes the prediction of greater levels of disability and dependence, through the presumed inevitability of later life being a time of increased weakness and ill health. In this, the fastest growing sector of the population, those aged 85 years and older, are generally assumed to be the most demanding of care, and therefore identified with great concern as being a drain on future health and social care resources (Bury and Holme 1991; Bootsma-van der Wiel 2001 Rowe and Kahn 1998). All of this is compounded by ignorance, as in reality relatively little knowledge is currently available about this population group and what knowledge does exist actually demonstrates an

observable compression in morbidity (Manton 1997; Rowe and Kahn 1998; Abbott 2004).

As with any of society's groups, older people, including those aged 85 years and older, are highly heterogeneous and, despite stereotypes to the contrary from ageist attitudes which pervade every aspect of our lives, they are not merely passive beings who can be broadly categorised simply based upon the presentation of disease or disability (Grundy 2003). Recognising these facts, as well as the fact that effective planning of services requires detailed information on the needs of older people, it would seem that much is to be achieved in addressing scant existing data. Such as how we can better understand healthy population ageing, perhaps through exploring differences between LE and HLE, and the gender trajectories within this.

Further challenges lie with the argument that some of the complex, multifaceted sensitivities of ageing, and indeed some factors for 'ageing well', are not tangible or easily explored through traditionally favoured positive empirical approaches (Bury and Holme 1991), made explicit using the example of the disability paradox. For some, the domination of positivism is due to an overreliance on biomedical and statistical evidence, which in turn moulds outcomes for reducing morbidity and mortality rates (Bootsma-van der Weil 1997; Levin and Browner 2005). However, others suggest that this dominance has prevailed as a result of ageing only recently becoming a fashionable area of interest for social scientists (Grimley Evans and Bond 1997). Therefore, we should not dismiss the progress in therapeutic intervention and disease management, brought about by the rapid increase in understanding ageing at a molecular level (Manton 2003). The challenge lies in the call for researchers to take current knowledge forward, questioning and integrating this with their own perspectives, in order to find innovative and more inductive approaches to ageing research and fill the gap in knowledge (Baars et al 2006).

This is a perspective that this study very much positions itself with.

CHAPTER 3: RESEARCH METHODOLOGY AND DESIGN

3.1 Overview

The previous chapter highlighted that the UK, like many other developed countries, is experiencing a marked change in the age structure of its population, where due to increased life expectancy there has been accelerated growth toward an ageing population (Vaupel 1997; Office of Population Censuses and Surveys 2011). Also revealed was the striking fact that life expectancy is continuing to increase by approximately two years per decade [table 2 p.14], despite all of the major forecasts by national and international agencies that it would plateau. At this time, those aged 85 years and older have been singled out not only as the fastest growing sector of an ageing population, but also the most demanding of its resources. The observation of this trend has given rise to two main divergent assertions: (i) our future society and its resources will be placed under increasing burden to a point which is unsustainable; (ii) ageist attitudes and assumptions are the cornerstones of predictions around 'burden on future society', as currently very little detailed knowledge to this effect actually exists.

Arguably, preference for one of the above assertions over the other is influenced by the perspective through which ageing is viewed, be that biomedical, psychological, sociological, or a combination of these [chapter 2]. Regardless of this, the fact remains that there is a need to address the gap in our current knowledge and gather detailed knowledge of the actual needs of an ageing population. Researchers are challenged with this and in doing so are called upon to consider the potential of exploring the complexity of ageing beyond traditional approaches and to interrogate what is currently accepted as 'factual or universally true' (Biggs et al 2003b, p.245), drawing instead upon philosophies which enable them to project beyond everyday thinking (Bury and Holme 1991).

It is the belief of this thesis that including the diverse perspectives of older individuals themselves, here aged 85 years and older, through their own voice, is an approach which not only meets this challenge but can provide

opportunities for radical new insights as how best we can meet the needs of an ageing population in terms of gathering information on their health, health-seeking behaviours, and ultimately 'ageing well'.

After providing information about the conceptualisation of this study, clearly stating its aims and briefly outlining its design, this chapter will go on to present and rationalise the underpinning research paradigm selected to best meet the aims of this study. Included is a discussion of the main tenets of the underlying philosophical debate surrounding the methodological approach, along with details and justification of the methods chosen for recruitment, data collection and analysis, in terms of their 'fit' with the adopted methodology, and ultimately the aims of the research itself. In an attempt to differentiate between these concepts from the onset, Denzin and Lincoln (2005) explain that where methodology is concerned with the 'how?' and 'why?' of conducting research, Silverman (2000) describes methods as the specific practice of collecting and analysing data. Transparent discussion of major strengths and limitations is provided throughout. As with any research involving humans as research participants, steps must be taken to avoid causing harm, and ethical issues are therefore also considered within this chapter. Furthermore, as those individuals aged 85 years and older are generally perceived to be difficult to include in research, practical solutions are presented as part of this discussion.

3.2 Conceptualisation of this Study

Statement of Original authorship

'The Newcastle 85+ Pilot Study' was conceived by Professor Tom Kirkwood and Professor Oliver James, employing this researcher, as a member of the core management team. The primary responsibilities of this researcher at that time lay with the design and development of study protocols, such as GP and participant recruitment strategies and the collection, quality and storage of data. Of the 89 participants who completed structured interviews within 'The Newcastle 85+ Pilot Study', this researcher recruited and completed interviews with 60% of these (n=53/89) [acknowledging nurse Michelle Hails as responsible for the recruitment and completion of structured interviews with the remainder]. Of the 116 records reviewed in general practice, this researcher

was responsible for 64% of these (n=74/116) [again acknowledging nurse Michelle Hails as responsible for the completion of the remainder].

However, the mixed methods study presented within this thesis was conceived solely and undertaken exclusively by this researcher. Including its design, collection of further qualitative data [including transcribing and coding taped in-depth interviews] and data analysis. Furthermore, quantitative data from 'The Newcastle 85+ Pilot Study', as presented within this thesis, was analysed by this researcher along with the interpretation of qualitative and quantitative results through meta-analysis.

Forming the Research Question

Whilst this researcher was employed to conduct structured interviews as part of the 'The Newcastle 85+ Pilot Study', many of the participants were observed to offer 'additional information' to closed questions, often adding richness in the form of lived experiences. Whilst structured interviews did not allow for the capture of such information, it was conceived that in applying a mixed methods approach an additional strand of qualitative data could be collected to add a rich depth to the overall breadth of quantitative data and explore influences of 'ageing well'. Therefore, the researcher sought additional approvals to complete this study which would also contribute towards the award of PhD.

Approvals

Peer review of the research protocol by the management team of 'The Newcastle 85+ Pilot Study' and Newcastle University PhD programme concluded that value would indeed be added to the overall knowledge of ageing. Approval was given along with notional permission to access quantitative data from structured interviews, dependent upon securing separate ethical, Primary Care Trust research and development, and Caldicott approvals. These were obtained in March 2005 and in-depth interviews commenced in March 2005. Whilst much time-consuming work is invested in obtaining such approvals, detailed guidance and requirements are fully available to researchers, therefore details of the processes are not considered here,

although copies of approvals are provided within the appendices of this thesis [appendices A, B & C].

3.3 Study Aims

The main area of exploration within this study, as first offered in chapter 1 of this thesis, is restated here as:

- What are the influences that contribute to our ability to 'age well'?

With two further 'derived' opportunities for exploration identified as:

- What potential does exploring 'ageing well' from perspectives which include those of the older person offer for policy and practice development?

- What are the benefits to knowledge when widening the methodological approach beyond empirical perspectives in order to investigate 'ageing well'?

3.4 Outline of Study Design

A convergent parallel mixed method approach was used to address the aims of this study, containing two strands of data collection, from two theoretical paradigms: (i) quantitative data were derived from 'The Newcastle 85+ Pilot Study' comprising of structured face-to-face assessments and review of general practice records with n=89 participants [40 male and 49 female] and a further n=27 participants [7 male and 20 female] who consented to review of general practice records only; (ii) qualitative data were derived from an additional in-depth interview with n=17 of the same participants [9 male and 8 female]. All participants were born in 1918 and all were permanently registered with a general practice within the Newcastle and North Tyneside region of North East England. Data collection from both strands was conducted by this researcher [with one other part-time research nurse involved in quantitative data collection] in the participant's usual place of residence, be that their own home or a care home [nursing/residential].

As indicated earlier, the intention of the subsequent sections within this chapter is to engage in detail with debates around the philosophical underpinnings of the research paradigm, providing logic and reasoning as to the methodological application, and the application of research methods. However, briefly the rationale applied to the selection of mixed methods as opposed to others lies in its providing an opportunity to explore perspectives of 'ageing well' beyond the traditions of empirical investigation, to include the voice of older people themselves. Mixed methods approaches are also suggested as having strengths in providing researchers with a broader understanding of the subject under exploration, by using more than one method to investigate a complex, multifaceted social issue (Brannen 2005).

3.5 Methodology

The social nature of humans is such that instinct draws us to make sense, or assume knowledge, of the world around us. Such knowledge is said to be based upon 'facts' or truths of what the individual thinks they know. However:

> "Contrary to popular assertion 'facts' do not speak for themselves."
>
> (Giddens 1989, p.18)

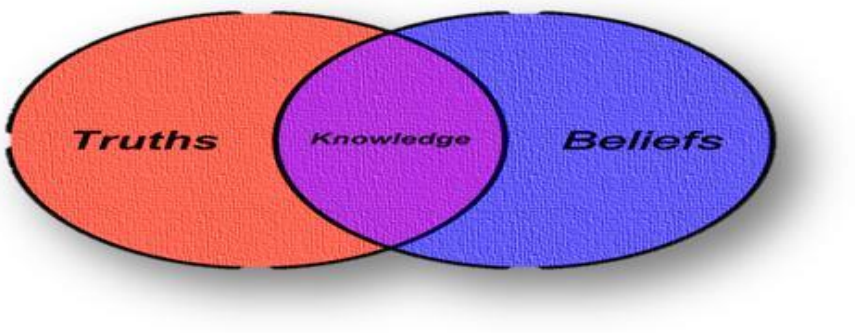
To elaborate, individuals draw upon a paradigm made up from a set of truths or beliefs through which they construct knowledge about their world (Houghton et al 2012). Paradigms are often inextricably embedded in culture, society, and what is currently in vogue, and shaped by two central concepts: (i) ontology concerned with what exists, what is believed to be true (Blaikie 1993); and (ii) epistemology concerned with the means of demonstrating what exists, gaining knowledge of something (Snape and Spencer 2003). Arguably, what is accepted as knowledge depends upon satisfying the criteria of the 'preferred' epistemology. Researchers, as we have already seen when reviewing perspectives on ageing [chapter 2], are not divorced from holding a particular ontological and epistemological position to guide methodology and generate 'knowledge'. Therefore, it seems appropriate that some of these issues and

surrounding debates are considered in further detail in order to define and justify the approach of this study.

3.5.1 Truth, Beliefs and Knowledge

From the evidence so far it would appear that truth is enigmatic, with no single objective truth but rather the potential for many conflicting and competing ways of looking at things and of 'knowing'. Truths are often blurred with beliefs and knowledge sits somewhere between the two (Russel 1926 cited IN Encyclopaedia Britannica online) [Figure 5].

Figure 5: Relationship Between Truth, Beliefs and Knowledge



(Source: Russel, 1926 cited IN Encyclopaedia Britannica online)

Until the 16th century, such concepts in Western society were largely based upon religious teachings of Christianity, magic and folklore. However, toward the end of the 17th century and in the early 18th century the emergence of a major philosophical movement known as 'the Enlightenment' began to bring about a fundamental change in the way in which individuals conducted their day-to-day business and made sense of the world around them (Walsh and Lentin 2011).

3.5.2 The Emergence of Positivist Paradigms

Through this change emerged positivism, stemming from the ontological position that there is one single, objective reality that lies in the physical or material world, which exists independently of human existence (Bryman 1988).

Epistemologically, reality can be observed and measured through the senses, using value-free methods of empirical reasoning such as standardisation, hypothesis testing, prediction and control (Hamilton 1992). Using deductive reasoning to test hypothesis, this approach puts forward hierarchies of knowledge, making judgements between the rational/irrational, knowledge/non-knowledge and lay knowledge/expert scientific opinion and is associated with quantitative research paradigms (Giddens 1976; Greene 2007).

3.5.3 The Emergence of Interpretivist Paradigms

Positivism remained virtually unchallenged until the latter part of the 20th century, until the emergence of interpretivism, which came from the opposing ontological position, suggesting that there is no single external reality, rather reality has different meanings to different individuals depending upon their contextual interpretation, which is driven by social factors and cultural values (Burr 1995; Houghton et al 2012). Therefore, epistemologically interpretivism would argue that empirical reasoning is only one view of many which can be drawn upon in order to construct truth and make sense of the world (Craib 1992). Using inductive reasoning to generate theory, reality is defined as the unique lived experience of the individual and their account of it (Guba 1990 cited IN Johnson and Onwuegbuzie 2004, p.14). In contrast to the claims of positivism that what is observed is value-free, this approach, which is associated with qualitative research paradigms, suggests that what is observed is value-laden, and that the researcher is inextricably linked to the research (Blaikie 1993). However, where positivism is criticised for failing to recognise the free will of an individual, interpretivism is criticised for failing to recognise or explain the constraints of social structures such as class, gender and ethnicity (Craib 1992).

3.5.4 Reliability, Validity, and Reflexivity

Few researchers of social behaviour now subscribe to the extreme positivist viewpoint that human behaviour can be explained through causal laws (Holden and Lynch 2004). In accepting the fallibility of human researchers, post-positivists introduced the ideals of reliability - being focused on the reproducibility of research results over time - and validity - focused on how well

the research reflects the reality it sets out to represent (Greene 2007; May 2001).

In quantitative research, concepts of reliability and validity translate, in their broadest sense, to standardising measurements and controlling external variables. In qualitative research, based upon the ideal that no one single reality exists and that reproducibility of all original conditions and variables in social enquiry is highly improbable, measuring the quality of research through concepts of reliability is irrelevant, with validity only being appropriate depending upon which definition of this is applied (Strauss and Corbin 1999; McDougal 2000). Instead, quality of this research is measured through the notion of trustworthiness, with truth value being a central component of this (Lincoln and Guba 1985). We are informed that researchers can demonstrate truth value through the design of their study, being systematic and transparent through techniques of recording data at source, having participants check the content of data, and performing analysis that demonstrates consistency in themes emerging from the data (McGloin 2008). All of these are returned to later in this chapter.

Recommendations also propose the need for reflexivity, whereby the researcher makes known their influences, particular alignments, beliefs and experiences, as these are believed to shape and influence the data collected and its interpretation (Walker et al 2013). This is divided into two required elements: (i) epistemological reflexivity, concerned with the rationale applied to shape study design and method selection; and (ii) personal reflexivity requiring the researcher to consider how their values, experiences, beliefs and interests may influence the research (Nightingale and Cromby 1999). Arguably, this chapter meets the criteria of the first of these elements, with the researcher vignette included in chapter 4, making inroads to the second. Additionally, chapter 8 considers limitations of the study.

3.5.5 Mixed Methods Approach

As outlined, the principal strengths of and conflicting world differences between positivist and interpretivist methodologies are vehemently defended and

criticised in equal measures. The opinion that quantitative and qualitative paradigms and their associated methods cannot and should not be mixed defines the 'incompatibility thesis' (Guba 1987 cited IN Teddlie and Tashakkori 2009, p.15). Discarding this 'either/or' debate, the 'compatibility theory' (Howe 1988 cited IN Teddlie and Tashakkori 2009, p.15) argues the existence of many overriding commonalities, including, shared aims in describing data, constructing explanations from data, and attempting to incorporate validity into the process (Sechrest and Sidani 1995 cited IN Johnson and Onwuegbuzie 2004, p.15). Increasingly, the paradigm debate has shifted toward accepting that the divisions between positivist and interpretivist paradigms are often blurred, exaggerated, and even false (Greene 2007; Teddlie and Tashakkori 2009). To assume one theoretical position as capable of fully explaining and encapsulating the workings and relationships of a social world is problematic (May 2001). The philosophical view of pragmatism accepts this, allowing the researcher to mix methods and implement whatever epistemological and methodological approach is most appropriate to 'answering the research question' (Hanson et al 2005 cited IN Morell and Tan 2009, p.245).

Strengths and Limitations

Mixed methods research enables the investigation of complex, multifaceted social issues (Brannen 2005), provides a 'more comprehensive account of the area of enquiry' (Bryman 2006 cited IN Creswell and Plano Clark, p.62), and enables researchers to:

> "Draw from the strengths and minimise weaknesses of both singular approaches".
>
> (Johnson and Onwuegbuzie 2004, p. 14-15)

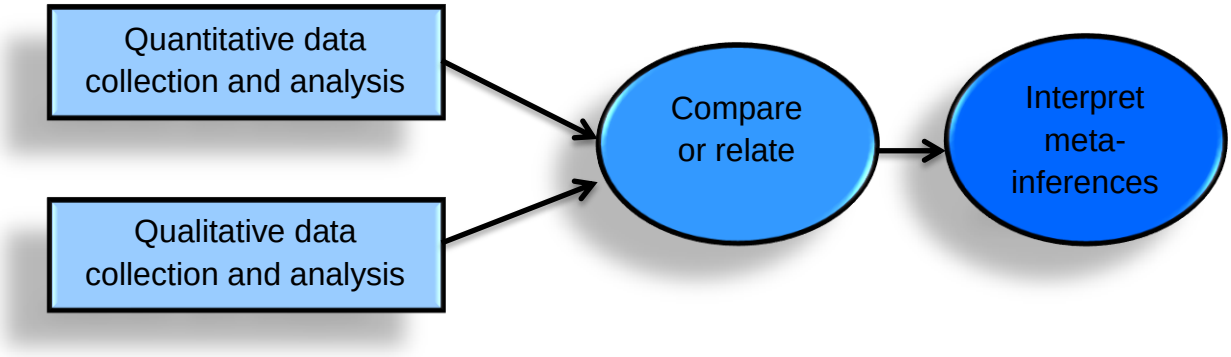
To critics who question what conclusions can be drawn if such divergent philosophically derived datasets conflict (Greene 2007), Moffatt et al (2006) offers a six-step approach to harness discrepancies and interrogate data more fully. However, some of the more general pit-falls to avoid in mixed methods research include making any claims that more data is better, or gives greater accuracy, or that one dataset is incomplete without the other (Morse 2003).

Critics of mixed methods also point toward uncertainty caused by the lack of consistency applied to terminology and definitions (Spratt et al 2004). According to Palinkas et al (2011) this continues to be a source of concern, as their findings from a review of research conducted over a 5-year period [2005-2009] in the mental health services found, that the majority of mixed method research failed to clearly state why and what typologies were applied. More recently, Creswell and Plano Clark (2011) have begun to address this, providing clear frameworks characterising typologies of mixed methods research. These, however, are not so prescriptive that they discard the philosophical position of pragmatism, which recognises that researchers create variances within these typologies in order to fit the research question within a real-world context.

Mixed Methods Typology Applied by This Study

To explore the complex social issue of 'ageing well' and address the gap in current knowledge, this study applies the principles of convergent parallel mixed methods design, involving the independent collection and analysis of two strands of data, from two theoretical paradigms: (i) quantitative data derived from structured interviews and (ii) qualitative data derived from in-depth interviews. Findings are then compared for convergence and divergence [Figure 6]. The rationale applied to the selection of this methodology and particular typology, in addition to the strengths identified above, is in offering researchers complimentary data on the same topic in order to generate greater understanding (Morse 1991 cited IN Creswell and Plano Clark 2011, p.77; Teddlie and Tashakkori 2009).

Figure 6: Convergent Parallel Mixed Method Design



(Creswell and Plano Clark 2011, p.69)

In principle, researchers using this particular typology collect data during one phase. However, due to real-life practicalities quantitative data was collected some 18 months prior to the start of the collection of qualitative data. Explanation for this variance is offered in the next section, with potential limitations of this considered in chapter 8. Additional variance from the 'textbook' typology also exists in that overall discussion of the data is guided by themes emerging from the qualitative strand, with quantitative findings adding context and breadth to these, as befitting the exploratory focus of the research question. This variance is defined as a QUAL + quan orientation (Morse 2003).

3.6 Methods

"Whatever methodology is applied, decisions will always have to be made about whom and where to collect it from and these decisions will have a fundamental effect on the quality and usefulness of findings."

(Reed et al 1996, p.52)

3.6.1 Sampling

The purpose of sampling is to gain access to participants who are perceived to be of theoretical interest. Whilst both quantitative and qualitative research shares the characteristic of seeking to provide a sample which will address the research question, they tend to favour those particular sampling methods which best fit their overall philosophy (Teddlie and Tashakkori 2009).

Quantitative Strand

Fundamentally, quantitative research leans toward probability sampling, whereby the probability of any individual being randomly selected from the population of interest is equal (May 2001). Calculations are made regarding sample size in order to provide statistical confidence intervals, indicating an accepted range from which findings can be generalised to the wider population (Arber 1993). In social research, this type of sampling can be resource-heavy, if not impracticable, firstly in striving to produce a comprehensive sample frame of the population of interest, and secondly in managing large geographical domains. Furthermore, bias from non-responses and exclusions are

problematic, particularly if the population of interest is ‘stigmatised’ in any way (Gilbert 1993). In this study, sampling of the quantitative strand was undertaken as part of ‘The Newcastle 85+ Pilot Study’, full details of which are publically available in Collerton et al (2007). Briefly, individuals invited to participate were all those surviving adults born in 1918 [turning 85 in 2003], regardless of health status [except for exclusion by the GP as terminally ill], who were permanently registered with one of four participating general practices recruited from a total of 39 within the Newcastle Primary Care Trust (PCTs [now CCGs]). Participating practices had an even training/non training ratio and reflected affluent and non-affluent areas of the city. A request was also made to the Primary Care Trust Contractor Services Agency (CSA) to provide a list of patients registered at the four participating practices. Lists were then cross-checked and queries clarified with the help of general practice staff, the outcome of which provided a sample frame of N=149.

Limitations

As the emphasis of the pilot study was to formulate recruitment and assessment strategies along with testing operational aspects from which a main study would be developed, power calculation to determine sample size was not conducted. As such, findings cannot be generalised to the wider population with any statistical confidence. Additionally, as a limited number of general practices were approached in the geographical domain then the non-probability sampling method of ‘convenience’, whereby participants from the population of interest are selected based on ease of access (Castillo 2009), could be argued, thus limiting representativeness.

Qualitative Strand

Qualitative research tends to favour non-probability sampling, typically not being focused on representativeness but rather more concerned with depth of knowledge, usually from a smaller number of participants (Coyne 1997).

The qualitative strand of this study was no exception and, being exploratory, utilised a ‘theoretical’ non-probability sampling method. According to Marshall and Bossman (2006), Coyne (1997), and Reed, Proctor and Murray (1996), this

sampling is always purposeful in that it targets a population group with characteristics that the researcher is interested in but also enables a process of next selection guided by emerging categories. In practice, those participants who consented to participate in the full schedule ['data collection' for definition] of 'The Newcastle 85+ Pilot Study' were purposefully selected as a rich source of data that would responding to the research question: all aged 85, community-dwelling and were known to the researcher through the collection of quantitative data.

Sampling Matrix

Theoretical sampling was aided through the development of a sampling matrix (Miles and Huberman 1994) [appendix D]. In practice, known demographics were placed on the horizontal axis of the matrix: gender; living arrangements; and total score from Mini Mental State Exam (MMSE). After discussion with an ethics committee, it was agreed that individuals scoring 21 or less [severe to moderate cognitive impairment] would be excluded from selection for in-depth interviews. This was agreed firstly to avoid causing any undue distress, and secondly, as the in-depth interviews in this study aimed to capture the subjective opinion of the participant, the use of a third-party informant would not have been appropriate. Those participants who had expressed the wish to withdraw from the quantitative strand [North East 85+ pilot study] were also excluded, giving the qualitative strand of this study a sampling frame of N=79. A unique participant identification number (PID) was placed on the vertical axis of the matrix [Appendix A]. After the analysis of each in-depth interview the next potential participant was selected from the matrix based upon relevance to emerging themes. Put simply, if the benefits of 'living with others' emerged as a theme then the researcher may have selected the next participant based upon 'living alone' to explore the dimensional range of the theme.

Limitations

Critics of this 'tool' argue that if qualitative research is to be truly inductive then no such knowledge can exist prior to data collection (Polit and Hungler 1995). Although defending its use, Reed et al (1996) state that relying on friends, colleagues, local knowledge or serendipity, such as in opportunistic or snowball

sampling within qualitative research, is a haphazard and an unsystematic approach. Ultimately they conclude, as qualitative research is targeted for its failings to describe each stage of the process explicitly, then using a 'tool' to do so can only facilitate transparency of the researcher's reasoning. Here it is imperative to emphasise that the sampling matrix does not predetermine the sample but, as a tool, enables the sample to develop through transparent next selection as determined by emerging data.

In total 18 participants were approached and interviewed in-depth from the matrix [no refusals]. As two of these participants were married they were interviewed together. As mentioned earlier, in order to maintain a truth value in qualitative data, participants were invited to review the contents of their in-depth interview, after doing so one participant telephoned the researcher the following day concerned by some of the family 'events' they had talked about. The researcher re-visited the participant to discuss their concerns and as a result it was felt that the best action would be to destroy the data. It is noteworthy to mention that this is a prime example of process consent applied in this study, defined later in this chapter.

In qualitative data, sample size [here n=17] is determined when reaching the point of theoretical saturation, where no new themes are emerging (Strauss and Corbin 1999). Critics question if such a 'point' can ever truly be achieved, and if it can would researchers identify it (Bulmer 1979), this study makes no bold claims. Rather, the opinion of Mason (2010) is cited in the researcher making some element of judgment, often governed by practical realities; which in this study occurred because data from the last two in-depth interviews conducted did not significantly alter emerged themes, and PhD deadlines were looming.

3.6.2 Data Collection

Data collection is the phase of the study concerned with gathering information from study participants. In this study interviews were considered the most appropriate method of data collection and, as identified, were conducted in the participants' usual place of residence. However the term interview is generic

and as now shown, both quantitative and qualitative strands have 'forms' of interview consistent with their underpinning philosophies.

Quantitative Strand

Structured interviews, defined as 'the systematic measurement of variables across cases' (Marsh 1982, p.6), were conducted with each of the participants to inform the quantitative strand of this study. These comprised 'validated' closed-response questionnaires and tools focused on examining the full spectrum of health, covering: socioeconomic status; family data; physical and psychological health [global health status, longstanding illness, angina, shortness of breath, falls, generalised pain, joint pain, fractures, incontinence, vision and hearing, depression]; disability; oral health; lifestyle [diet, smoking, exercise and alcohol]; social support and participation; use of primary care health services [from review of medical records conducted at the registering general practice to gather information on items such as disease diagnosis and management, medication, number of consultations][1].

The content and duration of interviews in general is often the subject of much discussion. With older individuals, we are informed that it can take up to four times longer to acquire information and that participant fatigue can be problematic (Hancock et al 2003), making the overall organisation and prioritisation of questions vital, but always within limits of what is acceptable and sensitive (Jacelon 2007). Based upon pre-pilot study trialling, 90 minutes was considered a reasonable duration for any one interview; therefore, the schedule was split into three separate face-to-face structured interviews to be conducted one week apart, and one structured assessment completed by the interviewer at the participant's registered general practice. In fact, the mean duration (standard deviation) of interviews were found to be: interview 1 - 82 minutes (17); interview 2 - 79 minutes (102); and interview 3 - 82 minutes (13), which supports the effectiveness of trialling. Potential to modify the schedule beyond

[1] Measurement, function and blood test also formed part of the structured interview but as these tests are not pertinent to this study they have not been listed here. Again, full details of 'The North East 85+ Pilot Study' protocol are publicly available (Collerton et al 2007).

three interviews was also factored in to accommodate the needs and abilities of participants; although few required this, with acceptability of the schedule being drawn from the fact that 96% rated their involvement 'positively' or 'very positively'. Participants were also able to consent to the entire structured interview schedule (n=89: 3 face-to-face interviews and 1 review of general practice records), or review of general practice records only (n=27, taking total participation to n=116) ['recruitment and retention diagram' chapter 4].

Strengths and Limitations

Standardisation is the primary strength of structured interviews, asking the same questions to each participant in the same way, thus increasing reliability. However, during interviews confounding factors exist, such as the ability of the researcher to remain neutral, ask each participant questions in turn, in the same manner, offering the same elaborations if required. This necessitates adequate researcher training along with the composition of standardised elaborations as reference material (May 2001). Further limitations challenging the validity of interviews, particularly those which are face-to-face interviews include the participant wanting to present themselves favourably to the researcher, commonly termed 'social desirability'. Here postal questionnaires may prove useful, although response rates with this method tend to be lower and provide no opportunity for researcher elaboration (Bradburn et al 2004).

The use of the word 'validated' when describing questions and tools within structured interviews is also questionable, as validation is, in fact, inadequate in older population groups (J. Bond, personal communication, Jan 7th 2013; Jylhä 2009).

Qualitative Strand

In-depth interviews, defined simply as a 'conversation with a purpose' (Kahn and Cannell 1957 cited IN Marshall and Bossman, p.149), were used in the qualitative strand of this study. This form of interview tends to be unstructured with the researcher having a broad open question to start, with subsequent questions shaped by responses (Holloway and Wheeler 2010). The use of an 'interview agenda', comprising a list of pre-identified subject headings modified

to suit the flow of conversation, can aid focus and prompt discussion in areas of specific interest, particularly for more novice researchers (Burns and Grove 1999). This aid was implemented in this study [Appendix L], albeit only being 'used' during the first 4 or 5 in-depth interviews. The mean duration of in-depth interviews was 75 minutes, ranging from 63 to 104 minutes.

With participants' consent in-depth interviews were tape recorded, a method previously identified as increasing truth value by reducing bias occurring from researchers relying solely on note-taking, as words or phrases can be substituted (May 2001). In practice, and perhaps as the researcher was already known to participants through quantitative data collection, the use of a tape-recorder was found to be non-intrusive and enabled the researcher to attend to the participant rather than taking notes, although others report increased formality and intrusiveness (Bowling 1997; Al-Yateem 2012).

Transcribing

In-depth interviews were transcribed verbatim by the researcher into text using Microsoft Word. Although time consuming, it was believed that a greater understanding of the data was achieved, along with enabling the process of analysis to begin (Lapadat and Lindsey 1999). According to Tilley (2003), researchers often neglect to give due consideration to the interpretative nature of transcription, and how this can influence their work, particularly if they are not undertaking the transcription themselves, therefore calls are made for transcription processes to be made clear.

> "We do not speak in paragraphs, nor do we signal punctuation as we speak. The judgements involved in placing something as simple as a period or semicolon can shape the meaning of the written word and, hence of the interview itself."
>
> (Marshall and Bossman 2006, p.110)

In acknowledgement, with the exception of opening and closing speech marks to denote where excerpts from in-depth interviews begin and end, capital letters

determining a new speaker, the use of apostrophes, --- [three dashes] to represent a pause in conversation, … [ellipsis] representing where one or more words have been omitted, and the use of squared bracketing [ ] to provide the reader with additional information pertinent to the conversation, no other formal punctuation was included during transcription. Upon discussion with supervisors, 'ermms' and 'ahhs' were also removed from transcripts as a means of keeping conversation flowing, whilst colloquial dialect was retained as it was felt this represented the individual. Each transcription was colour- and numerically coded with individual page and line numbers. Colour-coding was a particular success as it made quotes instantly recognisable to the researcher. Researcher questions within text are as: 'R: with *text in italics?*'.

Strengths and Limitations

Although criticised for its susceptibility to 'social desirability' and also as being time-consuming and costly as opposed to other methods such as postal questionnaires, in-depth interviews provide a flexible method to explore meanings and understandings of the phenomena under investigation in greater depth, from the perspective of the individual as lived by them (Bowling 1997). Some suggest that as participants are able to place emphasis on matters important to them (Kurzel 1992; Rubin and Rubin 1995; Burns and Grove 1999) then validity is increased (Polit and Hungler 1995), whilst others warn that the potential for increased validity depends upon the skills of the researcher, to competently pursue cues, tease out issues, and to be aware of their influence in manipulating the direction of the interview (Hammersley and Atkinson 1983; Fielding 1993; Lee 1993; Burnard and Morrison 1994; Doody and Noonan 2013).

In order to develop skills, the technique of talking freely into the recording device to document thoughts before and after each interview was used. These reflections, along with recordings of the actual interview, were played back and difficulties discussed in early supervisory meetings. One example of this was the researcher becoming self-aware of 'filling the silence' during in-depth interviews, whereby advice was given to think about the silence in terms of what it might be communicating to the topic of conversation. Here the literature

explains that a pause in a conversation does not automatically mean that a topic is unimportant, rather that it is extremely important, so much so that a great deal of judgement is being internally processed as to whether to present this in external conversation (Randall and Koppenhaver 2004). Through gaining this understanding, strategies were developed such as internal counting and repeating what was last said, thus permitting participants to determine when silences were ended, or the topic of conversation changed.

3.6.3 Data Analysis

In accordance with described principles of convergent parallel mixed methods, separate analysis of quantitative and qualitative strands was carried out, using methods appropriate to their individual philosophical underpinnings, before bringing together findings from each strand to compare for convergence and divergence to inform meta-inferences.

Quantitative Strand

Structured interviews were externally sourced for double data entry into an Excel file. Data was then checked for discrepancies by the study data manager Pauline Potts, and discrepancies resolved by members of the study team including this researcher. Cleaned data was then stored for export to a statistical package. In this study, version 19 of Statistical Package for the Social Sciences (SPSS): IBM Corp. Released 2010, IBM SPSS Statistics for Windows, Version 19.0. Armonk, NY: IBM Corp. was used. Data was analysed using descriptive statistics. Via the checking processes undertaken by the data manger, missing data was reported as occurring randomly through interviewer error. However, this study used variables where data was complete, aside from reporting social class and self-rated health where 2 cases were omitted in error by the interviewer and here valid % is given. The use of different denominators when reporting descriptive statistics is also accounted for, primarily due to variances in variables resulting from either face-to-face interviews or review of general practice records, which were explained earlier.

Strengths and Limitations

Arguably, findings from quantitative data analysis are only as good as the original source of data.

As previously discussed, the aim of 'The Newcastle 85+ Pilot Study' was to formulate and evaluate recruitment and assessment strategies to inform a main study, rather than infer findings to the wider population. Therefore, no power calculation to determine sample size was undertaken. However, considerable attention was given to the development of interviews and assessments, with pre-determined coding responses such as 'not applicable' to account for missing data.

Qualitative Strand

Analysis of in-depth interview data was undertaken through the method of constant comparative analysis. Described as the process of constantly reducing data, first through open coding or creating categories within the data, and then comparing each of these categories for underlying similarities and merging them to create core categories (Glaser and Strauss 1967 cited IN Fram 2013, p.3). As already identified, this process continues until 'theoretic saturation' is reached, whereby no new dimensions to the category emerge. Ultimately, theory emerges in relation to how categories inter-relate (Strauss and Corbin 1999).

In practice, open coding began when reviewing the tape recording of the first interview and noting down any broad categories which emerged. The interview was then transcribed verbatim and openly coded in greater detail, drawing out emerging themes or categories and identifying them for further exploration, informing the interview agenda and next selection of participant from the matrix. This process was repeated after each interview. Again as inferred earlier, the final two interviews, although contributing to the range of core categories, did not add overall novelty. The researcher therefore decided to conduct no further interviews, although as previously discussed, claims of reaching theoretical saturation are tentative.

Strengths and Limitations

Strength in this method of data analysis is in adding 'truth value' to findings. Put simply, emerging themes have been checked and re-checked for consistency throughout all fragments of the data, therefore if particular themes are seen to appear continuously there is good evidence that it is valid and actually exists (Smith and Biley 1997). The main criticism, as already identified, is the difficulty of theoretical saturation, or the researcher ever really 'knowing' when the next interview will produce no new data (Bulmer 1979). Again, further limitations lie in the time-consuming effort required by this method of analysis, where in reality, little can be done to offset this aside from meticulous advance planning (Hendry and Farley 2004; Bell 2005).

Meta-Inference

In accordance with the mixed method design, inferences drawn from separate analysis were then considered in terms of convergence and divergence. These findings were integrated with existing knowledge, or indeed lack of knowledge within the literature, in order to form meta-inference or conclusions (Teddlie and Tashakkori 2009), such development and formation of meta–inferences make up the content of the following data chapters.

3.7 Ethical and Practical Considerations

As identified earlier, this study was submitted for approval to Gateshead and South-Tyneside Local Research Ethics Committee [now merged into North East Newcastle and North Tyneside Ethics Committee 1, with favourable ethical opinion being obtained on 02/03/2005 [ref: 05/Q0901/21]].

Conducting detailed research involving any human participants raises ethical issues that need to be confronted seriously (Lee 1993), while involving individuals aged 85 years and older presents further unique challenges (Jacelon 2007). As already established through the literature, this group is not homogeneous and as such consists of individuals on all levels of the spectrum including many potentially vulnerable individuals with cognitive, functional or sensory impairment and who may be housebound (Davies et al 2010).

In England and Wales, the introduction of the Mental Capacity Act (Department of Health (DoH) 2005) enshrined in law consent procedures to be followed where individuals lack capacity, the overarching assumption being that individuals have capacity to consent unless demonstrated otherwise. For the study presented here such an Act was not in existence, therefore the development of novel recruitment and consent procedures was necessary in order to secure as high a level as possible of ethically sound and productive engagement with members of the population aged 85 years and older [Appendices E, F, G,H, I, J & K]. This was a primary responsibility of this researcher and was used to inform a follow-on longitudinal study; protocols developed here were commended by the ethics committee and also adopted by Newcastle Primary Care Trust as an example of good practice. Aspects were also adopted within the Northumberland Tyne and Wear (NTW) and the Newcastle upon Tyne Hospital (NuTH) NHS Foundation Trusts research groups. Full details of the protocols developed are published in Davies et al (2010). However, this information is considered vital, and as such the following summarises the ethical challenges of, and successful strategies for, involving, recruiting and retaining this important age group in research.

3.7.1 Consent

The basic paradigm of consent reflects the principles of autonomy, in that participants should be informed, competent and non-coerced. However, such criteria are arguably more about satisfying the legal aspect of consent, as in reality the consent relationship between researcher and participant is often not so clear-cut (Hughes et al 2008). In particular, it is not always possible to give full information to potential participants at consent, especially when applying qualitative research approaches, as it is not known in advance what themes will emerge (Williams 1995). Here then a degree of judgement about how informed, competent and non-coerced an individual is will always be required. Consenting older adults is no different, but emphasises the importance of addressing such issues (Hughes et al 2009).

In addition to developing a consent protocol and supporting documentation compliant with legislation, requiring consent to be voluntary and able to be

withdrawn at any time [Davies et al 2010], the study adopted the concept of ‘process consent’, defined as an on-going process of consent decision-making between researcher and participant rather than a one-off process (Ramos 1989). In practice, this approach created much greater transparency and flexibility, as participation was bespoke to the needs and abilities of the participant.

Capacity

Despite statistics identifying the presence of significant cognitive impairment in around one-fifth of people aged 85 years and older (MRC CFAS Jagger 2007), researchers making judgements about capacity based upon age and appearances fall into all of the trappings of ageist assumptions addressed within the previous chapter. As stated, The Mental Capacity Act, which made explicit the need to assess capacity, was not available to this researcher at the time of this study. However, principles of good practice were drawn upon with the overriding aim that incapacity must be demonstrated through assessment, this being facilitated through development of a comprehensive consent protocol and supporting documentation in consultation with Dr Julian Hughes, a Consultant Old Age Psychiatrist and also an expert in ethical issues. Central to this was a consent checklist and pathway, or algorithm, which assessed capacity, the individuals understanding as to the nature and demands of the study, judging retention and use of information to make and communicate a decision [again see Davies et al 2010].

It was made clear to participants, their relatives and carers that consent was not legally binding, could be withdrawn at any time without reason, and that usual care would not be affected by this decision. A copy of the signed consent form was provided to participants and significant others where appropriate.

Lack of Capacity

At the onset of the quantitative strand of this study, the consent protocol required that independent opinion should be sought from an appropriate proxy[2] for individuals lacking capacity. After reviewing study information the proxy was asked, using their past and present knowledge of the participant, to determine whether in their opinion the participant would have had any objection to entering the study when cognitively intact, and to confirm that they would not be caused undue distress by participating. If the individual approached as proxy was not willing or indeed able [lacking capacity themselves], or if no close relative or friend was identified, then other relevant social/care networks were considered.

Priority was not automatically assigned to proxy opinion; indeed if the researcher believed that the participant was refusing all or any element of the research study either verbally or non-verbally then consent was judged to have been withdrawn. An example here might be reluctance to hold out their arm when drawing blood. Of those who agreed to structured interview, 11% (n=10/89) required proxy opinion, of which 60% (n=6/10) resided in an institution. As identified, individuals with severe and moderate cognitive impairment were excluded from in-depth interviews.

Loss of Capacity

It is important to note that capacity or loss of capacity can be transient, for example due to toxicity from an acute infection. In such cases research activity was suspended until such a time that capacity returned. If, however, loss of capacity was felt to be 'permanent', then proxy opinion was sought for continued participation in the study. Where the researcher was made aware of loss of capacity after interviews were complete, proxy approval was sought for continued use and storage of the data collected. Again this practice was later to be outlined as a specific requirement of the Mental Capacity Act.

[2] Namely their next of kin, immediate carer or legal representative (Power of Attorney), now defined by the Mental Capacity Act as a consultee.

3.7.2 Minimising Burden

In addition to measures put in place to minimise burden through restricting the duration of interviews, it was considered that requesting participants to travel to a research venue may result in burden. Therefore, all interviews [structured and in-depth] were conducted in participants' own homes. Although evidence clearly citing this as a source of burden is scant, as reasons for refusal and attrition are often complex, indications from randomised trials suggest that the distance between study site and the person's residence affects participation, with those at greater distance being less likely to participate (Ory et al 2002). Feedback from structured interviews supported this decision, with 51% of participants stating they would have declined participation had they been required to travel. Reasons given related to lack of time and health; age was not a factor. An additional benefit of the domiciliary setting may include participants feeling more relaxed and in control as a result of familiarity with the environment. This is a particular advantage when considering the aim and conversational aspect of in-depth interviews.

3.7.3 Benefit and Risk

Potential benefits to participants of research may include feelings of altruism, to benefit 'the greater good' (Boles et al 2000); there may also be an appreciation of the social opportunities provided by interviewer visits (Jacelon 2007). Indeed, comments from participants of this study included: "I am just glad I can be of help"; "I look forward to your visit"; and "I enjoy the company". Given this, Hughes et al (2008) state that researchers have a responsibility to ensure that research engagement continues in an appropriate manner, remembering that the research relationship is based upon trust which should not be misrepresented in order to coerce an individual to participate or remain in research. Similarly, the cessation of research needs to be carefully thought through, so as not to leave the participant feeling bereft or used in any way (Hughes et al 2009).

To reduce risk, researchers are required to pass full advanced Criminal Records Bureau Clearance, which checks for any past criminal convictions [Now Disclosure and Barring Service under the protections of Freedom Act

2012 conducted as part of the 'research passport']. The carrying of photo-ID cards out in the field is also recommended by this study, as is registering the study with local police, who provided a named contact for participants [and their families] to check the legitimacy of the study. The option of a chaperone was also always available to participants.

The risk to lone field researchers out in the community is also an area that requires consideration, particularly when involving a vulnerable group. Often older people are viewed in terms such as passive, frail individuals. However, such preconceived and often unsubstantiated ideas should not take away the responsibility of the research design to ensure the safety of its field workers, nor should it forget that research participants, especially in the community, are rarely interviewed in isolation as often there are family members, friends, carers, passers-by and pets present. Here, a safety protocol was developed, and this has since been rolled out by Newcastle University and Newcastle Acute Trust for community researchers. Again, the exact details of this protocol are publicly available in Davies et al (2010).

3.7.4 Confidentiality

The topic of confidentiality is paramount throughout the research process and during the writing-up phase. In practice, all data was held on secure password-protected, encrypted firewall databases. As stated earlier, upon recruitment into the quantitative strand of this study each participant was assigned a unique participant identifier (PID). Only this researcher had access to identifiable data, linked through PID, while anonymised quantitative data was available to 'The Newcastle 85+ Pilot Study' team. To increase confidentiality further the PID was linked to a separately held fictitious name when participants were recruited to the qualitative strand of the study. These names [and those allocated to family members] are used when presenting data from in-depth interviews as they are felt to be more personal. In accordance with the requirements of the ethics committee, links between PID, fictitious names and identifiable data will be destroyed six months after the completion of PhD. Previously mentioned approvals obtained from NHS Trust Caldicott Guardians address data protection in accordance with the Data Protection Act.

3.7.5 Written Information

For both strands of this study potential participants were sent a recruitment information pack consisting of an initial letter of invitation to 'opt into' the research. Details of the letter explained the aim of the study [including, upon approach to the qualitative strand that the study would be used as part of a PhD], a prompt to read the comprehensive accompanying information booklet, and a visual identifier of the named researcher. Varying recruitment packs were developed to take into consideration those participants who had use of a telephone, those who did not, and those who were in care [nursing or residential], here with the added emphasis on identifying and engaging additional 'gatekeepers' (Davies et al 2010), a topic which is returned to. However, the emphasis was always on the researcher to make 'first contact', avoiding potential burden from the use of other methods such as reply slips

From the experience gained within this study, recommendations are offered for the use of a clear font such as 'Arial' or 'Times New Roman', with a font size of no less than 14, to be visible to as many individuals as possible in the target population. The use of meaningful, stimulating visuals was also found to be appealing, but care was taken not to distract from or confuse key information. It was also important to avoid the use of jargon and present clear sentences. Researchers should also consider that some participants may have very specific and diverse needs to aid communication, the use of loop systems and audio tapes being just two examples.

3.7.6 Time

The need to provide potential participants time to consider research implications is a priority, as at no time should individuals feel under pressure to make a decision to participate. As such, the recruitment protocol not only included all necessary written information, as described above, but also set out crucial timescales of one week from the day after delivery of the initial invitation pack, until follow-up contact. The aim of this was to allow time to absorb the information and, if individuals should wish to do so, discuss implications with

family members or significant others, but not so much time that the detail of the study is forgotten.

3.7.7 Gatekeepers

As identified, the population aged 85 years and older is as heterogeneous as any other group in society, and individuals within this population may include those viewed as vulnerable. As a consequence, layers of gatekeepers, all of whom require some level of negotiation - possibly even before meeting with the older person - cannot be ignored. To avoid merely paying lip service to this it was the intention, where appropriate, to engage gatekeepers at the very onset by making it explicitly clear to potential participants that should they want another person to be present at interviews, then appointments would be arranged to accommodate this. This often meant being available 'out of hours' to fit in with schedules of family members.

Care Homes

For individuals living in care [nursing or residential], an additional layer of gatekeepers required careful consideration, namely care home managers and their staff. It was vitally important not to ignore such individuals, as not only do they have a vested interest in the provision of care and safekeeping of participants, but also detailed knowledge of the participant. Practical resource implications can also be addressed through gatekeepers, such as staff time should participants require assistance, providing a suitable environment to ensure that participants have privacy, and considering other timetabled appointments so as not to overburden participants.

Active involvement of gatekeepers can also be used to immediately address concerns over participation of individuals in this age group in research, particularly useful in avoiding routine exclusion based upon assumptions of capability. Throughout this process, it was essential that the older person's free will and privacy were not ignored, and all letters addressed to them were sealed and delivered directly, the exception to this being if it would cause undue distress. Examples of all recruitment documentation were provided to staff and,

understanding that staff could not release relative contact details directly, copies of information for families were provided for forwarding, if appropriate.

3.8 Summary

This chapter has clearly justified the methodological approach and methods used to appropriately meet the aims of this study.

This began with the separate consideration of quantitative and qualitative research paradigms and their underlying philosophical and theoretical viewpoints, in recognition that it is these viewpoints from which we make sense of the world, and which inform our research. The complexity of the relationship between philosophy, theory and social research was also discussed, concluding that as overall components of research they cannot and should not be applied in an ad hoc manner. Similarly, the methodology and method applied by the researcher in order to make philosophies and theories workable are required to be consistent to the overall theme.

Discussion then moved to examine how these paradigms, once thought to be incompatible, are now being more readily blended in mixed methods approaches, making known the philosophical and epistemological position of this study. In doing so, fundamental issues pertinent to a mixed methods approach, relating to claims of its strengths to enhance reliability, validity and quality, were discussed alongside limitations, including that which claims the researcher to be inextricably linked to the research process and therefore able to influence proceedings. To address this comprehensive discussion of transparency, truth value and reflexivity was provided.

Both quantitative and qualitative strands of this mixed methods study have been described in detail, starting with the quantitative structured interviews of ‘The North East 85 + Pilot Study’ through to the qualitative in-depth interviews. Consideration has also been given to the task of best practice, and the ethical, practical and legal requirements of involving people in research, with some unique considerations and recommendations for research involving older adults.

Ultimately, research should ensure a definite ‘flow’, in that what is presented at the onset of the research needs to be examined and concluded upon in the results. It is the belief of this researcher that such a ‘flow’ has been logically and transparently presented within this chapter, whilst also demonstrating that the automatic exclusion of individuals from research based solely on age, is unacceptable. The following chapters now turn attention to presenting findings gained from that described here.

CHAPTER 4: SOCIODEMOGRAPHICS AND CONTEXTUALISATION

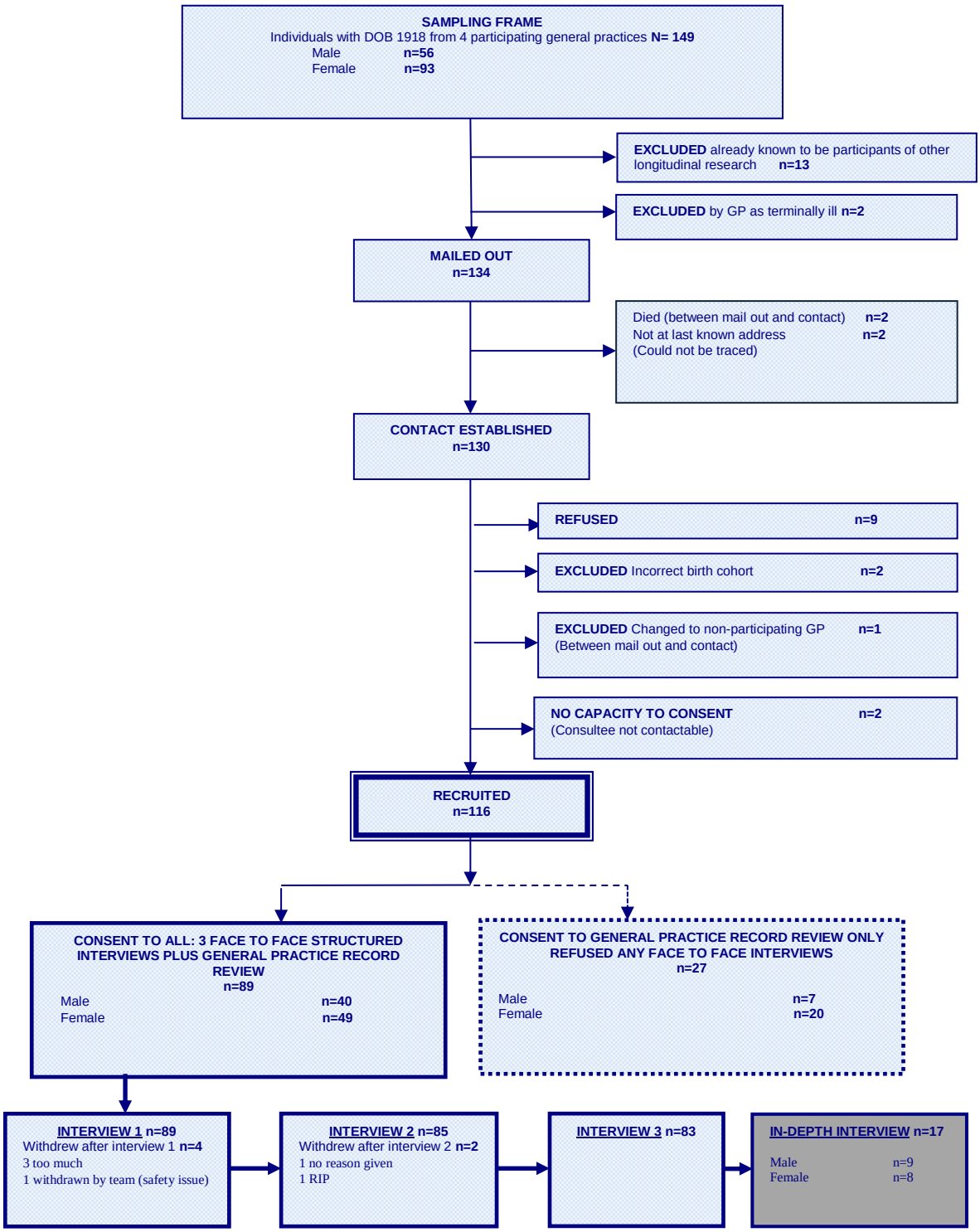
4.1 Overview

This chapter presents the reader with key recruitment and participant sociodemographic information from quantitative data, with the aim of contextualising the sample population and the ensuing discussions within the following chapters. Participant vignettes derived from qualitative in-depth interviews are also offered, providing a rich additional layer of description of those individuals who participated in in-depth interviews. As the theoretical underpinning of the qualitative strand of this mixed methods study is the belief that the researcher is inextricably linked with the research, a researcher vignette is also offered to provide transparency as to what influences may have been 'brought to' the research. An overview of the themes to emerge from qualitative in-depth interviews is also given, these being central to leading the enquiry within this thesis.

4.2 Structured Interviews: Recruitment and Attrition

Figure 7 below clearly illustrates the trajectory for recruitment and attrition to structured interviews, where overall 79% of potential participants were recruited from the sampling frame (n=116/149). Although this rate of recruitment compares favourably with other UK longitudinal studies of ageing, often involving younger cohorts (Adamson et al 2005), and with similar studies internationally (Ostbye et al 1999; Deeg et al 2002; Carpenter et al 2004), it is confined by the limitation that only 4 general practices of the 39 within the city of Newcastle upon Tyne were approached to participate in this pilot study, with the intention of developing recruitment and assessment protocols to inform a future main study. In developing such protocols, it is also accepted that variation in local circumstances may require procedures used here, and described in the previous chapter, to be modified for other populations.

Figure 7: Recruitment and Retention



4.3 Structured Interviews: Participant Sociodemographic Data

As identified in chapter 3, sociodemographic data is derived from structured interviews. To establish representativeness of the study population, at the current time, where possible findings were compared to that of the 2001 census data for Newcastle upon Tyne and North Tyneside, with some good comparability. However, representation of those individuals living in a care home required attention. The findings of comparisons are as follows.

4.3.1 Sex

As figure 7 shows, the majority of participants agreeing to participate in structured interviews (n=89) were female with a ratio of 1.2:1, as compared to a ratio of 1.9:1 in the 2001 census for Newcastle and North Tyneside, determining that females were less likely to agree to participate in the study than males. Where reasons for refusal were offered (n=27/36), the most commonly occurring reasons for both sexes were health-related (n=19/27). This tends to support previous findings from the literature stating that although more females than males survive to an older age, they do so in poor health.

4.3.2 Ethnicity

In relation to ethnicity, information from the 2001 census reports a population which was 89% white for England and Wales and 99% white for Newcastle and North Tyneside. Ethnicity in this study is 100% white, and whilst accepting some limitation, it is with future studies that resource intensive and carefully personalised approaches which respect cultural and religious sensitivities as immigrant ethnic groups reach older ages (Rooney et al 2011).

4.3.3 Marital Status and Children

Of the participants, 94% (n=84/89) reported they had married, with the remaining 6% never marrying. Of those married, 34% (n=29/84) were still living with their spouse; however, the majority (63% n=53/84) were now widowed for a mean average of 19 years (range 1-43 years). One of the consequences of longevity is to experience bereavement not only through the death of your spouse and peers, but often of your children. Here, for the 80% (n=71/89) of participants who reported having natural children, 9% (n=13/148) of these

children had died. The death of others with whom we have formed an important personal relationship, including spouse, was found to impact on an individual's perspective of ageing well, affecting key social networks and support, a theme returned to within chapter 7: social connectedness.

4.3.4 Living Arrangements

97% (n=86/89) of participants lived in their own home [house, bungalow, flat or flat within sheltered housing with warden], of which 57% (n=49) owned the property. 3% (n=3/89) of participants lived in a care home [nursing or residential] as compared to 11% for Newcastle and North Tyneside in the 2001 census. Poor representation of this group in the sample population is primarily attributed to recruitment barriers which include: the complex negotiation of access to an individual often belonging to the most vulnerable group in terms of being very sick, frail and dependent upon the care of others. Historically, such barriers have led to these individuals being excluded from research at the onset; however, this experience was utilised to develop specific protocols for care home recruitment, as detailed within the previous chapter, that were used with great effect in the main Newcastle 85+ Study where 12% (n=102/852) of participants recruited to structured health assessment lived in a care home.

Of the 86 participants living in their own home, 57% (n=49/86) reported that they lived alone, with a 33:16 female to male split. For those reporting that they lived with another person, the majority lived with their spouse (n=29/37), and for the remaining 8 participants [all female], 6 lived with their children and 2 with their sister.

4.3.5 Socio-economic Status

Socio-economic status of study participants can be assessed by a variety of measures throughout life, for example, years of education, occupation or income. Here occupation was selected, and details of main occupation for the participant and spouse [where applicable] were asked, with the intention of assigning operational and analytical class. However, assigning main occupation to female participants [and to the wives of male participants] was problematic, particularly where 'housewife' was reported. Therefore, the National Statistic for

Socio-economic Classification (NS-SEC) head of household was used, and females deferred to their husbands' main occupation. Results from this show that whilst all classes were represented, the most densely populated classifications were group 2.0: lower managerial and professional occupations (21.8% n=19/87) and group 7.0: routine occupations (20.7% n=18/87). Full details of these findings are presented below [Table 4].

Table 4: NS-SEC Analytical Class Head of Household

		Frequency	%	Valid %	Cumulative %
Valid	1.1: large employers and higher managerial occupations	7	6.0	8	8
	1.2: higher professional occupations	7	6.0	8	16.1
	2.0: lower managerial and professional occupations	19	16.4	21.8	37.9
	3.0: intermediate occupations	9	7.8	10.3	48.3
	4.0: small employers and own account workers	1	0.9	1.1	49.4
	5.0: lower supervisory and technical occupations	16	13.8	18.4	67.8
	6.0: semi-routine occupations	10	8.6	11.5	79.3
	7.0: routine occupations	18	15.5	20.7	100.0
	Total	87	75.0	100.0	
System Missing	Not asked (interviewer error)	2	1.7		
	Total	89	100.0		

During in-depth interviews, the theme of ‘social classification’ did not emerge, perhaps because individuals do not tend to think in such terms during everyday conversation. However, much emphasis was given to the topic of work and the transition to retirement in terms of identity, resources and opportunities, all of which impact upon perspectives of ‘ageing well’. Therefore, we will return to this in detail within chapter 5.

4.4 In-depth Interview Participant Vignettes

As outlined within the overview of this chapter, the inclusion of the following detailed vignettes is intended to provide rich factual sketches of participants by placing them within their own surroundings (Ely et al 1997). The participants of this study are not only long-lived, but survivors of some of the most remarkable historical periods of our time, starting in the year of their birth, 1918 - the year that World War I ended, the Spanish Flu claimed 200,000 British lives, and propertied women over the age of 30 were given the vote. Where appropriate, their stories will be placed within a historical context to provide the reader with a level of detail which contributes to the overall findings of the research.

As a prelude to detailed discussions in the following data chapters, some of the themes which emerged as important to participants are touched upon here. Vignettes are presented in order of participant selection and subsequent interviewing. As indicated previously, all participant and family names have been changed to maintain anonymity.

4.4.1 Alan

Alan was born in a council estate in Newcastle upon Tyne and had never moved from the area. He started school aged 4 and left at 14 to train as an engineer at Armstrong Vickers, where he worked until retiring from all work aged 63. Alan did not serve during World War II (WWII) as he was in a “reserved occupation”.

When asked about his upbringing, the first thing Alan identified was that he was the eldest of nine siblings:

> “I’m the eldest of nine and I think there’s six or seven still alive --- me father was a miner and --- I say that I practically brought the family up you know
> *R: You did?*
> Yea with being the oldest”
>
> (Alan, p.1, ll.7-10)

This role of responsibility as a ‘father figure’ was clearly important to Alan’s identity and as such it was one which Alan sought to maintain throughout his life:

> “With all these brothers and sisters and --- me father wasn’t the kind of person that brought them up he didn’t do anything but that was it he didn’t do anything --- and with me being the eldest I had to sort of be father to them and I --- whether I was good bad or indifferent I don’t know but I you know sort of brought them up and told them what kept them on the right and narrow path and --- oh I’m still --- gaffer …
> *R: And how does that make you feel?*
> Quite proud really and worried
> *R: Why worried?*
> Well was I old enough did I do the right thing --- you know at the time I certainly did think so but did I --- but they still think a lot of me yet you know
> *R: And what does that mean to you?*
> --- Oh I accept it and I’m grateful”
>
> (Alan, pp.8-9, ll.379-422)

In the above dialogue from Alan, there are also indications of the ‘historical’ hardships for working class men and their families, particulalry during Alan’s early childhood. Here the effects of the Great Depression of 1929 would have been felt and many men in Britain would have been out of work. Alan’s father was fortunate to be employed as a miner in the coal industry, the major employer within the North East at the time, with 170,000 men working as miners

in Durham alone in 1923. Mining was hard and extremely dangerous work, prompting 'The Samuel Report' (1926 cited IN BBC 2011) and strike action which aimed to improve conditions and prevent wage cuts. However, deprivation was widespread and due to lack of general support, strike action lasted only nine days.

Alan's father died at the age of 71, his mother, a housewife, also died aged 71.

Alan lived alone in the council flat he had shared with his wife until her death three years ago. He and his wife had two daughters, both of whom were still in close contact, something from which Alan gained a great sense of pleasure, and seemingly far removed from the role his own father had fulfilled:

> "My two daughters still love me --- a lot so I must have done something right somewhere"
>
> (Alan, p.11, ll.546)

4.4.2 Anne

Anne was born in Birmingham. When asked to talk about herself she first identified that she was an only child and that her father had been a civil servant and had died at the age of 95, her mother, a housewife, had died aged 92.

Anne described that she had found being an only child difficult at times but felt, on the whole, that it had enabled her to become 'self-sufficient '. A skill which she had relied upon in life to help her succeed:

> "... my mother and father lived in this huge old very dilapidated mansion ... in the grounds of a factory in a very poor area of Birmingham I was an only child and my mother didn't want me to mix with the children in the neighbourhood I suppose because of the area any way I had no children to play with and I made up an imaginary playmate … when I was about 4 they were able to get a very pleasant house in what had been built as a garden village … and I went to a school which was quite a distance away and there weren't any children round there at the village I had

> friends at school they didn't half rag me at first because although I hadn't mixed with the children in Birmingham I had this terrible Birmingham accent which wasn't acceptable of course at this school anyway I made friends of course but none near the town so I always grew up rather a lonely girl and had to be self-sufficient and used to paint and do puzzles and things like that you see"
>
> (Anne, p.1, ll.22-36)

In 1931, when Anne was aged 13, the family moved to Manchester and Anne attended a ladies boarding school and recalled very happy memories:

> "I loved it and I loved working there and my best subject really was biology and the biology mistress had said to my parents now Anne must be a vet because that's what a lot of women those days had done if they were good at biology but I didn't want to be a vet I wanted to be a doctor so from then on I made sure of it and was accepted at the University of Manchester and studied there for my medical degree"
>
> (Anne, p.1, ll.44-48)

In 1936, around the time when Anne would have attended university, disparity between the sexes would still have been apparent given that only some eight years earlier in 1928 the suffragette movement had won voting rights for all women over the age of 21, matching that of men. When asked about attitudes towards women studying medicine, Anne responded:

> "I was certainly in the minority … there were only about fifteen of us (women) in about one hundred students and there were still prejudice I can remember on ward rounds there were some of the consultants you'd be round a bed and you would ask a question and the consultant who didn't like women --- he would answer the question but he would look at one of the men as he answered"
>
> (Anne, pp.2-3, ll.99-103)

WWII was declared in 1939 during Anne's time at university, and in 1942, when working as a house surgeon in Manchester, Anne was called up into the army as medical officer to a Royal Artillery unit:

> "I didn't do anything terribly exciting I was in this country all the time but I enjoyed it and met my future husband in the mess there"

(Anne, p.2, ll.59-61)

After being demobbed in 1947, Anne and her husband settled in Newcastle upon Tyne, as he was from the area. Anne talked intently about her career and how she had worked in the local children's hospital up to the birth of her first child in 1950, returning to work part-time in 1955 when her second child turned two years of age, attending at baby clinics in some of the deprived areas of the city. After this Anne described her career progression as 'seizing opportunities'.

Anne retired from her main career at the age of 65 but continued doing work for women's health until the age of 70. When asked what had made her so driven in her career choice and progression in the face of discriminatory attitudes, Anne responded:

> "Because I have always been self-reliant I have always had to make my decisions and carry them out --- I learned that as a child --- I suppose that's it really"

(Anne, p.4, ll.159-161)

Since the death of her husband eleven years ago at the age of 75, Anne has lived alone in the house which they owned. She was still in contact with her two children, but not overly so due to their 'leading busy lives'.

4.4.3 Bill and Brenda

Bill and Brenda still lived in the house in which they had raised their family. Married for 64 years, they had met whilst serving during WWII:

Brenda: “When I joined you know I was only a girl and I said I would do anything so they took me to this gun site you know just me and there was another girl called Violet and they put me to help with the cook --- I mean it was in December and it was snowing and we had to make this kitchen in a field … you never saw anything like the cook he’d been a cook in the merchant navy and he had this white apron on which was black and he had this oven in the middle of a field nothing else nothing around it or anything and he had this stew on the top of this oven and he was stirring it and it was bitterly cold and he had a drop right on the end of his nose --- anyway when he was all finished I had to go and wash these dixies [large aluminium cooking pot] so there was a special place where they had hot water and so I was supposed to wash them and that’s what I was doing and the Orderly Officer and Orderly Sergeant had come around and they said to me because it was only about my first week there and they said you’re not used to doing this are you I said no he said go and get those lazy people he said get them out of that barrack room and tell them to come here and do this work --- and he was sent [points toward Bill]
Bill: There were only two of us in the room and I was picked
Brenda: He’s been washing the dishes ever since”

(Bill and Brenda, pp.50- 51, ll.1911-1944)

Bill was born in a small suburb of Cardiff South Wales and lived there with his parents, two brothers and a sister. His father was a coach painter for Western Welsh and had died at the age of 82 his mother was a housewife and had also died aged 82. Bill talked freely about his upbringing, his family and schooling from the age of 5 to 14 years, often referring to his childhood and family as ‘steady’ and providing the basis for his life:

“I mean we belong to a Sunday school system in those days all the kids went to Sunday school and we learned our bible all the religious instruction all set us in good stead I also joined the band of hope which

was a temperance organisation and you signed a pledge not to drink alcohol

Brenda [interrupts laughing]: Yes and which he broke as soon as he was a teenager

But we had a steady life

R: What do you mean by steady?

There was nothing untoward in my life at least except the usual illnesses of others and deaths in the family I mean that happened a lot but I had a very steady father and mother

R: And do you think that has had a long term-effect on you?

It does it leads the whole basis for one's life it leaves I think the principles that never leave you"

(Bill and Brenda, p.4, ll.123-140)

Principles and respect during childhood featured heavily throughout Bill's interview, during which he put forward strong beliefs that these attributes were being eroded in modern society:

"They don't respect anybody now they don't respect authority in schools outside school

R: Why do you think there's that lack of respect?

It's been very gradual I don't know whether you've noticed but there's the matey syndrome where you call everybody mate I don't believe in that I wouldn't call everybody mate that's my only mate [points toward Brenda] there's no respect people used to call you sir if they didn't know you I mean I still do"

(Bill and Brenda, p.32, ll.1225-1236)

After the war Bill secured a job as a civil servant with the ministry. Established in 1948 and based in Longbenton, this employer was to become a life line to the North East toward the end of the 20th century, after the closure of the region's pits and shipyards. Bill stayed with the ministry until his retirement some 20 years ago.

Brenda was born in Newcastle upon Tyne and apart from traveling around England during her time spent in the army, she had always lived there. Brenda was the eldest of four brothers and three sisters. Her father had been a publican and her mother, who had lived until the age of 90, was a housewife. Brenda recalled they had been well off until her father changed jobs, for reasons of which she was not aware:

> "Well my father was manager of pubs we were quite well off but he actually chucked his job so that had a great effect on all of us so after that he used to work on the buildings and in the winter he was laid off so money was really short … so my poor mother was marvellous at creating meals out of nothing"

(Bill and Brenda, p.12, ll.446-451)

When Brenda had talked of her father earlier in the interview she described how his strong beliefs about the conduct of women had shaped her behaviour, again representing something of the attitudes of that time:

> "I had a father who was very strong a strong father a strong bodily father also he was very strong in his beliefs and his beliefs were that women had to behave themselves in the home … although we were never told how to conduct ourselves we just knew"

(Bill and Brenda, p.5, ll.194-199)

Brenda did not talk in any great detail about her schooling apart from stating she had started aged 4 and left to go to work aged 14:

> "After school I was sent out to work straight away to work in a grocery shop a grocery chain actually and it was a thing I just accepted --- I changed my job when I was 16 and I went to work for a manufacturing chemist and worked there till the war started and ooh and everybody was so excited about the war"

(Bill and Brenda, p.3, ll.82-89)

Brenda continued to talk of the war as being an adventure and her wanting to be involved on any scale, leading to the story of how she had met Bill. After they married, Bill and Brenda had two daughters and a son. Brenda stayed home and cared for the children. Although she had aimed to return to paid work once the children were at school this, as chapter 5 will illustrate, did not go according to plan.

The role of caring for others was a theme expressed throughout Brenda's interview, a role from which she had gained a sense of pride and satisfaction. Later in the interview, when asked if she had any regrets in life, Brenda replied:

> "You see there are some people who have the idea that you've got to achieve all the time higher and higher and it makes sometimes I think for dissatisfaction"

(Bill and Brenda, p.49, ll.1853-1855)

4.4.4 Cyril

Very early on during the in-depth interview with Cyril he identified that recently major changes had taken place in his life. His wife, for whom he had provided care, had died six months ago, he now lived alone, and in Cyril's words he had 'deteriorated':

> "Yes I don't look after my wife now you see I'm just looking after myself the daughter comes in every night straight from work to make sure I've got something hot a hot meal but sometimes I've started it when she comes in and I say go and sit down have a read of the paper
> *R: Your daughter she wasn't doing that before?*
> Oh no no she wasn't doing that before but she still came in to see her mum like she used to come in the middle of the week to see how she was but I think she's worried like because I've deteriorated

R: You say deteriorated can you just explain to me how?
I don't know it's just I think I just missed having her around and doing things for her I miss that more than anything else and I think that's what made it worse because I didn't know what to do with myself I was sort of --- unsettled and people say get yourself out get yourself out don't stop in"

(Cyril, pp.4-5, ll.194-218)

Cyril then went on to talk about the 'Fellows of Services', an organisation which he had attended for many years. For the past 15 years Cyril had fulfilled the role of almoner, which involved visiting and 'looking after' members who were sick. Since the death of his wife however, his club assistant had been visiting him. It seemed this was a situation that Cyril was still coming to terms with:

"… He comes and visits me like now
R: What does that mean to you your assistant coming in to visit you?
Oh well I like I suppose I like people coming in --- but that's what I used to say to the wife before she died"

(Cyril, p.6, ll.263-267)

During the interview Cyril also talked about his upbringing in Liverpool. He was the middle child with two sisters. Cyril confided that he had always had a difficult relationship with his older sister, which remained true even today:

"She still lives in that house [the house his mother and father had owned] but she's not married she doesn't like married people she doesn't like me either we never get on very well --- we start just talking on the phone hello hello you alright yes that's as far as we get and then we start fighting … she always thinks she's the boss of the family and I don't like it because she thinks that she's the boss"

(Cyril, p.17, ll.814-825)

Cyril's father had worked in heavy industry and died at the age of 75; his mother had been a housewife and died at the age of 95. Cyril started school aged 5 and talked of the discipline the teachers had instilled, and the punishments for tardiness. Like Bill, Cyril felt these were lacking in today's society:

> "I would say about seventy per cent of the families nowadays don't bring up their children the way I was brought up if you didn't behave yourself properly you got a clip over the ear or you would be told in no uncertain terms --- if we were late for school the bell used to ring and if you weren't inside when that bell rang the yard gate was shut and you stopped outside it was the caretaker who rang the bell he was outside and he would know who was outside and as soon as they had started school you were let in but you were late and if you were late twice in that week you got the cane … if you were late a third time you would get two strokes on the hand and boy you would get it --- but it taught you it taught you a little bit of timing you know don't waste time I see a lot of kids who are wasting their life now
> *R: How does that make you feel?*
> It makes me feel despondent I think and sad but they're not even trying to make their life better"

(Cyril, pp.19-20, ll.931-949)

Cyril left school aged 15 and worked as an errand boy until WWII broke out and he joined the army. Cyril talked animatedly and at length about his time in the army, how he loved the discipline and the fitness regimes, and how well they were looked after in terms of a regular diet. He reported that these were lessons which he drew upon for the rest of his life:

> "I was always so skinny … nothing but skin and bone but then I'd been in the army about six months and I'd put on a stone in weight and it was just the regular diet fresh air and that sort of thing then I started doing running exercises and me PTE instructor said oh you're good at running are you righto we'll put you in this race he said oh yes you're one of mine [laughing] and he put me in this race and I won it and he said so you're a

good runner I'll have to get the head PTE instructor from the regiment --- he had been the coach for Stoke-on-Trent football team and staff told him so he said okay I'll give you some exercises to do … --- of course I started running faster and faster [laughing] so he started putting me forward for the cross country race … I went do you think I'll win it and he says no he says I don't think you'll win it but I think you'll come in a canny number so I just went and I come in third and he says oh you're better than I thought and he used to put me into all sorts of races then"

(Cyril, p.12, ll.555-576)

After the war Cyril worked as a bus conductor for the corporation, a job he described as still giving him 'plenty of exercise'. Cyril retired from the corporation aged 65 and, aside from the dancing which he and his wife did, 'took up a more sedentary life' doing woodwork, making dolls houses and donating them to charity. In their seventies, after a cerebrovascular accident, Cyril's wife was left with profound physical and cognitive limitations. Cyril became her main carer. They no longer went dancing.

4.4.5 Coleen

When first invited to talk about herself during her in-depth interview, Coleen answered:

"Right --- born 1918 St. Dominic's school on New Bridge St --- didn't really do much learning we just enjoyed it … left school at 15 went to work at a furniture makers did not like it [laughing]
R: You didn't like it?
Hated it
R: What did you hate about it?
Well --- I was only two days there and the second day they gave me a hammer a cramp … and nails and allsorts to do frames for easy chairs and I was that high [laughing and gesturing how small she had been]"

(Coleen, p.1, ll.3-13)

Coleen soon left her employment at the furniture makers to work in a local bakery, a job which she loved. However, upon marriage, Coleen left this job to start a family. When WWII was declared, Coleen's husband attended for his 'fitness to serve' test where he was found to have cardiac disease. Tragically this would cause his death aged only 28:

> "So I started courting [laughing] before the war --- aye that's right but we were unlucky very unlucky my husband --- he wasn't passed for the war because they found he had heart disease so that happened then never mind we had our May [daughter] and it was only just after the year after the war when he died
> *R: How old was he?*
> We were both 28"

(Coleen, p.2, ll.77-87)

When Coleen's daughter May was 14, Coleen married for a second time. She remained married for 44 years, until her husband's death 5 years ago, upon which she gave up their council house and moved into warden controlled sheltered accommodation and concluded of her life:

> "So that's that --- there's not much to tell really"

(Coleen, p.3, ll.117)

This statement being far from true, Coleen began to talk freely and in greater detail about her background. She had been born in Newcastle upon Tyne and lived in a council house with her parents, five brothers and two sisters. On marrying her first husband she had moved in with his mother, who was recently widowed, so her husband 'kept up the house'. When her husband died Coleen remained with her mother-in-law, as in her own words:

> "The day he was buried we got a letter to say we had been allocated a house in Benton on the new estate I didn't take it because I couldn't

leave his mother she was just on her own”

(Coleen, pp.4-5, ll.179-181)

During this time, around the end of WWII and on the back of the 1942 Beverage Report, all of the participants would have lived through the introduction of many social reforms which aimed to improve the health and quality of living for working class people, such as the welfare state, NHS and social security. New modern social housing such as that offered to Coleen, with indoor sanitation, was an integral part of this.

Throughout her in-depth interview, Coleen maintained that family was very important to her. Coleen talked with great pride about providing care for her grandchildren and great-grandchildren to enable their mothers to go out to work:

> “I was privileged to do it because I couldn’t do it for my own privileged I wouldn’t have missed that time with those kids for all the tea in China it was great
> *R: It was great so it meant a lot to you?*
> Yes it’s something to do and it gets you out and I appreciate --- well actually I was over the moon to be able to look after them fancy even today there’d be a lot of grannies that couldn’t do it that’s how I’m grateful because I’ve been allowed to do it
> *R: And why do you think you’ve been allowed to do it what’s made you compared to other grannies be able to do it?*
> Because of my health”

(Coleen, p.35, ll.1576-1595)

Examining the concept of health and perspectives within this is identified as an important aspect of the wider exploration of ‘ageing well’, and therefore the focus of chapter 6.

4.4.6 Doreen

Doreen was born in the very heart of Newcastle, 'where the Marks and Spencer's shop now stands'; the second child of four children, two boys and two girls, she was the only survivor.

Doreen's faith featured strongly within the interview and during particularly difficult and sad times of her life, Doreen appeared to have drawn strength from this:

> "Yes --- I mean my mother died when she was only 54 and I nursed her when she was ill --- before that I had another child a baby but the baby died when she was just over 2 month old a little girl about a year after my mother took ill and we found out it was cancer the doctors told us and my dad and I nursed her at home … some people say that God is cruel and things like that I used to say well no I lost my first little girl I was very upset at the time but there must have been a reason because my mother died my mother took ill and there was no one there to look after her and I looked after her because my sister had just got married and she had a little girl and she couldn't keep coming up and that and if I had that baby I wouldn't be able to help and I always look at things that way you know --- I always say something happens for a reason and I try and not get upset over things you know"

(Doreen, p.5, ll.228-236)

Family meant a great deal to Doreen, stating that the closeness she felt to her family as a child remained important. Doreen reflected on this and suggested that she felt sorry for modern day families:

> "Well I feel sorry for people who live away --- like I said when I was a child there was that closeness now there isn't you know that's fair enough you know it's because they live away I think it's a shame in one way like … I don't know I think things have changed a lot"

(Doreen, p.2, ll.82-85)

As with previous participants, within Doreen's interview health was a major focus, which she described as poor since her forties when she was diagnosed with cancer and required treatment for over a year. After this Doreen had undergone many operations, but things had seemed to settle down until approximately twelve years ago with a failed hip replacement:

> "It was the hip operation that caused it --- it wasn't a success I had to go in twice I had things done to it I mean I was alright at first I was walking around a bit and then the hip went into the pelvis you know and it had to be taken out at the finish it was all rotten and from there on these other things started to crop up even when I went into the hospital they were going to do something about the hip I was in for a while before the colostomy started and that was caused through being in there"
>
> (Doreen, p.7, ll.380-385)

The overall impact resulted in Doreen being wheelchair-bound and requiring on-going daily care. Since the death of her husband 15 years ago, Doreen had lived with her daughter Jess. Jess was an only child and had never married; she provided her mother's main care. Doreen spoke strongly about not wanting to be a burden:

> "As long as I'm no bother to anyone that's all right as I say I don't like being a bother to anybody if I can help … I'd love to do it myself to help myself you know I mean you can't change the way things are … you know I mean things when you look back you might think I wish things hadn't happened but as I say they happen for a reason"
>
> (Doreen, p.15, ll.786-789)

The topic of support provided by families, and the impact upon ageing well, are returned to in greater detail within chapter 7 Social Connectedness.

4.4.7 David

David was born in North Shields and during his childhood had lived with his parents, four sisters and two brothers, all of whom were now dead. David talked warmly of his family and in particular his father, whom he described as a 'story teller':

> "She'll tell you [points toward wife] she used to come down there and sit there an' listen while we were courting sit down there an' listen to him talking I cannit tell them as good as me fatha … and when we got married we used to go down every Saturday every Saturday … and used to call and get a couple of bottles of Guinness or stout or something we used to get a couple of big bottles of Guinness or stout and fish and chips a pile of fish and chips … and we used to go along and take them home and me mother and fatha would be 'oh great' they all used to sit down and have the fish and chips and after they filled themselves with fish and chips and that and really enjoyed them salt and vinegar and all the lot and lovely sit down there and then after they licked their fingers and all the rest of it we sat down there and he would sit and tell these jokes and stories --- sit there fascinated --- he could really tell a good story"

(David, p.26, ll.1419-1434)

At first glance David's account of his father seemed to depart from other participants, who described their fathers in a more authoritative manner, being head of the household and having financial responsibility. However, further discussion with David revealed that these traits of authority were also evident in his father, as well as illustrating the role adopted by the women, including his mother:

> "Ah me mother ran the house but me fatha was the one who fetched the wages in that was the way it worked none of the mothers worked sometimes you would find some of them did a little bit of cleaning for neighbors round and about like that sort of thing you know someone who was maybe a bit better off than they were and they would say ah well

> Mrs so and so can you come and do a little bit of washing for us and that and they did they had to do all that sort of thing --- because it was their duty it was their duty to look after things in the house same as when they used to make their own bread they used to have a big stone dish aye you had them about that size and about that deep [gestures] and it was like stone you know and it was all painted brown on the outside and cream on the inside used to make all the bread there and they had the little coal fire with the oven on the side … ah we used to love that seeing me mother baking … you know them stotty cakes you can get now well they made all them aye they made lovely flat cakes the stotty cakes"
>
> (David, pp.9-10, ll.502-523)

David also spoke of his education, reporting that schools were strict and you had to respect the teachers, again something lost in modern society. In 1932, aged 14, David won a scholarship and reported that he could have gone onto further schooling with 'the brainy kids' but refused as he was eager to go out to work. As with many of the male participants, David talked at length about his work life experiences. During WWII David signed up to join the Navy and served for twelve years. The ship on which he was serving was bombed and David was recommended for bravery:

> "I think it was about three in the morning … and there was a bang and here it was a submarine they had in the bay and it threw torpedoes at the Royal Oak and hit it and it sank --- there was eight hundred and odd lost on there --- drowned on it cause it was in dock and they were taking stores aboard you see ready to go and they sank it then and there … we went all the way round the harbour trying to trace the sub we were on all night there while picking up the bodies and taking them ashore"
>
> (David, p.18, ll.995-1001)

Given the importance of his working life, David reported that he had 'coped' with retirement at the age of 60. This he had managed through keeping active, doing a lot of gardening, keeping an allotment and making model boats. However a

recent deterioration in David's mobility and health had limited these activities. His home had undergone adaptations such as having a stair and bath lift fitted, and his wife of fifty years was now his main carer:

> "I cannot do things I used to --- to put it as simple as that but you see as I say you have to accept it if you don't accept these things you'd go bonkers you would do --- as I say I've always had a strong willpower and a sense of humour --- it's still there"

(David, p.26, ll.1403-1405)

4.4.8 Edward

When invited to talk about himself during his in-depth interview Edward responded:

> "Well I'm the sort of person I take everything as it comes really I don't harp on yes I've had good times I've had not so good times but well I suppose from being young I've been more or less on my own"

(Edward, p.1, ll.11-13)

Here, Edward explained that as a young child living in Essex with his parents, older brother and sister, and younger sister, his mother had been 'taken away' from them because of her 'health':

> "You know I was just a kid --- but anyway there was trouble with my mother… in those days you see it was such that say the father of the house my mother being ill she wasn't at home she was taken away my father was struggling to keep his job which in them days you had to --- and so you didn't get love off them --- when I go back like that I can't --- [becomes upset]"

(Edward, p.1, ll.28-42)

Edward was clearly emotional recalling these events and explained that as a consequence the children were separated and put into council-run children's homes. Edward never saw his siblings or either of his parents again. However, he did go on to talk of his time at the 'school' with fondness:

> "We couldn't stay longer than 15 that was the limited age and it was run by the people from the Hackney district you know they had guardians I can tell you now I don't suppose there's a school like it because we had everything everything as I say I was sent there and I couldn't have had a better life we had everything we had cricket pitch football cubs scouts"
>
> (Edward, p.2, ll.56-60)

Upon leaving school aged 15, Edward and one of the other boys got a job delivering groceries to the large hotels and shops in the West End of London. During the narrative Edward talked of his determination to do well, giving credit to his 'school' for instilling this, an attribute which he repeatedly identified as valuable throughout the course of his life:

> "Not long after I learned to drive they gave me a little Ford van and I used to have to run from the warehouse in Bow along to the West End where the offices were and deliver the papers to the warehouse and I did that for about six months I suppose I was reaching ahead of myself because I had learned to drive and I thought well where do I go from here and I really think to this day that I only got that way of living from school --- next thing I knew war had been declared --- on the Sunday morning we went on parade and we heard Chamberlain's speech 'no war in our day' or something stupid like that [laughing] --- as I say on Sunday morning when war broke out I got called up and in the army you used to have to read the board what they put up for the day you know and my friend came up to me one day and says 'your name is on that board' I said 'my name' well anyway it was up there and I say's 'I wonder what this is for' so I went to the corporal and I said 'what do I do here' and he says 'well you do what it says there report to sergeant so and so' anyway it came out that I had to report to the corporal who was in charge of the officers

> mess and I went there --- well when you're young like that your thinking all manner of things [referring to some of the actions of other young soldiers] I was thinking I'm not going to start that game I'm in the army and I want to be a soldier --- anyway it all came to light and I suppose being from the school I was intent on doing everything right and I kept myself I'm not being big headed or anything but I kept myself as far as I could I kept myself better than him next door [than the next man]
>
> (Edward, pp.4-5, ll.197-230)

After the war, Edward left the army to work in retail and eventually owned his own fruit and vegetable business, which he described as a heavy physical job. He also married and had two children, however the marriage failed and sadly he became estranged from his children. Edward now lived with his current wife in a privately owned bungalow which had been modified to assist with his reduced mobility. Edward retired aged 64 due to ill health. This, as a reason for retirement, can have major implications for transition to retirement and as such its effects are considered in detail in the following chapter.

4.4.9 Frank

Despite physical limitations, Frank lived alone in a first-floor council flat, a situation made possible by an extensive daily home care package. Frank had been widowed for twenty years and had one child. On starting the in-depth interview Frank immediately said:

> "Yes I am an old man but I do not have old man's thoughts"
>
> (Frank, p.1, l.6)

When asked to expand, Frank explained that he loved modern-day technology as it helped him to keep up to date with the world:

> "I love the technology
> *R: You love the technology?*

I do yes and even at my age now I know I can't walk very steady on my own if I'm on my own in the middle of the road I've got to walk where I'm looking I can't turn and keep walking I'll fall --- my hearing is not so good I do a lot of lip reading when the conversation gets going I can't understand what people are saying and I am losing my eyesight I can't do lots of things but I love this [points to his laptop resting on the arm of his chair] with this I can find out what's going on"

(Frank, p.1, ll.21-34)

Frank was born in Newcastle upon Tyne, the younger of two children. As his father continued to serve as a duty sergeant in the Army sometime after the end of WWI, Frank had lived in a council house with his mother, older sister and grandparents for the early part of his childhood. His mother and grandmother looked after the house and his grandfather worked as a painter in the shipyards until he got 'paid off'. In his spare time, Frank's grandfather painted pictures; Frank talked fondly about how he wished he had taken more of an interest in these:

"He used to paint pictures but I'm very disappointed this is one of the things which in my younger days I didn't take any notice of I didn't realise that as I got older I'd be taking more interest in
R: What do you mean by that as you're older you'll be taking more interest in what is it you take interest in?
How useful these things would be or how in my later years how these things were made and that
R: Do you mean your grandfather's pictures he painted at the time or do you mean you became more aware of art?
I didn't know the value of them
R: Of art?
Of art yes
R: And why do you think over time that has changed?
Oh I see what you mean because when I was young I wasn't thinking of growing old … I was enjoying myself out with my pals playing cricket out in the back lanes and all these things and sometimes he asked 'look at

> this picture' and I wasn't interested in it I couldn't really grasp --- I couldn't grasp what that picture would mean to me because my grandfather painted it … but now I wish I had one"
>
> (Frank, pp.3-4, ll.131-153)

Frank attended school from the age of 4 until the age of 14, describing his standard of education as 'not very high' and his schooling as:

> "Too Victorian you know sit talk when you're spoken too not until and things like that"
>
> (Frank, p.5, ll.223-224)

Like many other participants in this study, Frank suggested that modern day schooling lacked discipline. However, Frank's views departed from that of the majority in stating that the school discipline he had experienced was too harsh, so he would not welcome its return. Frank then gave great insight to the difficulty of trying to apply the past customs of his generation to younger generations:

> "What people do today I don't see the right or wrong I don't judge that's the way people are living today I lived yesteryear and nobody could have told me that I lived right or wrong that's the way I lived but today the patterns changed it's another era we're working in"
>
> (Frank, p.8, ll.361-364)

From leaving school Frank reported serving in the war and then working as a brick layer until his retirement, aged 63. The brevity of detail in his account was unusual compared to the work-life histories from other male participants, where dates, duties, and time served were central to the conversation. However, what Frank did focus on were the many interesting people he had met during this time. Socialising featured strongly throughout Frank's interview; he still had a

busy social life going out to meet friends a couple of times a week, an activity which offered him great support since the death of his wife:

> "Now when my wife died that was a shock and of course people were saying Frank what are you going to do I'd say oh I don't know --- now there's one thing my wife used to say to me --- Frank if I die first will you keep going to bingo well in those days I wasn't that hundred per cent interested in the bingo you couldn't get a drink there and things so I wasn't a hundred per cent --- and inwardly I would say no I'm not going to bother with that and a couple of weeks after I lost her people said Frank why don't we go to the bingo … come on we will go with you and we went to the bingo again and from then meeting people again and I got interested Heaton bingo is my second home I can go there on my own and people will say hello Frank and I've a special feeling with them all"

(Frank, p.16, ll.766-780)

Frank also identified that contact with his family, particularly his two granddaughters, was extremely important to him. However, Frank commented on his role within the family, indicating that he didn't feel able to deal with some situations:

> "Oh yes I haven't got a commanding role I've got --- I'm now oh hello granddad how are you and well the two granddaughters who I speak to on the phone and they come up and that one's [points to photo] coming up on Monday to see me they organise me now they got my central heating in they got my windows in new electrics in new carpets all over the house new units in there
> *R: Did you mind that?*
> No no no no because really it's something I wanted to do myself but I'm not sort of clever enough to be able to do things like that now or you know I can't speak to important people I wouldn't know where to start"

(Frank, p.19, ll.906-925)

4.4.10 Eileen

Since the death of her husband, Eileen now lived alone in their privately owned house.

On stating her age, Eileen said:

> "I can't believe that this is possible that I'm 89 now
> *R: You can't believe it?*
> I can't believe it no no the years are just flying over I mean it's been 5 years since my dear husband has died and I just sometimes think how I have managed without him but he's there all the time I've got great faith which keeps me going yes he's there all the time with me as a matter of fact he was in the room last week standing there [points to area within the room] the shadow came in just for a second --- I just sensed somebody came in through the door and I looked and he was standing there in his suit like he always did he always used to dress smart and I just looked then he disappeared but that was a great comfort to me
> *R: It was a great comfort?*
> Yes I know he's there all the time after that and that does help me an awful lot"
>
> (Eileen, p.1, ll.8-30)

Like Doreen, faith and attending church were very important to Eileen and she too had taken great comfort from this during difficult times of her life.

On recalling her childhood, Eileen explained that she had been born on the Isle of Wight and was the eldest of two daughters. The family moved to Newcastle upon Tyne for her father's work; she didn't remember much about her father as he died of peritonitis aged 32 when she was just 7 years of age. After her father's death the family went to live with her mother's parents in their council house. Her mother was required to work as she was not old enough to claim widow's pension. As previously identified, this period was some time before the introduction of the welfare state and benefits:

> “My mother had to go out to work at six in the morning because she worked in an office and she stayed there until she was 65 she became a supervisor but it must have been a very very hard life for my mother because she had no pleasure at all because she had to go out to work then come back and look after two children and in those days you didn’t get any money at all five shillings a week that’s all she got and these days you get pounds and pounds”
>
> (Eileen, p.2, ll.84-89)

Eileen compared her mother’s experience as a widow to that of her own, praising the introduction of the benefits system. Eileen’s mother never remarried and Eileen said she still felt ‘bitter’ about the hard and lonely life of her mother:

> “I know my father died but why did my mother have to be sacrificed because my father died”
>
> (Eileen, p.6, ll.268-269)

After leaving school aged 14, Eileen went to work as a secretary, resenting the fact that her parents had ‘allowed’ her older sister to join the WRENS and travel during WWII whilst she had to stay home with her mother. When Eileen married she gave up work and as her mother’s health deteriorated during the last 5 years of her life she moved in with Eileen, her husband and her daughter. Eileen recalls:

> “those were the happiest years of her life she would say and my husband was just like her own son he was so good to her --- yes she came and she was so happy here --- very happy indeed”
>
> (Eileen, p.3, ll.106-108)

Eileen’s mother died aged 79.

4.4.11 Florence

Florence was born in Newcastle upon Tyne and now lived in a privately rented house in the same city, with her husband and youngest son. She had three other children, two daughters who now lived in New Zealand, and an older son who lived locally and visited every weekend for Sunday lunch.

Florence described family and her ability to 'look after them' as being very important to her. She suggested that this 'value' had probably come from her childhood experience growing up as part of a large family, the youngest of eight children. During her childhood the family lived in a large property above a family-owned shop. Her father did not carry out shop work, instead being involved in the financial side of the business. When necessary her mother worked in the shop but mainly she took care of the family.

After leaving school Florence worked unpaid in the family shop for a short time until she married. When she was aged 21, her first child was born and WWII broke out, at which point she witnessed many of the single women being called to the war effort. Florence talked of regrets of not being able to go to 'work', something she endeavoured to remedy once her children were old enough:

> "For all I had an easy life I wanted to go out to work my mum --- stupid [laughing] --- never mind wouldn't let me I had to stay at home she would say 'and your father wants you straight home'
> *R: Is that what was expected of you?*
> I think so but when I looked at other people all my friends were going out to work it was just for coppers you see that was the argument with my mum she said if I could keep myself then by all means but there was no way I could keep myself you know … but that was the one thing in life apart from that I don't think I have had any regrets but I did think when I got my family up I said to my family I'm going out to work"

(Florence, p.14, ll.664-674)

In her 40s Florence secured paid work and continued in this job she 'loved' for 10 years, until what she described as a family problem occurred. Florence's mother died suddenly aged 70, leaving her father who was in need of constant care. After a family discussion, Florence gave up work and her father came to live with her and her family until he died at the age of 92.

Florence compared the opportunities she had with the opportunities for women today. This resulted in her not objecting when her own daughters wanted to move to New Zealand. In talking about this, it transpired that some time ago her husband had wanted to make the same move:

> "As it happens my husband wanted to go to New Zealand just after the war and I wouldn't leave my mother stupid really but there you are because my Mum was sort of domineering --- [sighs] --- yes I wouldn't say I encouraged them to go but I certainly didn't make any objections at all but I didn't want them to --- but that's the point"

(Florence, pp.21-22, ll.1038-1045)

4.4.12 Gordon

Since the death of his wife 1 year ago, Gordon lived alone in the same house in which they had raised their son and daughter. The house, a council property which in the past Gordon's parents had rented, featured strongly throughout the in-depth interview. Before this house, Gordon vividly recalled the living conditions of the one room he, his parents, four brothers and one sister had shared:

> "Well it was just you were just in the one room you had to eat and sleep in the one room like and that was bad that's how the bairns got pneumonia and died and that you know [Gordon's younger sister and one of his younger brothers had died as young children]
> *R: And what about a bathroom and a toilet?*
> Oh we didn't have those we just had to go through this old man's place at the back --- he rented the room next to us and he lived in the back room

and we used to have to go through his place to the back yard to the toilet"

(Gordon, p.3, ll.139-150)

Gordon's father had served as a colour sergeant in India during WWI and, like many, struggled to find work upon discharge. The family lived on hand-outs until finally his father gained employment at the shipyards, which, like coal mining, was a major industry and employer within the North East of England. At around the same time, Gordon's parents received the keys to their newly built local-authority house:

R: "What was the feeling like to go into that house?
Oh it was ten times better … you know we had a front room a kitchen well a scullery that's what they called the kitchen two bedrooms and a downstairs …
R: And can you remember moving in?
A ha then there were no roads the house had just been built there were no roads down or nothing we had to walk across planks to get the furniture in"

(Gordon, p.4, ll.165-178)

Gordon described his childhood overall as 'roughing it a little', however he never went hungry; even when food was in short supply he was fed bread and lard to fill up on and sometimes his father's friends gave them something from their allotment.

Gordon attended the local school from the age of 4 to 14. He recalled hating algebra and always feigned illness on the day; however, he loved art and painting. Like others he also talked about the discipline at school:

R: "So what was it like being at school in those days?
Oh it was grand --- mind if you done anything wrong you got the strap then --- we had one big teacher … he had this strap it must have been

about an inch and a half wide and then quarter of an inch or more thick you used to put your hand out and he used to go up on his toes and fetch it down if you tried to go like that [gestures moving hand away] you know he used to catch you on the blooming wrist
R: Did you ever get the strap?
Oh I had it once or twice" [laughing]

(Gordon, p.9, ll.424-436)

Gordon left school without formal qualifications and went to work as a delivery boy in various shops until aged 16. At that time he was able to get an apprenticeship as a joiner with Swan Hunter ship-yards. Gordon talked fondly of his working life and particularly his time at Swan Hunters.

Gordon, his brother and two of their friends had also joined the territorials 'not thinking that war would break out', and three years into his five year apprenticeship Gordon was called up into the Army. When he was called up he had to report to the shipyard immediately and was transported out the next day without saying goodbye to his mother:

R: "So you didn't even get to say goodbye to your mam?
No no went straight to down to Yarm … we done a bit of training down there … we were standing in the square in Yarm on the 3rd of September in full kit rifles and everything standing there in Yarm Square listening to Chamberlain announcing that England had declared war on Germany then we just went back to our barracks
R: And what was the mood like then?
Oh there was just --- everyone was there like you know we were standing fiddling with our rifles and that you know saying hey I felt great like you know when they … declared war on Germany like so we were did a bit learning on how to do explosives and all the rest of it like and that was that and we went down by boarding camp down beside Aldershot got inoculations and all the rest of it and we were over in France on the 27th of October
R: That quick?

> We went over on my brother's birthday he was 21 on the 27th October so that's when we landed in Cherbourg"
>
> (Gordon, p.17, ll.808-834)

After WWII Gordon returned to Swan Hunters and moved back into the family home, where in his own words he decided:

> "I had just come out the army like and I says oh I'm going to have a few years on the loose like you know --- having a good time with the lads"
>
> (Gordon, p.21, ll.1031-1032)

At the age of 30, Gordon married a local girl one year younger than him and when his father died in his 80s, Gordon, his wife and their two children moved back into the same house Gordon so fondly recalled moving into as a child, to now look after his mother, who lived until she was aged 90.

Gordon retired from Swan Hunters aged 64, after which he felt he'd 'slowed down considerably'. At the time of interview Gordon described his main health problems as loss of mobility and, more frustratingly, loss of sight due to macular degeneration. In this regard, Gordon stated he felt a burden to his children, particularly since the death of his wife. However, the familiarity of knowing exactly where everything was in the house afforded him comfort and independence.

4.4.13 Gwen

Since the death of her second husband just over a year ago Gwen lived alone in a privately owned house. She had one child, a daughter to her first husband.

Gwen was born and lived her childhood in the centre of Newcastle upon Tyne with her parents, two sisters and her brother. Gwen's father had his own business but when she was aged 11 he died suddenly, and in the absence of

the welfare state Gwen's mother, like Eileen's, had to work 'to make ends meet'. This she did by making pickles and preserves and selling them door to door.

Gwen described herself as a 'feisty' child and said her mother had called her 'the tiger', her younger sister being 'lady la la' as she was the prim and proper one. Gwen, with some delight, illustrated this through recalling an event at school:

> "I've always been a bit of a one --- at school I was prefect and I got un-badged in front of the whole school for standing behind the school house door when prayers were on eating my sausage sandwich"

(Gwen, p.18, ll.867-869)

Leaving school aged 14, Gwen worked in a factory where she met her husband. Aged 19, Gwen gave birth to their daughter and for financial reasons moved in with her mother, who would provide childcare whilst Gwen went back to work. Tragically Gwen's mother died just 3 years later, and at the same time her husband left her for another woman:

> "My younger sister had just been married and so she came and lived with me because she thought my husband was going to come and divorce me and it wasn't fitting so she says and she came to live with me and I was at work and she phoned one day to say he was taking all the furniture out of the house every stick of furniture he even took all the bairn's clothes with him out on the street and honestly --- I didn't deserve it"

(Gwen, p.4, ll.168-173)

Gwen continued working and met her second husband when her daughter was 13.

Gwen described her family as not very big but very close. However, Gwen was quick to add she still liked her own place and it was enough seeing family every

day, this after a recent heavy cold which worried her daughter so much she had wanted Gwen to move in with her. Gwen had ‘firmly but politely’ refused.

4.4.14 Harriett

Harriett was born and had lived in Newcastle upon Tyne all of her life. She had three older sisters and a younger brother; until the age of 8 she had to share a bed with the latter, of whom she said:

> “I had to cart around with me all the time because he was younger”
>
> (Harriett, p.1, ll.33-34)

Harriett talked with great affection of her father being a strong man. One incident she recalled was returning from school to find her father, a coal miner, having been brought home after a pit accident:

> “I remember coming into the house seeing him in bed --- he wouldn’t go to hospital or anything in fact he wouldn’t have the ambulance bring him home in case he frightened my mother --- but I remember his leg turned black right up to there [gestures above knee] the doctor when he came said oh you’ll have to have your leg off but the woman down the street she used to keep pigs and she used to have bran and all that for the pigs and she used to bring the hot bran … and put it on my father’s leg oh I used to hear the swearing [laughing] but it took all the blackness away and all he had to get was his big toe off”
>
> (Harriett, p.2, ll.88-97)

Harriett’s father didn’t work for at least 5 years after his accident, eventually returning to work at the top of the pit. As identified earlier, coal mining was extremely dangerous and many men were injured or killed. The North East suffered loss of lives during ‘pit disasters’, and in chapter 5 some of the men talk of the hardships of this work and recall childhood memories of the

Montague pit disaster in 1925. Harriett's father lived until he was 84; her mother, a housewife, until 83.

Harriett started school aged 4, and at the age of 10 her headmaster put her forward to take an entrance exam for grammar school, to which her parents had to contribute three pounds a term:

> "I passed my scholarship and went to the secondary school when I was 11 … if my father had been in the forces I would have got my uniform paid for but … my mother had to buy the uniform which was mostly second-hand --- I used to think everybody had money to spend at school but me --- but really they done their best for me"

(Harriett, p.3, ll.136-140)

Leaving school aged 17, Harriett refused jobs working in shops. She wanted an office job. Her old headmaster arranged an interview for her in the offices for Raleigh Cycles; Harriett was successful and worked there throughout the war, being exempt from war duty. During this time Harriett met her future husband; he was called up to serve in the war and posted to the South of England for training, and here he was told he was to be transferred abroad:

> "So he got in touch with the minister at the army and … arranged for us to get married on Saturday so he says get such and such train down to London and I couldn't take it all in properly … I couldn't go out and seek a dress or anything I didn't have any coupons with me --- the manageress [where Harriett worked] said she had plenty coupons that I could borrow but of course all the shops were closed … so all I ended up with was a new hat so I definitely had something old something new"

(Harriett, pp.9-10, ll.447-460)

Harriett and her husband saved until they had the money to buy their own house; this was unusual at the time and according to Harriett, was the cause of jealousy.

Harriett and her husband had three children, two girls and a boy. One of her daughters had now moved to Australia, her other children still lived in the North East but not ‘too close by’ according to Harriett. She also had three grown-up grandchildren. Harriett now lived alone in the family home since the death of her husband 6 years ago. She recalled looking after her husband who had been ill for about a year before his death:

> “Well he just used to sit you know I used to wash him a little bit but he didn’t like --- I got a young lad from Social Services he came but he didn’t like anybody looking after him the lad just used to wash his hands and his face he wouldn’t let him wash his body or anything --- he didn’t like anybody looking after him it was his job to look after me”

(Harriett, p.14, ll.667-674)

4.4.15 Harry

Harry lived in Newcastle upon Tyne in a privately owned house with his wife. Harry confirmed during the interview that although their first child had died in infancy they had fourteen children and remained a very close family. He was particularly proud of how his family had ‘turned out’ and he still felt an important figure in their lives.

Harry was born in Gateshead, moving to Middlesbrough with his father’s job as area manager of the brewery when Harry was aged 8. He was an only child, but unlike Anne, he reported to having many friends and never feeling lonely. Harry compared his childhood behaviour to that of today’s children:

> “As a child I was never in the house as long as I could get out for football cricket always had some physical activities and I think that kept us healthier children these days are more overweight because of television they sit in the house and they don’t exercise enough”

(Harry, p.2, ll.67-70)

Harry then went on to talk about work, reporting that he had continued in paid work up until the age of 81. At this point the interview shifted in focus around the deterioration in his health, which had led to his retirement. The theme of deteriorating health continued to dominate as Harry who had suffered a major stroke 4 years ago, appeared to be very much still coming to terms with the effects of this:

> "I had to live with it --- I made a remarkable recovery I think --- but the after-effects now are becoming more paramount my legs have suddenly gone --- I used to do a lot of dancing and that and that seems to have all gone in the last twelve months the deterioration has been more rapid in the last twelve months"

(Harry, p.3, ll.113-116)

Harry did talk briefly about his time in the Army: the excitement and comradeship and how Army life was healthy:

> "The army made you healthy the physical training in the army you reached a fitness … I don't think I would have reached if I had not been in the services"

(Harry, p.5, ll.206-208)

4.4.16 Ian

Ian was born in Newcastle upon Tyne, the eldest of four brothers. During his early childhood his family lived with his grandparents, until they were given a room with no private facilities:

> *R: "Do you think those living conditions … affected your health?*
> Hey I'll tell you people were dying with consumption just like that --- T.B. you were one very lucky family if you didn't lose somebody"

(Ian, p.1, ll.40-46)

Ian's family lived in these conditions of poverty all through his schooling. Ian also raised the subject of having to pay for healthcare, as the National Health Service was not established until 1948:

> "Pet hey the conditions hey you know what it is the conditions that us lived in English people --- well the working class … they divn't know what poverty is I didn't know what money was --- you know pet --- my Dad he had ill health he had bronchitis it was my mother who kept him alive do you know how she kept him alive --- with putting poultices on his chest
> *R: A poultice?*
> You know what the poultice was made of --- bread --- bread boiled in an oven and put on a linen and put on his chest for the heat well unless … they've got linseed oil or something like that --- but that was the old fashioned system in them days
> *R: Did you not ask a doctor to come and see to him?*
> No do you know what you had to do to get a doctor … you had to pay so much a week you had to save up --- so people never used to bother with them they hadn't the money you know a penny was a penny you know it was terrible pet"
>
> (Ian, pp.2-3, ll.76-111)

Ian's father died from bronchitis during one particularly bad winter, he was aged 48; his mother lived until the age of 80 and never remarried.

Despite living in poverty, Ian, like other participants, talked of never feeling hungry:

> "The food I ate was great --- the reason why every day we had we at least had a hot dinner but it was something in the present the majority rabbits you know chickens was a luxury nobody bought a chicken … but sheep head boiled we used to make a soup out of it we used to go to the fruiters and get what they used to call a packet of pot stuff … a turnip a carrot and a leek you know and you made broth with that and in the broth

> you made suet dumplings and put them in you know … we didn't get any luxuries … we used to get jam on a saucer a penny packet of tea pet hey I've seen all that you know seen all that terrible the conditions --- conditions for people unemployment was terrible hundreds of fellows standing about on corners ends nothing to do with their time you know just shortly after the First World War you know my Dad was one of them you know he had worked on the ship yard and he was finished"
>
> (Ian, p.3, ll.115-131)

At the age of 14, Ian's parents were offered a newly built council house. When he first married, Ian and his wife were also given a council house which he described as 'infested'. Ian, who was not called up during the war - instead being retained at the shipyards to build warships - saved every penny towards buying a property for his family. He had two sons and a daughter, and it took until his daughter was 14 years of age to move out of council housing into private housing, an achievement he seemed to recall with great pride. Ian retired aged 65. The house he had worked so hard to buy was sold when his wife died over ten years ago and he now lived alone in a small council property.

4.5 Researcher Vignette

White, female, and born in Newcastle upon Tyne's General Hospital in 1967. The eldest of four siblings, having one brother and two sisters. My father worked for the local council as a foreman joiner until he was retired aged 58 on medical grounds. My mother was a housewife until I was aged 14, when she returned to part-time paid work and then full-time work. She retired aged 60. Our family home was provided by the local authority and situated in a densely populated estate. My parents purchased the house under the Conservatives' 'right to buy' scheme.

I left school aged 16 with some qualifications, and worked in retail until the age of 19 when my first son was born. Four years later I married, and one year on I gave birth to my second son.

In 1993, with childcare support from my parents, I returned to education - enrolling in a higher education foundation course for adult learners. Results attained secured a place at university to undertake a BSc degree programme in Nursing Studies which was completed with first class honours. During the time at university the marriage to the father of my children ended.

From my studies and in the early stages of my career, I developed an interest in the field of ‘geriatric care’, as it was then known. Primarily this was due to observed variations in the care of older people from placement to placement and also when compared to other areas of care. It was also observed that at this time the topic of ageing within the degree programme was delivered within one half-day of teaching, which was focussed very firmly on biomedicine, here associating increasing age with disease and loss. Many of these observations appeared at odds with my professional and personal experiences with older people, who were vibrant, engaged, and in many cases central characters within their family right to the end stages of life. To expand, longevity within my family is common and I grew up with two sets of grandparents and great-grandparents. Being ‘typical’ of North East families who tend not to move away from the area, resulted in close proximity and day-to-day contact within our family. Ultimately, these diverse experiences led me to question attitudes held towards older people, and how these might affect the training of health professionals and ultimately the care delivered. Here, there seemed great potential to make an impact, and so I made a career choice to practice in this area. One of the prevailing memories of this decision was a ‘professional’ comment made to me that ‘I would be wasted’.

I was fortunate enough to secure a nurse post working within a day unit which aimed to centralise health care for older people under one roof. Here, care crossed primary, secondary and tertiary boundaries, providing specialist clinics, diagnostics, and rehabilitation. Within 2 years I gained promotion to senior nurse in charge and became involved in clinical research. Such was my interest in research, I pursued a career pathway to a senior position managing clinical trials, to completing an MSc Research Methods programme with distinction, and ultimately to combining this with the field of ageing in my current position as

Senior Research Nurse Manager within the Institute for Ageing and Health, Campus for Ageing and Vitality, Newcastle University.

In 2007 I married again, gaining two step-children around the same age as my sons, and a father-in-law who is now aged 93 [2013], generally adding to the complexity of life.

4.6 Summary of Main Themes from In-Depth Interviews and Comparison of Key Sociodemographic Variables (85+ Structured Interview Sample and In-depth Interview Sample)

Figure 8: Main Themes Emerged from Qualitative Analysis

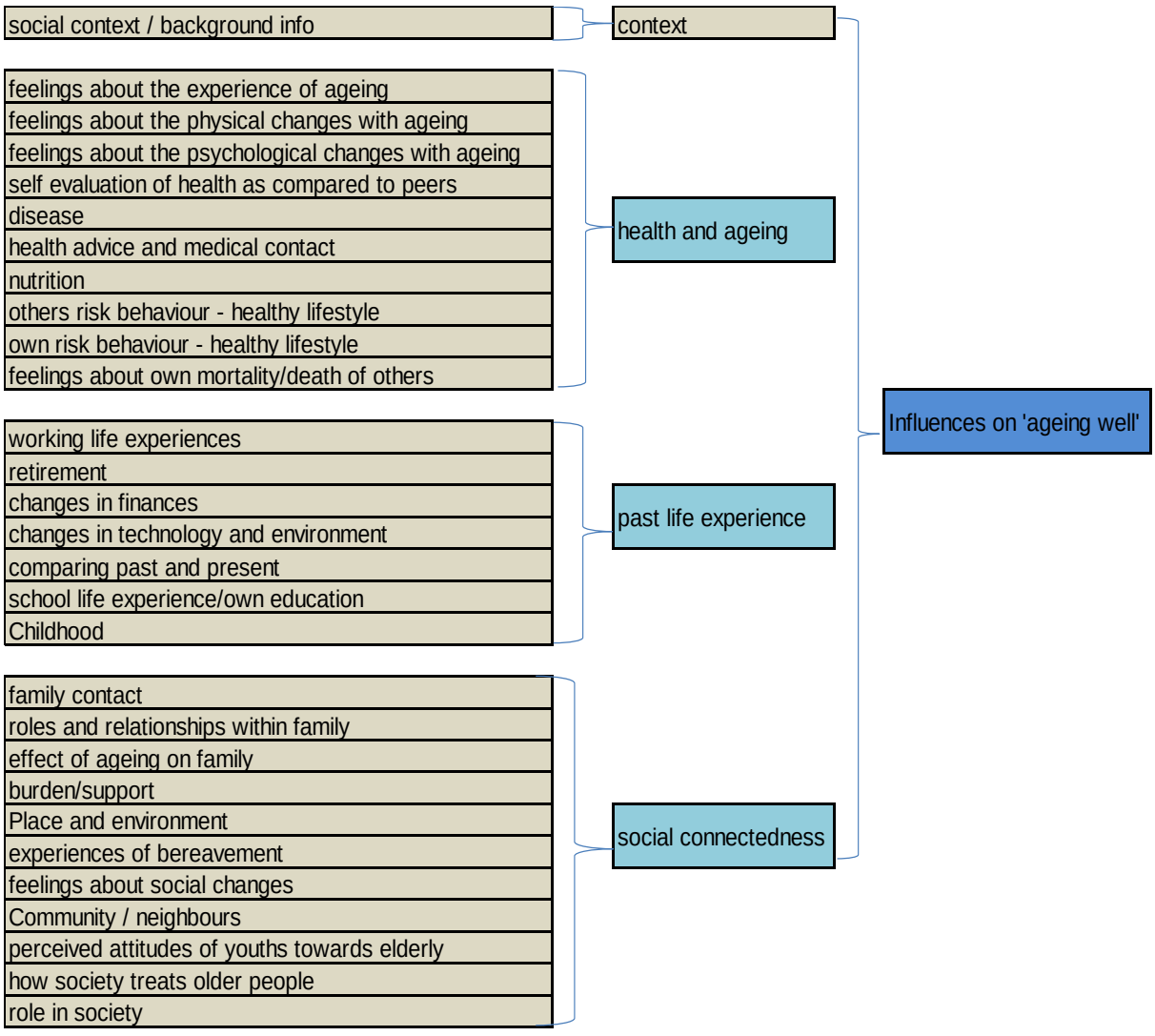


Table 5: Comparison of Key Sociodemographic Variables

Variable	% 85+ Structured Interview (n=89)	% In-Depth Qualitative Interview (n=17)
Male	45% (n=40/89)	53% (n=9/17)
Female	55% (n=49/89)	47% (n=8/17)
Married (ever)	96% (n=85/89)	100% (n=17/17)
• *Now Widowed*	62% (n=53/85)	65% (n=11/17)
• *Now Divorced or Separated*	0	0
Never Married	6% (n=5/89)	0
Had children	80% (n=71/89)	94% (n=16/17)
Lives in Care Home	3% (n=3/89)	0
Lives in Own Home (house, flat, bungalow or Sheltered accommodation)	97% (n=86/89)	100% (n=17/17)
• *Lives Alone*	57% (n=49/86)	59% (n=10/17)
• *Lives with Spouse only*	34% (n=29/86)	35% (n=6/17)
• *Lives with others*	9% (n=8/86)	6% (n=1/17)

4.7 Summary

This chapter has met its aims in chronicling key data detailing recruitment figures and broadly defining the study population in terms of its main social and demographic characteristics, tabulating [table 5] these characteristics to compare those participants who participated in quantitative interviews and those who participated in quantitative and qualitative interviews. Further rich description, in the form of vignettes, was also provided for those participants who took part in in-depth interviews, as well as for the researcher, in order that the reader 'know' the key players in the study and their potential for historical and personal influences. Some of the main themes emerging from participants' dialogue being introduced within the vignettes.

Ultimately, the combined information presented provides an explicit, robust description of context and adds value to the more focussed discussion of findings now presented in chapters 5, 6 and 7.

CHAPTER 5: EXPLORING THE PAST LIFE EXPERIENCE OF WORK AND TRANSITION TO RETIREMENT AND THE RELEVANCE TO 'AGEING WELL'

> "*R: Do you feel any different now to when you were younger?*
> Well --- the fact is that age has taught me a lot of things which I hope at some time I've used to an advantage … you don't realise that you're picking these things up but they are there … younger people have still got to learn and you're there you can tell them things that's happened in your life and hope that they pick a little bit up ... you know that's the whole purpose of it --- it's a natural thing"

(Cyril, p.18, ll.858-882)

5.1 Overview

Upon first consideration of data from in-depth interviews it quickly became apparent that participants had experienced and navigated their way through many significant historical and personal challenges during the course of their everyday lives, some examples of which were used to inform and provide context to the vignettes within chapter 4. Perhaps unsurprisingly, evidence and timelines from the literature [appendix M] inform us that individuals who have lived longer are more likely to have been exposed to challenging life events, and in many cases, have come to successfully master strategies of adaptation or acceptance in order to cope with them (Marcoen et al 2007).

The idea of 'successful mastery' is closely linked to areas of psychological literature, where individual influences on ability to cope with, adapt to, manage and accept change are considered. Where previously this literature drew heavily upon theories of personality (Harris and Cole 1980), more recently the focus has shifted towards examining 'protective factors' using terms such as 'resilience', 'emotional regulation' and 'hardiness' (Isaacowitz and Blanchard-Fields 2012; Miller 2010). Particular emphasis has also been given to the potential for individual growth, whereby experiences of change, or as now more commonly termed, 'transitions' throughout the life-course are regarded as a process rather than a series of isolated events (Arber and Evandrou 1993;

Martin and Martin 2002). In this perspective, the experience and management of past transitions impact upon future transitions. The relevance of this in relation to 'ageing well' is only now starting to emerge, with studies examining the long-term effects of childhood experiences such as, parental care, childhood nutrition, education and cognition, and childhood stress such as loss of a parent or parental divorce and how these 'play-out' into adulthood (Martin and Martin 2002; Cho 2011; Gale et al 2012). Despite this, the overreliance on empirical measures and an absence of good qualitative in-depth exploration, such as might bring the perceptions of the individuals themselves to the debate, is a missed opportunity that arguably limits our understanding of the issue. Indeed, during the in-depth interviews of this study many of the participants spoke of their childhood experiences as 'character building', developing a 'good work ethic', learning 'discipline' and being 'active'. Thus adding significant perspective to objective quantitatively derived measures of education, occupation and socioeconomic status in relation to 'inequalities', 'hardships' and 'disadvantage', characteristics which are now more often used by researchers to identify resilient or 'robust survivors'. One particularly extreme example of which examines the experiences of Holocaust survivors now reaching advanced old age (Shmotkin et al 2011). In the present context however, it could be said that individuals who have lived beyond their 85th year are indeed survivors and therefore these characteristics deserve our attention.

To consider the challenges of each past life-course event raised by participants during in-depth interviews is beyond the scope of this chapter. Therefore, to explore in detail the relevance of these events to 'ageing well' the theme of work and transition to retirement was selected. The rationale for this decision was that this 'theme' emerged, somewhat unexpectedly, most strongly from in-depth interviews. However, findings from the literature suggest that the transition from work to retirement is frequently cited as one of the major periods of change during an individual life-course (Miller 2010, Martin et al 2011).

In establishing why the transition from work to retirement is particularly challenging, this chapter first provides some contextual discussion toward some of the key historical aspects of work that the participants of this study would have lived through, given that the period an individual has lived through also

has a bearing on forming individual attitudes and expectations, affecting management of transitions (Arber and Evandrou 1993). The chapter then considers data examining the nature of work, in terms of its value in providing resources and 'gains' which may become challenged in retirement. Throughout, evidence is presented which highlights different and often disparate experiences from two primary standpoints, the first relating to manual and non-manual paid work, the second to gender. The discussion then moves on to consider the transition to retirement, illustrating that the demographic shift toward an ageing population has required legislative responses. Influences on and experiences of retirement are also detailed taking into account how these 'realities' mapped to expectations, where again issues of gender are highly relevant.

The chapter then summarises the key issues, in order to provide broad insights as to the extent to which the challenges of past-life experiences affect 'ageing well'.

5.2 An Historical Context

From a policy perspective, the impact of population ageing and the formal workforce is a key topic debated at length within the literature. Without doubt, World War II (WWII) is located as a fixed time-point for the structured rapid decline of older people within the formal workforce, and three main explanations for this are given: (i) the decrease in demand for labour and skills offered by older people with the shift away from industry; (ii) a reduction in labour and withdrawal from roles by older people which may be explained by the thinking of the day, such as the now-discredited disengagement theory [chapter 2]; and finally (iii) some combination of the two previous factors (Orbach 1963 cited IN Harris and Cole 1980, p.253; Walker 1983 cited IN Jeffereys 1989, p. 65; Phillipson 1990; Künemund and Kolland 2007).

For the participants of this study who would have been aged 21 years when WWII broke out [appendix M], living through this key period will have played a major role in shaping their accounts of work. Women's contributions to the war effort during WWII had a significant and lasting impact upon the role of females within the economic work place, as prior to 1939 work for women was mostly

limited to secretarial or domestic services. This was observed within many of the female participants' in-depth interviews, where it also emerged that upon marrying and having children the expectation was for women to leave work and concentrate on domesticity (Lewis 2001). However, as more men were conscripted to or volunteered for service, women were encouraged to fill the roles traditionally thought to be men's work, culminating in the National Service Act of 1941 and the legal conscription of women; this in addition to many women still running the home, although now without the support of their husband (Harris 2011). At the end of WWII, women were summarily dismissed and expected to return to unpaid domestic work. Here the government is accused of using John Bowlby's theoretical concept, the 'idealisation of motherhood' to influence this, where the social and developmental disadvantage those children, termed 'latch-key kids', of mothers going out to paid work was powerfully described (cited IN McLeod 2007 online). Yet, as will be illustrated throughout this chapter, this encounter with independence is recognised as changing society in terms of women striving for equal opportunity and equal pay.

5.3 Work

Influences such as education, undoubtedly guide an individual's particular work-life pathway, also bound up with this is complex debate on socioeconomic inequalities and their impact on morbidity and mortality (DHSS 1980; Townsend et al 1992). In economic terms, one of the main functions of work is given as providing an individual with financial reward (Harris and Cole 1980). This stance, however, is heavily contested by sources advocating that it assigns little or no status to unpaid work predominantly undertaken by women (Freidan 1963), this despite the economic value of unpaid domestic work being estimated at around £739 billion per annum (Stevenson 2008).

Some of the gendered complexities surrounding work have already been alluded to within chapter 4, when describing the challenge of determining the socio-economic status of female participants, primarily as a result of the system failing to recognise unpaid domestic work (Reid 1981 cited IN Crompton 2008, p. 51). Here, all female participants were deferred to their husband's

occupation, despite nearly three-quarters (n=35/49) of female participants reporting to have undertaken paid work. However, if 'head of household' classification had not been adopted then approximately one quarter (n=13/49) of female participants reporting 'housework' would have been excluded from any quantitative analysis drawing on social classification. In this regard, Fisher (2003) concludes that neither the labour market nor the household is gender neutral, and both tend to favour males. All forty men reported a paid work history.

Due to its demands and interdependence on others, work is viewed for many as a constraint or matter of duty, with transition to retirement bringing a sense of relief and new opportunity (Sweet and Moen 2012). Conversely, to others these same demands provide structure and purpose to everyday life, giving an individual a sense of identity and a means of obtaining the esteem and camaraderie of others (Harris and Cole 1980). Despite these conflicting views, experiences of work clearly held great importance for participants, as when asked "*Tell me about yourself*" during the opening conversations of in-depth interviews, much of the conversation from the age of leaving school, for both men and women, was dominated by detailed accounts of work.

Broadly, from the analysis of in-depth interview data, two main categories emerged from participant accounts of paid work, namely: those who had undertaken manual work such as heavy industry, and those who had undertaken non-manual work primarily in a more managerial capacity or profession. This finding, despite the previously noted gender issues, maps to the two most commonly populated categories of the NS-SEC head of household (category 2.0: lower managerial and professional occupations (21.8% n=19/87) and category 7.0: routine occupations (20.7% n=18/87)) from structured interviews, the full details of which were presented in chapter 4.

5.3.1 The Nature of Work: males

For those male participants who had undertaken manual paid work, their story usually started out in some form of retail as a means of earning money until they were old enough [16-17 years old] to take up a trade apprenticeship or 'serve their time'. The main employer in the area at that time was Swan Hunters

shipbuilders, commonly referred to by participants as Swans. As both Gordon and David illustrate below, this event marked a coming of age, a transition from boyhood to manhood, and 'gains' felt from this, such as pride, belonging and camaraderie are introduced:

> "After the shop I was sixteen and tried to get a job and serve my time as an electrician but there were no vacancies at Swans for that the only vacancy there was was for a joiner so I said I might as well take that
> *R: Can you remember the first day?*
> Oh it was old then just walking through the old wooden gates then I remember
> *R: What did you feel like when you were going through those gates?*
> Oh it was different than working in shops like you know you felt all grown up with all the other blokes
> *R: So you preferred that?*
> Aye and the older fellas who were there --- there were some old blokes proper joiners you know
> *R: What did you think of them?*
> Oh they were good blokes like but if you used to get hold of a hammer and if you didn't hold it back over like we used to get it right at the front you know right at the head at the head like that [demonstrates] you used to get your knuckles rapped to keep your hand back properly on the handle hammer [laughing] they used to rap your knuckles and say 'get a hold of that properly' and bash you with it --- bash your knuckles with it--- there was one lad couldn't get away with holding it at the bottom a bloke got a hold of his hammer got a saw left about this much of the hammer shaft on you know about three inches he cut the rest and the kid started crying his eyes out aye it was a proper old wooden claw hammer you know and he cut the handle off because he wasn't using that end
> *R: So did you enjoy your time at Swans?*
> Oh aye"

(Gordon, pp.11-13, ll. 643-734)

“I left school at fourteen and I got a job in the butcher’s shop and the butchers we used to help him kill the steers and that you know … we had our own yard for slaughtering them in … I used to serve in the shop and on a Friday we used to get a bicycle out you know with the big metal front and the little front wheel and we used to get that and fill it up with about a hundred and odd parcels of meat sausage all kinds of butchering fill the basket right up and set off and deliver them ... to about forty or fifty places maybe … I was knackered after that --- yeah after the butcher’s shop I went into the yards there at Swans and I think I was what seventeen when I went in there and I used to work on the ships as an apprentice plater --- ah the jobs were dangerous then they had laddies about twelve year old maybes fourteen you know some of them just come away from school and they used to go as rivet lads … you would hear someone shout ‘Hoy a hot un’ and the rivet lads would get the tongs and throw it [a rivet out of the fire] a good way up … and a catcher had a metal … funnel … and we’d be watching for the rivet coming and catch it in that and then he’d … get the windy guns you know the little hammers he’d be on one side and the other one the other side he’d be hurling the windy hammer on the other side and … you know and blow all the metal round it on the side until it was flush into place and they would spray the end you know like that to make it like a mushroom --- they used to do that with all the rivet holes you can just imagine all day doing that … a new starter there --- the ladies … his mother would buy him a boiler suit or a bib and brace and she would get him a new cap and the first thing you used to hear is ‘oh he’s a new starter’ they’d take the cap up and they’d rub it in all the rust and everything like that you know and they’d go home when they finished at five o’clock and they’d go home and they’re as proud as owt ‘ooh he’s had a rough day’ they’d tell their mother --- it was comical the way they went on but there was camaraderie no doubt about it they all worked hard no doubt about it they all worked hard and they loved it”

(David, pp1-6, ll.51-282)

Although both of these participants talk of the rituals of entering the adult world of work, the excerpt from David draws particular attention to the physically demanding and dangerous nature of the work. This subject was echoed by many of the men who had undertaken manual work, with some comparing their experiences with that of modern day, drawing two main conclusions: firstly, suggesting that the physicality of their work had kept them healthy and strong, a benefit which much of modern day work could not offer and one which will be explored in the following chapter, and secondly that people today would not accept the conditions they had worked in. When questioning this apparent change over time, participants offered the explanation that this was the natural order of progress, where the working conditions of their fathers had been worse and something they themselves would not have accepted. Here Alan picks up this point, talking around his poignant childhood memories of a mining disaster and the accepted danger of this kind of work and how, although things had changed with the introduction of health and safety, there was an acceptance that things can always be improved upon:

> "... I remember standing in Scotswood when Ginger [one of his father's friends] come running along in his work clothes shouting the Monty's a-flood [Montague pit] --- that was 1925 ... and he come he was one of the ones that got out --- he lived along there you know he had to pass my place to get to his home he was going home he didn't know what he was doing --- and me father took us up that night --- up the Monty and I went and --- well he didn't take me right up the family went up we were standing and the Monty was up the bank a little bit and they were pumping the water was pumping pumping out it was too late then it was you know it was all over then and --- and then I remember the funeral after they got them all out --- it absolutely poured and --- and it affected me that because you you feel as if God's not doing this you know --- and it was a mass funeral --- and it poured and poured of rain that day --- just one of those things I was too young then in 1925 I'd only be seven year old but I knew that Ginger bloke and I was bound to have known other people that was dead oh it affected me you see I can still remember it it's one of the things in me mind … oh there was more risk then than what there is now --- because the first thing they do before they go on any kind

of job any kind of work is safety there was no such thing as safety then they didn't know about it the job had to be done so you just had to do it
R: So do you think things have changed for the better in some ways?
Oh they're changing for the better all the time but they'll never catch up
R: What do you mean by that they'll never catch up?
Well as you sort one thing out there's another problem"

(Alan, p.15, 11.706-747)

In the following quotation from Ian, he reflects upon his own work conditions and in comparing this with the work of miners, describes why he 'stuck with it' to provide him with the desired income to support the life he wanted. However, Ian was clear that this was not a life he wanted for his children:

"For all I went through hard times at work --- I've been to work I've come home sore you know oh aches and pains you know they talk about work now you know but there's one job that was worse than mine that was the pits [coal mine] --- then mine --- ours was the second --- ship building
R: And what made the pits worse?
Conditions --- conditions not only that the accidents that happened we had accidents in the ship yard but in one pit alone 186 people killed in one go just like that in the pits terrible terrible --- there were thousands killed in the pit terrible --- oh the conditions … well to tell you the truth I've had some hard times I would say it's a lot easier these days you know at one time I should have changed my job but I couldn't get a job that great in cash you know to keep me in the way I wanted to do --- so I stuck with it like but I said I didn't want any of my children to go into the ship yard no"

(Ian, p.22, ll.1071-1094)

For the men in the non-manual work group, such as Harry, conversations placed more emphasis on a sense of status, of 'being in charge', and the responsibility this carried for the welfare of others:

> “I became in charge I became a manager and I had an office job as well as an outside job ... I had an administrative responsibility and then I had a responsibility to the commerce of selling and the team of salesmen --- there was a lot of mental work involved”
>
> (Harry, pp.5-6, ll.225-271)

The mental capacity of the work rather than physicality or danger was a topic reaffirmed by Bill who, by his own account, had never experienced danger at work - having worked in the Ministry as a Civil Servant since its opening until his retirement. For Bill, it seemed important to emphasise the intellect his work had required and that he had not allowed this intellect to dwindle some twenty plus years later. One particular example of this arose when Brenda, his wife, was complaining about the space Bill had taken over in the lounge:

> Brenda: “I’m going to tell them and he won’t like it I mean look at that corner he’s got all of that room and I’ve got this little bit --- can you see
> Bill: Yes and this bit [points to the corner of room] is mine
> *R: So the books and papers and everything there are all yours?*
> Bill: yes
> *R: And is that important to you?*
> Bill: Yes
> *R: And why is that important can you just explain a little bit?*
> Bill: Because it’s an environment to which I’ve been used to all of my working life --- do you get it
> Brenda: Excuse me he sits there and does crosswords he’s a crossword buff and sends them all in and one week he won both The Observer and The Times crosswords the same week and he had a letter from an old man who lives down south
> Bill: In Devon
> Brenda: In a place called the Hold and he said I’ve been trying to do that all my life but never mind congratulations to you --- he’s very smart”
>
> (Bill and Brenda, pp.21-22, ll.828-857)

5.3.2 The Nature of Work: females

For the women, although it was still possible to identify the two broad groups of manual and non-manual paid work, accounts from in-depth interviews tended to chronicle a less rigidly bound work pathway than that of the men, introducing additional dimensions such as the desire to work versus constraints. This compares to data gained from structured interviews where nearly a third (n=11/35) of the female participants who undertook paid work also reported a significant interruption when starting a family.

Constraints for women are widely reported within the literature as a phenomenon which cuts across the breadth of the social spectrum. Factors such as raising children, caring for or supporting husbands and caring for older relatives are all cited as responsible (Sefton et al 2010). Literature in this area also suggests if these women do return to work it is generally at a lower paid, or part-time rate, to fit around family commitments, which undoubtedly puts them at a disadvantage in terms of pensions and other financial entitlements (Phillipson and Walker 1986 cited IN Hockey and James 1993, p. 111; Hardy and Shuey 2000; Baum 2002, Fawcett Society 2010). Certainly data from structured interviews indicates that female participants were 80% less likely than their male counterparts to have an occupational pension. Here, Sefton et al (2010) conclude that this is primarily as a result of the pension system not being designed to meet the needs of women and their different life-course experiences. Rather, it was constructed on the 'breadwinner model' and the assumption that women would depend upon their husbands' occupations, again indicating a gender disadvantage.

The following from Anne illustrates this 'disadvantage'. It also highlights the constraint of prejudice against women entering certain professions, such as first introduced in Anne's vignette [chapter 4] when she talked of her determination to study medicine despite attempts from her teacher and parents to steer her toward a more "acceptable" career for a woman:

> "… There was still prejudice … the year we married 1947 in the spring of 47 I got this job as school medical officer in Newcastle and I kept on with that until 1950 when I worked until ten weeks or so before my first child

was born and retired from work then [aged 32] and had my second child in 1953 and still didn't do any work --- my youngest son was just about two at the time and I didn't want to leave him then oh yes this Doctor asked if I would be interested in a half-time salaried job helping doing baby clinics and I applied for the job and I got it … and I was still fortunate enough to be paid as a half-time salaried doctor I was very lucky from that point of view … oh there's one thing I do regret very much I was badly advised actually if this ever crops up in your case for goodness sake do it but you see because I was only employed half-time and I only paid into the pension scheme from 1974 when we were taken over so when I retired I only got about eighty pounds a month pension … but I very very much regret not buying extra years and I always said to other women who have been talking about pensions to watch out for that"

(Anne, p.3, ll.103-148)

Over the years, historical forces have broadened the career opportunities for women. Due to this, there has been an increasing feminisation of the workforce, and medicine is no exception (Elston 2009), and yet economists and researchers fail to focus on the unique work-life experiences of women and their transition to retirement, instead continuing to base findings on typically male pathways (Moen 2001; Künemund and Kolland 2007).

Picking up on this notion of an increasingly feminised workforce, the following from Gwen compares current trends to her own childhood experiences, alluding to the influence of consumerist attitudes. Gwen also introduces the idea that the drive for financial independence is the reason for women having fewer children:

"As a child I had a wonderful home life wonderful … I think life it's just as good now but I think it's just the way they live now I think it's women having to work let's face it they need to keep a really good home now I think that's got a lot to do with it --- they're all expected to work because one man's wages doesn't keep a house and buy the things they want nowadays

R: Do you think that that's a bad thing?
Well I don't think a lot of women want to stay at home --- they don't want to I think it's changed completely
R: Why do you think they don't want to stay at home?
Well a lot of women like to be independent I think and a lot of them won't have a lot of children"

(Gwen, p.18-19, ll.877-897)

For female participants within the non-manual paid-work group, higher professional occupations such as medicine represented the minority, with the majority being made up of office-based or secretarial occupations. Harriett typified this and, as her vignette in chapter 4 highlighted, she recalled with some pride passing a scholarship to attend secondary school. Despite this achievement, Harriett's parents had expected her to follow her sister into retail work and Harriett recalls having to 'find the nerve' to manipulate such an external constraint to fulfill her aim of working in an office. Harriett did this successfully and worked throughout WWII until the age of 28 when she left work to start a family. Harriett never returned to paid employment:

"As I say I went to work in the chemist which I didn't like … I just wanted to work in an office I didn't want to work in a shop … my sister said try Freeman Hardy Willis it was a shoe shop … I was put on a month's trial but at the end of the month I told them I didn't want to work there I don't know where I found the nerve because jobs were quite scarce …
R: So what happened when you went home and said that you were not taking the job?
Oh I didn't say that I refused to stay I just said oh the jobs finished now and the headmaster from the secondary school he kept in touch … he sent a girl to the house and told me to go to the Raleigh Cycle company … anyway I got that job but they only wanted short-hand typing done and I didn't have any of that so I had to go to Skerries [night class] for short-hand"

(Harriett, pp.8-9, ll.375-420)

For female participants in the manual paid-work group, interruptions to work because of marriage or starting a family tended to occur at a younger age [late teens early-twenties] than their non-manual group counterparts [mid to late twenties]. For those who did return to work after having children, the incentive for this was often driven by financial necessity, perhaps because of some other transition such as that experienced by Gwen when becoming a single parent through separation from her husband:

> "Oh I had to go out to work I mean my rent which was a lot then and all I earned was four pound that's all the wages were then that was a good wage at [names large department store] … and I worked there for four and a half year and then left there and I went to … [names clothing store in centre of Newcastle] this is before your time and I worked there thirty years
> *R: So was work important to you Gwen?*
> No it wasn't important it was the case of having to"

(Gwen, p.5, ll.215-230)

Other financial drivers such as transition to widowhood were also identified. Indeed this had been the case for Coleen, who talked not only of her need to return to work after the death of her husband, but also - as illustrated in the following - of the constraints she felt in terms of what she believed was 'fitting' work for a single mother and her reasons why:

> "So May [Coleen's daughter] was 4 when her dad died --- I had to go back to work at another bakery a bit further away [names local bakery] I was a waitress after that and I liked that but you've got to be careful in jobs like that or you're not wanted
> *R: What do you mean not wanted?*
> Well some of the waitressing jobs weren't very respectful and you wouldn't get a decent man so May was fourteen when I met and married a lovely man"

(Coleen, pp.2-3, ll.91-103)

Although Gwen and Coleen, finding themselves as single mothers, had returned to paid work in order to financially support their children, neither of them gave up work upon re-marrying, and they both continued to work until aged 60. This finding led to further discussions around their decision to remain in paid work, and here it became clear during their accounts that the emphasis had shifted away from financial necessity toward the gains of work-based friendships and the support this had offered them throughout further life events. The following abridged excerpt from Coleen describes this:

> "Well you see this was just after the war when my husband died and there were other lasses where I worked who needed company so they asked me to join them … and we started to go out to different pubs to play darts --- like what they do at football teams you know … and we went all over the pubs lovely [laughing] … we did that for 47 years at one pub which was down the bank and then we moved to another because people were getting old and they just couldn't manage going down the bank …
> *R: And can you explain what being part of this group meant to you?*
> Well being amongst so many people that's how you learn to cope with things when I lost my second husband they made me get ready and go out … and well when it first happened they were on the phone wondering because I didn't want to be miserable in front of people … but when I came back they'd say 'where've you been' … and I always felt better when I came back I'd carry on again getting a bit better than I was yesterday put it that way … but they've all died now --- yes I've lost them all --- terrible --- I still cannot believe that they've gone somehow you know … "

(Coleen, pp.17-20, ll.744-916)

This gain is similar to that described by the men who talked of camaraderie, although the men made no specific reference to continued support from this source during future life events. However, the overall value of support from social networks and connectedness emerged as an area of particular relevance

to participants' perceptions of 'ageing well', and as such this is the focus of chapter 7.

For other women, the return to paid work after having children was driven by a strong desire to do so, often expressed as wanting to gain confidence or redress missed opportunities. Nonetheless, as the following accounts suggest, strength of desire did not always secure successful outcome. For Brenda, her desire to return to work was outweighed by the concern for her mother alone in her flat:

> "… Heavens they don't wait till you die now they put you in a home it takes the guilt away from the young ---
> *R: Why do you think there's guilt?*
> Because they have to go out to work and they're at work and all the time they're thinking of their mother at home I never really went out to work and I just had to dash over there and I can tell you I was back and forwards back and forwards for years wasn't I
> Bill: Yes
> *R: And was that important to you?*
> Oh heavens yes at one point mind I was getting a bit fed up and wanted a little bit of money so he said [points to husband Bill] I'll get you a job in the ministry so I said right then and he said all you have to do is answer the telephone because I mean if I had any skills they had disappeared into the home which is what happens and you lose your confidence so I thought right I'll get my confidence back as well so I said right I'll take it I only stayed three days and all the time I was thinking of my mother because at that time she was alone in the middle flat and I was thinking how she'll get up and go down the stairs because she had fallen down the stairs and broke her hip and I used to think she's got nobody to go and get her a cup of tea --- and you know I mean she was a marvellous mother but she expected you to do that"

(Brenda, pp.19-20, ll.755-783)

For Florence, the desire to enter paid work after having her children was driven by the dissatisfaction of being expected to work unpaid in the family shop after leaving school. From the conversation that continued it was made clear that Florence sought to remedy this:

> "When I got my family up I said to my family I'm going out to work the only thing I can do is shop work grocery so I went to the corner shop oh yes yes so I got a job so I had it for about three weeks on the Saturday 'cause I had to work Saturday Matty [Florence's husband] had to look after the children [laughing] he didn't like that so he got me a job in the railroads where I had Saturday off [laughing] I knew all that why he had done it but you've got to have a sense of humour but in the end it was a good move
> *R: So did you enjoy working there?*
> I realised then what I had really missed I missed that I would have had a… well I wouldn't say a better life but I would say I had more confidence"

(Florence, p.14, ll.674-690)

Florence continued to work at the railroads for ten years until her mother died, at which point Florence left work to take over the care of her father. The subject of leaving work to provide care for others is an important one, and as such is considered in detail later within this chapter. However, at this point it is worth considering that similar to the interruption to work-life to care for children, caring for older relatives is yet another illustration of the economic disadvantage felt by women. The fact that the responsibility for caring falls mainly to women should not, according to Sefton et al (2011), impact upon pension contributions as they should be linked to the valuation of unpaid caring activities. Unfortunately such economic disadvantage accumulated over a woman's life-course is all too often the case, and may become magnified should they reach old age with neither the resources or, due to reduced global fertility, the children to provide care for them (Esplen 2009; Brodolini 2011).

For the women expressing little or no desire to return to paid work, commonality in their dialogue was observed in giving much effort to rationalising the decision and justifying the value of their work within the home:

> "Well I reckon things seem to be getting worse all the time don't they --- you know you even got to listen to the news and things like that
> *R: Why do you think that might be?*
> I don't know it's just the outlook that people have now --- to me even marriages and that now how many break up to what there was years ago and people think of their possessions and home and think I must have this and I must have that --- there's not that homeliness I mean to me even when Jess [Doreen's daughter] was little I always vowed I wouldn't go back to work --- I was always there for her coming in from school and what not I would always have ...we used to have coal fires --- I would always have a nice coal fire ready for her coming in or something like that and even her little play mates used to say when their mams were working 'I wish my mam was at home' I often heard them say that"

(Doreen, p.2, ll.98-109)

5.3.3 Paid Versus Unpaid Work

An endemic lack of value attached to unpaid domestic work is perhaps to be expected when considering the wealth of historical and current literature, such as seminal works from Oakley (1974). On the other hand, we have seen that further examples from the literature lay the blame for problems within society squarely at the feet of working mothers (Bowlby 1951 cited IN McCleod 2007 online), although reached from different 'pathways' both of these viewpoints imply an importance attached to unpaid domestic work. Elements of both these viewpoints were also evident in male and female participant in-depth interviews. As seen below in Ian's account when talking of his mother, there is clear recognition of the value of unpaid domestic work in 'keeping the family right':

> "My mother never worked my wife never worked from the day I got married I said 'you're not working' and she never worked at all --- you might think I'm bragging or boasting but I'm not I said look I've been

brought up by my mother with meals on the table and everything and I want the same I wouldn't marry you if you had to go to work … my daughter never worked neither … now I've seen … where people have went into work we've had kids in our house at seven o'clock in the morning because their mother and father are away to work --- I know circumstances have changed you know in this world

R: What kind of circumstances have changed?

Everyone wants their own house their own car and everything … my mother was a hard worker we didn't know what money was she had it hard yes my mother kept us all alive --- she had a hard life brought four lads up taught them right from wrong kept us right aye"

(Ian, pp.5-7, ll.245-333)

5.4 Retirement

Taking into account the various social, psychological and economic gains associated with paid work, it is unsurprising that retirement is a challenging age-related transition.

Within the literature, clear definition of retirement is elusive. The same complexities surrounding the characterisation of work, being paid or unpaid, are also present when seeking to characterise retirement. On this subject Savishinsky (2000 cited IN Künemund and Kolland 2007, p. 168) claims that rather than providing clear definition to their work, researchers rely on their research participants to determine if they are retired or not. The obvious problem is that individual participants do not necessarily apply the same criteria (Künemund and Kolland 2007). For those researchers favouring economic terms, the definition of retirement is somewhat clearer and entails the transition from an economically productive role to an economically non-productive one; although there is still much ambiguity in defining non-productivity (Harris and Cole 1980). In addition, it is argued that the emphasis given to economic productivity reinforces much of the social stigma felt by older people, where ageist attitudes, some of which were outlined in chapter 2, view this group as general free-loaders having little value and little or no status (Foner 1984 cited

IN Hockey and James 1993, p. 148; Kolland 2004 cited IN Künemund and Kolland 2007, p.177). The following examples from Cyril and Harry give an all too bleak account of the personal impact this has; the mood is one which gives the feeling of being a burden, with a sense almost of accepting a loss of any future:

> *R: "How do you think the younger generation views people of your age?*
> --- I think that the younger generation the present younger generation have got no conception of what old age people are like they don't consider old age people no matter how old they are or how clever they are --- a lot of older people have a certain amount of knowledge but they don't seem to have the method of passing their knowledge on to the younger ones
> *R: Why do you think that is?*
> I don't know it's just that the younger ones have a different conception of older people of old age they don't seem to regard old people with any --- any thought at all they think they're old and they're past it things like that
>
> (Cyril, pp.18-19, ll.898-910)

> *R: "What do you see for yourself in the future?*
> I don't think I've got any future except six foot under --- that's the only thing that's my future …"
> *R: What do you think your role is at the moment?*
> I don't think I've got much of a role"
>
> (Harry, p.11, ll.516-519 & p.17, ll.839-854)

In examining these particular experiences further, the effects of the arbitrary and abrupt post-war retirement legislation within the UK, being 65 years for men and 60 years for women, can be drawn in. For many years this legislation has provided an interval of age from which 'old age' has often been defined (Walker 1990), and been used as a 'push factor' to manoeuvre a population group out of the labour force whilst making it unattractive for employers to invest in their human capital (Sulaiman 1990 cited IN Hockey and James 1993, p.138; Gruber

and Wise 2002 cited IN Künemund and Kolland 2007, p.177). This complete absence of any consideration given to individual skills and ability has led to the legislation being blamed for the marginalisation of older people, ultimately resigning them to the scrap heap (Arnds and Bonin 2003 cited IN Künemund and Kolland 2007, p.185).

More recent innovative responses to the challenges of an ageing population have included legislation to remove age discrimination in the workforce and the abolishment of mandatory retirement ages (H.M. Gov.UK 2010 & 2011). Although the full effects of these will arguably take some time to be realised, such initiatives are said currently to be doing little in the way of retaining older individuals in the labour force, as they do not go far enough to challenge the entrenched nature of ageism in western society (Brooks 2011). The result has often been a rise in incentives, or push factors, for early retirement, or at least retirement by the age of 65 years, with ‘golden goodbyes’.

The following sets out to understand in more detail the influence of such ‘push’ and ‘pull’ factors on individual transitions to retirement. To facilitate this, trends from quantitative data were first selected in order to determine the existence of patterns or groupings, derived from responses to the question ‘How old were you when you stopped all paid work?’. As current legislation for retirement age was not in existence at the time of asking the question, previous statutory retirement ages of 65 years for men and 60 years for women were used as cut points for categories, irrespective of causality.

Findings identified three main groupings [Table 6] matching those presented by Godfrey et al (2004), namely: ‘retired early’ denoting retirement before statutory age; ‘retired on time’ denoting retired at statutory age; and ‘worked beyond’ denoting retired after statutory age or still working. Findings also indicated that although fewer women reported a history of paid employment, men were more than twice as likely to ‘retire early’ and four times less likely to ‘work beyond’.

Table 6: Point of Retirement

Classification Group	Male	Female
Retired early	20/40	7/35
Retired on time	15/40	11/35
Worked beyond	5/40	17/35

When next comparing reasons for retirement from qualitative data to the findings of table 5, the complexity of individual experiences tended to play out across these 'groupings' and here the more fluid themes of: 'planning retirement'; 'changing health'; and 'providing care for others' emerged.

5.4.1 Planning for Retirement

Applying the word 'planning' assumes some level of control over an event. However, for many individuals much of what is perceived as having control is, in fact, externally influenced by additional constraints such as the social structures of opportunity and finance, not unlike push/pull factors.

During in-depth interviews most of the male participants recalled planning for their retirement, with many speaking of having the 'opportunity' to do so, primarily thanks to pull factors of early retirement packages. For some this provided the resource to pursue interests and fulfil ambitions. Such was the case for David who, on retiring from the shipyards aged 60, planned to fill his day making model boats and gardening, a hobby to which he had been introduced during his last two years of service [R&R duties] when he was given the job of second gardener, and also for Harry, whose decision to retire from employment aged 62 allowed him to fulfil his desire to set up his own company.

In the case of female participants, conversations around planning for retirement were less common, and where they did occur they tended to be brief, and shaped around the experience of their husbands' retirement. On this, the literature explains that women are required to adapt to having their husbands around the house - often having to alter their daily social routines - which for many can result in loss of independence (Atchley et al 1983 cited IN Connidis 2001, p. 71), the outcome of which, according to Godfrey et al (2004), can lead

to couples either finding new shared experiences, or becoming distant and resentful.

A further consequence for women who entered into paid work was working beyond the age when they could have retired in order to coincide with their husbands' plans for retirement:

> "I retired from my salaried job at 65 that was the retirement age you see and I continued to do two family planning clinics a week until I was 70 which I enjoyed doing them but it also made sense as my husband was still working …"

(Anne, p.3, ll.140-143)

This finding may also account for previous figures demonstrating that female participants in paid work were four times more likely than male participants to 'work beyond' retirement age.

The benefits of planning in preparation for retirement have been investigated, for example through studies measuring satisfaction rates. These have found positive correlation between planning and retirement satisfaction, particularly for men (Dorfman 1989, Quick and Moen 1998, Moen 2001). Adding to this, Warr et al (2002) suggests that planning, referred to here as personal choice, is a major contributory factor to high levels of well-being associated with those who 'retire early' or 'work beyond'. Interestingly in contrast to this, research undertaken within the field of grief suggests that the death of a loved one is no less stressful because of prior knowledge of the impending loss and potential for preparedness (Sweet and Moen 2012), suggesting that preparation and planning for a major event does not guarantee positive outcome. Ultimately in the case of retirement, success may rest on how the experience meets up with expectation, regardless of planning (Holcomb 2010).

The following extract, taken from the in-depth interview with Alan, provides a clear example of disparity between the experience and expectation of retirement where, having taken the opportunity to retire early from the company

he worked for, Alan quickly realised that his planning or preparedness had not fully taken into account the financial impact:

> "Well I never had a big paid job I was in engineering and in engineering you didn't get paid much --- … I always had to work overtime on Saturdays and Sundays to make a living wage and run the car --- now that was the thing I didn't reckon on that if I lost me overtime I would lose the car cos I couldn't run it --- …
> *R: So when you retired?*
> No cos well … when I looked at it I did run the car for quite a while after I was retired but I had to get rid of it … and by the time I had got rid of the car and I'd levelled things up so I didn't have that much expense
> *R: You levelled up?*
> yes I'd adjusted by that time … but when I've got to go there and oh I've got to go right the way round there and it's just across the street you know like from --- say from here to TSB and you know where it is the Green Market that was a long way away --- and you [nods to researcher] do it not all the time cos you just get in your car [laughing] --- that frustrates me now I had cars and you know that you're standing there and someone will say well its only two minutes but they're talking about two minutes in a car man
> *R: So you always drove a car?*
> Ah ha I loved it drove a car for a long time yes"

(Alan, p.6-8, ll.260-375)

Alan's account not only suggests the loss of pleasure and independence gained through driving, but provides an opportunity to introduce literature which describes that retirement forces many older people into financial dependency and poverty (Walker 1990). It is possible that in the face of financial loss older people adjust to accommodate this, as with Alan who 'levelled things up'; however, in his identifying the event suggests it had long-lasting impact and meaning for Alan, perhaps in terms of loss of independence.

Further examples of a mismatch between the experiences of retirement against expectations are given within the two following headings; here however, focus shifts toward examining how additional life events or further transitions can account for such disparity.

5.4.2 Changing Health

Previously this chapter referred to the retirement experiences of David and Harry, where it appeared that successful transition to retirement had been achieved, in that they had both talked around gaining the freedom and resources to pursue other long-held interests and ambitions. However, the advantage of longevity enables continued exploration of the experience over time, and here further data revealed that the very strategies set in place to manage transitions can become threatened if an additional challenging transition, such as change in health, should occur. In the first of the following two accounts, David's reaction to health problems - which had severely limited his mobility and capacity to leave the house - is one where he had modified his expectations from gardening to now feeling happy on days when he was able to get into the garden to inspect it, a situation he had come to accept. However, in the second account from Harry, who after fulfilling his retirement ambition to start his own company had then survived a cerebrovascular stroke which left him with impaired mobility and reduced cognition, the disparity between the expectation of retirement and the experience remained apparent, albeit with some indication of his attempts to rebalance this in his starting to complete crossword puzzles:

> "I used to love the garden --- I used to have an allotment down yonder growing tomatoes and that sort of thing growing fruit and veg and all that you see --- that was a good part of retiring … plus the fact I used to make model boats
> *R: So when you retired were you still very active doing your garden?*
> Oh yeah
> *R: What about now?*
> Well I don't get to do much now you see I don't get out much I get up in a morning I get up and I'm happy if I can go out and walk around the

railings there with me stick and check what's going on [points out to the garden] but that's me lot

R: How does that make you feel?

Well I changed with what I can do and what I can't do --- I accept change …"

(David, p.19, ll.1041-1061)

"I was 62 when I retired to start my own business but I packed it up just because of the stroke …

R: So because of your health?

More or less

R: How did you feel at the time?

Well I wasn't pleased about it but I realised that I had to call it a day because I couldn't cope with the work --- at the time and I handed it over to my son and he took it over … there was a lot of mental work involved I found that it was getting heavy and my capabilities mentally had slowed down --- it was all figures it was all working out mathematical and I found it was all getting too heavy and I couldn't cope --- boredom set in a bit after that [after he quit his business] --- I must admit because I'm not a reader I don't read I never could read

R: So how did you deal with the boredom?

Crossword puzzles … I didn't have time for them before I've got time for them now because I've got time on my hands --- when I started my own business it was a full twenty-four hours a day seven days a week … I didn't have time for things like sitting about and I didn't watch much television but now when boredom kicked in and I had to find something else to do rather than television and I started doing crosswords and things like that

R: And do you think that's helped?

Maybe occasionally yes"

(Harry, p.6-7, ll.250-333)

When looking across in-depth interview data it became apparent, particularly for male participants, that retirement was indicated as a specific time when a marked change in health and ability was noticed. In the following Gordon clearly uses pre- and post-retirement comparisons to illustrate this point:

> "I've got arthritis here and there you know --- just before I retired there when I was sixty-four and that I was climbing right the top of Swans cranes and I was alright before I retired --- since I've retired I've slowed down a lot you know I've got a bit arthritis and my eyesight has deteriorated up towards a couple of years back or more --- I can't even climb up stairs now"

(Gordon, p.26, ll.1274-1285)

This finding may be linked to some of the earlier outcomes suggesting that for many of the men, particularly those in manual work, physicality was of major importance, seeming almost to bond the men in camaraderie. Not only through changing health but also retirement itself, the loss of physicality was a real identity challenge where, to compensate, many of the male participants talked of the need to remain physical, 'keep active', 'keep busy'. According to Ekerdt (1986) and Jerome (1989), this is a common reaction which attempts to provide a continuation of work-themed relationships, often manifested through the uptake of voluntary work and involvement in group organisations and clubs.

For other male participants, the belief that retirement was a period of changing health seemed grounded in a sense of fear. Upon examination it appears that much of this belief was generated within social groups, in pubs and clubs talk of 'so and so dropping down dead the day after he retired' seemed commonplace and appears in the following extract from Ian, where the need to stay active upon retirement is greatly emphasised:

> "When I retired well there's only one old fellow in the club says to me 'Ian don't sit and watch that television or you know what will happen [makes thumbs down gesture] --- throw it out [referring to television set]'
> *R: Who said that to you?*

One old fellow he says ‘get out and about or you’ll be done for’ and I was always out and about even when my three children I used to take them to the park every Sunday afternoon after we had our dinner I used to take them to the park --- left the wife you know she would be baking or something like that take them to the park out and about with them so when I retired I done it with my grandchildren when my daughter got married she used to come down with her two daughters and my son-in-law they used to come for their dinner you know when they first got married I took my two grandchildren out to the park and played with them you know active --- really really active”

(Ian, p.8, ll.363-376)

Interestingly this emphasis of needing to keep busy and active did not emerge within female participant in-depth interviews, absent possibly as a result of some of the gendered trajectories of work and retirement already identified, which suggest that women do not ordinarily ‘retire’ since there is a continuation of household labour (Sefton et al 2010).

For other participants, links between retirement and changing health were present within their dialogue, although now, rather than changing health being something which happened at the point of retirement, retirement had been forced as a result of changing health. The following from Edward vividly illustrates the abrupt manner of this transition after surviving a myocardial infarction and the challenges this presented to him, where in apparent attempts to gain control over this Edward corrects himself stating: work was not taken away from me I took it away from myself:

“You know I didn’t like finishing work for a start
R: Is this when you retired?
Yes
R: Why didn’t you like it?
I had something taken away from me I’ve done finished if you know what I mean it’s a funny thing because I was glad in a sense I could be with Sarah [Edwards wife] but apart from that it was what I did

R: Did you find it difficult? You use the phrase 'I had something taken away from me … '

Yes well --- well it wasn't taken I took it --- I took it away from myself as a matter of fact … well there were times when you came home and I said 'oh I wish I didn't have to go to work' but that's the sort of job it was it was a heavy job you had to lift this and lift that I mean I didn't have a choice

R: Because it was physical?

That was part of my job you had to lift"

(Edward, pp.9-10, ll.437-464)

5.4.3 Providing Care for Others

An additional feature of both David's and Edward's accounts of their changing health was the fact that their wives, both some 20 years their junior, had resigned from paid work to look after their husbands. According to analysis of data from the British Family and Working Life Survey (1994/5 cited IN Evandrou et al 2003, p.583), those who assume caring responsibilities close to the retirement stage of their life-course are more likely to leave paid work altogether, rather than adapt work arrangements. Additional data from structured interviews confirms that for those 27 participants in table 5 who reported early retirement, the reason 'to provide care for another' was given by over half (n=4/7) of the female participants, and nearly one quarter (n=4/20) of the males. When exploring the characteristics of care, care being defined here as 'protecting and promoting another person's welfare' (Thompson 1983 cited IN Connidis 2001, p. 70), women are not only more likely to step into the role of carer, but the expectation for them to do so is greater, so much so that a woman who 'fails' to provide care in a situation where it is required is seen as more culpable than a man (Badgett and Folbre 1999; Esplen 2009; Brodolini 2011).

Earlier in the chapter, Florence's experience of such an 'expectation' was alluded to, having 'retired early' from a job she loved in order to take care of her father after the death of her mother. In the following, the sense of duty perceived by Florence is made acute when family discussion turned to putting

their father into a care home. However, what also unfolds is how Florence comes to terms with her decision:

> "… There was a family problem because my mother died but my father was still alive and … --- my sister had him --- well my brother had him then my sister took him … but they didn't want to keep him so where was he going to stay now my other brother says --- we will all put together and put him in a decent home because he was going a bit you know [gestures making reference to loss of memory] … well I said 'just a bit … that's not right for him' and well that was it they looked at me … so I said I would take him so I had to give up work and I took him
> *R: Why did you volunteer?*
> Because I was a mug [laughing] I was I was a bit soft I was but I never thought I would of had everything to do for him because he had become incontinent and everything … for three years but I think oh well I did what I had to do … they altered the house with a wall there and he slept in there and I had to bathe him it was a shame because he was such a nice bloke my father and he was epileptic … well I thought when they were all on [referring to point when siblings wanted to put their father into a home] I thought oh heck somebody has to do it and I had Matty [Florence's husband] to think about but he said alright if that's what you want to do --- I'll be honest with you I never regretted it --- it was hard work I mean your whole life it definitely changed because if I wanted to go anywhere I had to arrange for somebody to be here
> *R: Did you get any support for that?*
> Well not bad but --- not enough"
>
> (Florence, pp.14-15, ll.691-733)

Almost as an side, the experience as given by Florence leads to an additional point within the literature, whereby carers, in this instance Florence's mother, essentially 'keep secret' the extent of care required, here with Florence indicating that neither she nor her siblings had realised the extent of their father's needs whilst their mother was caring for him. According to a report of findings from a study of older American women, this masking of problems is a

common strategy used by carers to enable them to maintain a sense of control (Matthews 1979 cited IN Hockey and James 1993, p.164-165). Alternate viewpoints within the literature suggests masking may be a result of women caring for their once-controlling sick husbands, who are now afraid to have visitors for fear of upsetting them (Rose and Bruce 1995 cited IN Connidis 2001, p.72). Regardless of these motives, the literature agrees that husbands in poor health derive considerable benefits from having a 'healthy' wife to care for them, whilst the reverse is not true (Connidis 2001).

As indicated, not all of the participants retired specifically to provide care for another. Nonetheless, in their transition to retirement some individuals found themselves in this position, again causing disparity between the experience and expectation of retirement. This was certainly true for Coleen who, as previously stated, had worked for most of her life and retired 'on time' aged 60. Of her retirement, Coleen explained that she intended to enjoy her new-found leisure time relaxing and pursuing hobbies, the latter of these often more intrinsic to men's experiences of retirement than women's (Hockey and James 1993):

> "Mind I was ready for being 60
> *R: You were ready for being 60?*
> Cos I retired
> *R: Was that a bit of a milestone for you?*
> Yes I was ready to put me feet up --- but I wish I had of kept on a little bit longer
> *R: Do you --- why?*
> Because my mother-in-law started being a bit --- I thought oh dear me I finished work for this … its starting again [meaning work] well first I just went to do little jobs for her but she was nearly 90 when she died there was always somebody needed help my mother-in-law straight away then … It was my mother … we just did it …It was your duty…
> *R: It was your duty --- is that exactly how you saw it?*
> Yes
> *R: Do you think people today have that sense of duty?*
> Some people have some people cannot get rid of their mothers fast enough I've seen it

R: You've seen it?

Yes

R: How does that make you feel?

Well you feel I would feel ashamed if that was me I would feel ashamed --- because we always looked after our own people … and old people

R: Why do you think we're not so good at doing that now?

I don't know --- it must have been since the war I think

R: The war?

Could the war do it --- everybody had to look after themselves you know what I mean … selfish"

(Coleen, pp.28-29, ll.1266-1332)

Whilst the literature is seen to continuously testify that women are more likely than men to provide care, it remains that there are 2.5 million male carers within the UK (Tinker et al 1990). Where women take on the caring role out of some sense of obligation or duty, such as illustrated by Florence and Coleen, men are said to take on this role gradually, for example stemming from sharing a household over a lifetime (Arber and Gilbert 1989 a).

By far the largest group of male carers are reported to be those who care for their spouse (Arber and Gilbert 1989 b; Evandrou 1990; Parker and Lawton 1991). Two of the male participants reported being a carer for their wife: Bill, who was one of the four men to 'retire early' in order to care for his wife Brenda; and Cyril, who retired 'on time' aged 65 and had enjoyed a very active social life going out dancing with his wife for some seven or eight years until, in their early seventies, his wife became ill and Cyril became her 'carer' for some fifteen years until her death. During his in-depth interview Cyril talked of his transition to carer and how he had been resentful at first as it had 'spoiled' their retirement plans. However, the role of carer seemed eventually to form part of his identity, or as he put it 'purpose', explaining how he now felt the loss of this:

"She was ill --- she was very ill --- and she was going to get better because they were treating her you see I've got every faith in hospitals because they know what they're doing and then when she died --- it

> seemed to be a --- sudden loss and that --- left me with nothing to live for for some time --- I used to live for her you see --- do everything for her --- I was used to doing that and for years even up to a few months beforehand I would take her out in her wheelchair get the wheelchair out take her out in that go for a walk mind she was happy she was in a motorised thing I didn't have to push it --- and --- I had a purpose in life make sure she was happy and when she died that certain purpose got lost"
>
> (Cyril, p.16, ll.755-764)

The transition to carer, or indeed to being cared for, can require considerable adaptation on an emotional range from conflict through to harmony (Johnson 1985 cited IN Connidis 2001, p.76; Wells and Kendis 1997). Here, in addition to feelings of resentment for plans 'spoiled', problems may occur from the close, often intimate, non-sexual physical contact required to provide care, as potentially changes to the power and dynamics of a relationship can cause conflict (Atchley and Miller 1983 cited IN Connidis 2001, p. 71). However, as Wilson (1995 cited IN Murphy et al 1997, p.73) reports from investigations of the 'very-old', the focus for couples is more on doing whatever is necessary for them to remain independent. Here the study illustrates the point using a quote from a participant who states: "I'm the ears and she's the arms", a sentiment very much echoed throughout the in-depth interview with husband and wife Bill and Brenda.

5.5 Summary

The aim of this chapter has been to explore the relevance of past life experience to 'ageing well'. It first considered the subject of work and its significance to the individual. The focus here was the importance placed on this subject by participants themselves, where during in-depth interviews the detailed inclusion of 'work' was readily drawn upon when introducing themselves and talking about their life experiences, this despite having been retired in some cases for twenty plus years.

Within the ensuing discussion it was revealed that many of the male participants talked of a transition into work almost as a ‘rite of passage’ into adulthood, whilst for females this was not apparent. Female experiences appeared linked to external constraints, often associated with social expectations such as marriage, childbirth and caring for others and these constraints continually figured as key determinants termed ‘interruptions to work’ throughout female participants’ dialogue.

Two main categories of work were identified, ‘manual’ and ‘non-manual’, although the additional category of ‘unpaid domestic’ work was then drawn into the debate, first when attempting to assign female participants to socioeconomic class using occupation, and then from in-depth interview data reporting ‘interruptions to work’. When comparing findings from the data to the literature, the evidence tended to support claims that interruptions to work and the lack of recognition given to unpaid domestic work place women at a financial disadvantage particularly in terms of pensions. However, where data from in-depth interviews departed slightly from the literature was in the ‘value’ attributed to unpaid domestic work, where in non-economic terms both male and female participants gave accounts highlighting the value of this role to the family.

Participants from the paid manual-work group spoke frequently of the physical nature of the work, both in terms of how this had kept them healthy and strong, and also with regard to the dangerous conditions which seemed to be commonly accepted, judging by comments such as ‘you just had to get on with it’. For participants from the paid non-manual group, focus shifted more to the intellectual properties of the work. For both groups, disparity between the overall experiences of male and female participants continued to be observed, with interruptions to work once again being the primary cause.

This gendered nature of the debate continued to retirement. Whereas many male participants talked of opportunity to retire or planning for retirement, few females did so, and here often in line with planning their retirement around that of their husbands. In retirement many of the male participants also emphasised the need to ‘keep busy’ or ‘keep active’ in both the physical and mental sense.

This relationship between filling the vacuum created when work ceases and successful adaptation to retirement is one investigated within the literature, where it is suggested that those who do not fill their time satisfactorily, unlike in the examples given from the data of spending more time on hobbies or fulfilling ambitions to gain a sense of achievement, appear to manage the transition to retirement less successfully (Moyle et al 2010; Nimrod 2011), or, according to more seminal literature 'fail to age successfully' (Rowe and Khan 1998).

Additional research considering the impact of keeping active and wellbeing in later life concludes that it is more the social element of activity that contributes to this, stating it is:

> "Less about what older people do, but rather of who with and how they feel about them"
>
> (Litwin and Shiovitz-ezra 2006, p. 237),

This notion appears more in keeping with the experiences of female participants who did not speak of the need to keep busy in retirement, possibly due to the continuation of unpaid domestic work (Sefton et al 2011), but went on to speak more of social interaction and the importance of support gained from this. We will return to this topic of 'social connectedness' in chapter 7. It is sufficient to state here that when talking of work and transition to retirement, the importance of support networks was clearly visible, be that described as camaraderie by the male participants or more overtly by the females when describing support that was given by work colleagues during times of great stress such as bereavement, and the loss felt for this support upon retirement [Coleen p. 117].

Accounts from in-depth interview data also represented those where any notion of planning retirement was a luxury, possibly due to lack of financial incentive from their employer, although in other cases this was more to do with unforeseen changes in circumstance forcing retirement, such as change in health or caring for another. These circumstances were also responsible for jeopardising plans for retirement, making the evaluation of transition to retirement highly complex, as the period of retirement is just that, a period in

which many of the strategies first put in place by an individual may themselves become challenged and continually require adaptation. This finding appeared to exert influence upon disparity between expectations for retirement and the reality of the experience. As the topic of health featured strongly throughout participant in-depth interviews and has significant relevance to their perceptions of 'ageing well', this theme is examined in detail in the following chapter.

To what extent then do these participant histories play out in relation to 'ageing well'? The findings suggest that the resilience shown by participants throughout in-depth interviews, who in their own words talk of overcoming hardships by 'sticking with it'/ 'getting on with it', tackle constraints by 'finding the nerve' and adapt to or, as many participants described, 'accept' changing circumstances, is the same strength which contributes to these individuals becoming a survivor cohort, enabling participants to overcome other challenging events, or as put by McNellis Carey (2006) be in control of strategies to cope with and compensate for losses commonly attributed with increasing age.

In conclusion, the findings in this chapter suggest that challenging past life events, of which work and transition to retirement is only one example, do have significance for developing individual strategies and characteristics to manage future events and therefore influence 'ageing well'. A final important point for discussion refers back to the global phenomenon of ageing as outlined in chapter 2, which presents considerable challenges for policy makers in having to consider the implications and available resource for this, as retirement is no longer:

> "A remaining time that is gone through by a small social group but an independent phase of life of considerable duration".
>
> (Kohli 1986 cited IN Künemund and Kolland 2007, p.172)

It is apparent that further legislative changes are necessary, firstly to challenge the economic focus of work and its perpetuation of ageist attitudes, and secondly to continue to strive for equality and individual choice in the field of work and retirement. A key component of this is the promotion of research

which specifically considers the gendered nature of the debate, particularly the development of policies that tackle the negative financial impact of interruptions to work for females.

CHAPTER 6: EXPLORING PERSPECTIVES OF HEALTH WITHIN THE CONTEXT OF AGEING

> "Well time has slowed me down and I've felt down-hearted at times but you get over it --- that's life it's as simple as that --- you accept it at the finish --- you might bloody fight it like hell but at the finish you accept it"
>
> (David, p.20, ll.1080-1082)

6.1 Overview

The previous chapter alluded to health as a primary factor influencing retirement, in some cases being described as the catalyst for retirement and in others as a challenge to strategies put in place to manage retirement. As a theme, health continually appeared throughout participant in-depth interviews, often providing rich accounts of individual perceptions of health, or lay health beliefs. In doing so, past and present experiences were used by participants to provide specific time-frames within their lives as comparative reference points, one example being health pre- and post-retirement as described in the last chapter.

Wider comparative time-frames were also used when participants talked of cause and effect over time, where particular correlation was made between childhood practices and current health. During these discussions, participants demonstrated considerable insight in questioning the deleterious effect of changes in the childhood practices they believed to have particular health benefits, such as nutrition and exercise, on the health of current and future generations.

But what exactly is meant by health? If the main tenets of the quantitative strand of this study are considered, health is something which can be measured to provide knowledge of prevalence of age-related disease and disease burden. This is a critical component in providing information to drive care and policy and address effective service planning (Salomon 2004; Collerton et al 2009; Jagger

et al 2011). However, data from in-depth interviews demonstrate that health is not a term that is always determined by disease-based models, as individuals are free to think beyond disease in their perceptions or beliefs of health. Findings from structured interviews support this, where despite the reality of considerable age-related morbidity, the majority of individuals remained independent within their own homes and self-rated their health positively. This finding gives some further explanation of the disability paradox, first raised in chapter 2, where high levels of morbidity and perceived good health are a common occurrence in older age groups (Conway and Hockey 1998).

The intention of this chapter, is to examine data pertaining to health in order to explore different perspectives, findings are placed within the context of ageing and the individual life-course. As with the previous chapter, it is believed that the societal norms and historic events to which participants have been exposed influence their construction, or their 'reality', of health.

The main body of the debate examines health-perspectives under two broad categories. The first of these is 'disease prevalence and disease burden', which includes interrogation of data to examine the complex interaction between measurements of disease, their impact, and health beliefs. The second is 'luck versus healthy lifestyle', which considers some of the lifestyle choices believed to impact on health and the rationale behind individual actions toward these. The selection of these two main categories is tentatively based on a natural division within the data. However, whilst such a division has been used here to facilitate clear description of a complex subject, it is not intended to deny interconnectivity.

6.2 Defining Health

Providing a definition of health that remains constant is impracticable, due to historic influences throughout time. Variations from society to society and indeed within societies are resolutely based upon factors such as cultural norms, politics, economics, an individual's social situation, and dominant theories of the day (Bond and Cabrero 2007). As a consequence, a vast amount of literature exists in relation to defining

health, some of which will be drawn upon within this chapter. However, the main thrust of the literature indicates that despite attempts by the World Health Organisation in 1946 to move perceptions of health away from being 'merely the absence of disease', the dominant theory still pervading much of today's western thinking remains as the 'biomedical model', rooted in positivism and focused on health as the absence of measurable disease (Levin and Browner 2005). This conceptualisation of health is, as much of the paradigm debate of the methodology chapter outlined, heavily criticised for failing to consider social and economic factors or inequalities, separating mind from body, and labelling an individual as either healthy or unhealthy depending on a medical doctor as the legitimising agent (Scambler 2003; Morgan 2003). Nonetheless, its value as a key area of importance for resource and policy planning was highlighted within the overview of this chapter as means of driving methods of empirical measurements of health and prevalence of disease.

6.2.1 Participant Health Beliefs

The domination of western thinking in terms of health as the absence of disease is not to say that individuals themselves deny the significance of their environment. The interpretivist approach here would be to claim that individuals make sense of their bodies by determining and managing their health through beliefs and knowledge they hold as true to them (Bury 1986) and as influenced by their historical and cultural understanding of knowledge (Jylhä 2009). However, as made apparent in chapter 3, truth is enigmatic, a point made evident here by Furnham (1994), when concluding that findings from a range of studies investigating lay health beliefs, each applying different methodological approaches, find commonality in the fact that lay beliefs of health are complex, interconnected and multifactorial.

When participants were asked about the meaning of health during in-depth interview, perhaps unsurprisingly due to early influences and the social familiarisation of health through medicine (Blaxter 1983; Cornwell 1984 & Calnan 1987 cited IN Bond and Cabrero 2007, p.114; Jylhä 2009), many of the conversations did centre on the absence or presence of disease. However,

continued discussion revealed additional characteristics as defining factors of health, such as physicality to perform particular functions, as the following from David illustrates. Interestingly, David also makes the link here between the physicality of his past work and the benefits to health, an idea first put forward in the previous chapter [p.110] and one which will be picked up again when examining healthy lifestyle later within this chapter:

> R: "Do you think that your work in the shipyards helped your health?
> I was never hefty but I was always strong so it must have given me strength I mean use your muscles and they'll keep going --- keep you healthy
> R: What does health mean to you what do you mean by being healthy?
> It means to me that I can run around or could run around and jump all that sort of thing --- healthy lungs healthy brain you know a sensible way of going on healthy lungs breathing muscles all that I could do --- being physical."

(David, pp.15-16, ll.829-842)

Similarly, in excerpts from Frank and Gordon below, whilst Frank talks of sensory loss, they both define health from a physical or functional viewpoint, with the ability to get out of the house singled out as the key characteristic of this:

> "I can't walk very well on my own --- if I'm on my own in the middle of the road I've got to walk where I'm looking I can't turn and keep walking I'll fall --- my hearing is not so good I do a lot of lip reading when the conversation gets going I can understand what people are saying --- and I am losing my eyesight … but health is one way in which you can get out and about and for me not to go out would be cruel"

(Frank, p.12, ll.583-596)

R: "If you could sum up what you think health is what would you say?

… Be able to get about --- to get about and do what you wanted"

(Gordon, pp.32-33, ll.1592-1595]

Whilst 'getting out and about' was a definition of health emerging from other participant in-depth interviews, further discussion found that it was not solely the ability to get out of the house, but also the opportunities for social engagement this offered. As the vignette of Coleen exemplifies [chapter 4] where she talked of health as being able to get out and look after her grandchildren, and by Frank who, as the next chapter will demonstrate, gave account of a very full social life and regarded being unable to fulfil this as 'cruel'.

Through the research of Herzlich (1973, p.115), Williams (1983, p.115) and Blaxter (1990, p.116), Bond and Cabrero (2007) describe this 'lay' emphasis on function - having the ability to work, play or perform everyday activities – as commonplace, particularly in older men. Although, as the following discussions will demonstrate, just as any other age group older people offer multiple representations of health, constructed through a variety of lenses. The work of Blaxter characterise some of these dimensions of lay health beliefs, charting nine representations [Table 7]. All of which feature, to some degree, within the data.

Table 7: 'Representations of Health'

Definition	Sample Response
Health	
as not ill	Someone I know who is very healthy is me, because I haven't been to the doctors yet.
despite disease	I am very healthy despite this arthritis.
as a reserve	Both parents are still alive at 90 so he belongs to healthy stock.
as 'the healthy life'	I call her healthy because she goes out jogging and doesn't eat fried food.

as physical fitness	There's tone to my body, I feel it
as energy and vitality	Health is when I feel I can do anything.
as social relationships	You feel as though everyone is your friend, I enjoy life more, and can work, and help other people.
as function	She's 81 and she gets her work done quicker than me, and she does the garden.
as psychosocial wellbeing	Well I think health is when you feel happy.

(Blaxter 1990 'Representations of Health' IN Bond and Cabrero 2007, p.116)

However, the particular relevance of Blaxter's work to this study is that it also attempts to consider the potential influence of 'life-course' on lay health beliefs, and where these may be at odds or coincide with the biomedical perspective of health, an area, as argued by this thesis, which remains under-researched. Until such a time that this vacuum is appropriately addressed, the assumptions synonymously linking increasing old age with deteriorating health [chapter 2], will remain unchallenged as they are based primarily on a biomedical model (Conway and Hockey 1998; Jylhä 2009). This, it is reasoned, is an area of exploration well fitted to a mixed methods approach.

6.3 Disease Prevalence and Disease Burden

Details of the questionnaires and instruments used to measure disease prevalence and disease burden within structured interviews were reported in chapter 3. In the following sections of this chapter those measures which provided context to themes emerged from in-depth interviews will be considered, to include: physical health [global health status, longstanding illness, diagnosis of diseases from review of general practice records]; disability; lifestyle [diet, smoking, exercise]; and use of health services.

First considered is prevalence of disease, calculated by combining longstanding illness, as self-reported by participants, and disease diagnosis from general practice records.

Figure 9: Self-Reported Longstanding Health Problems

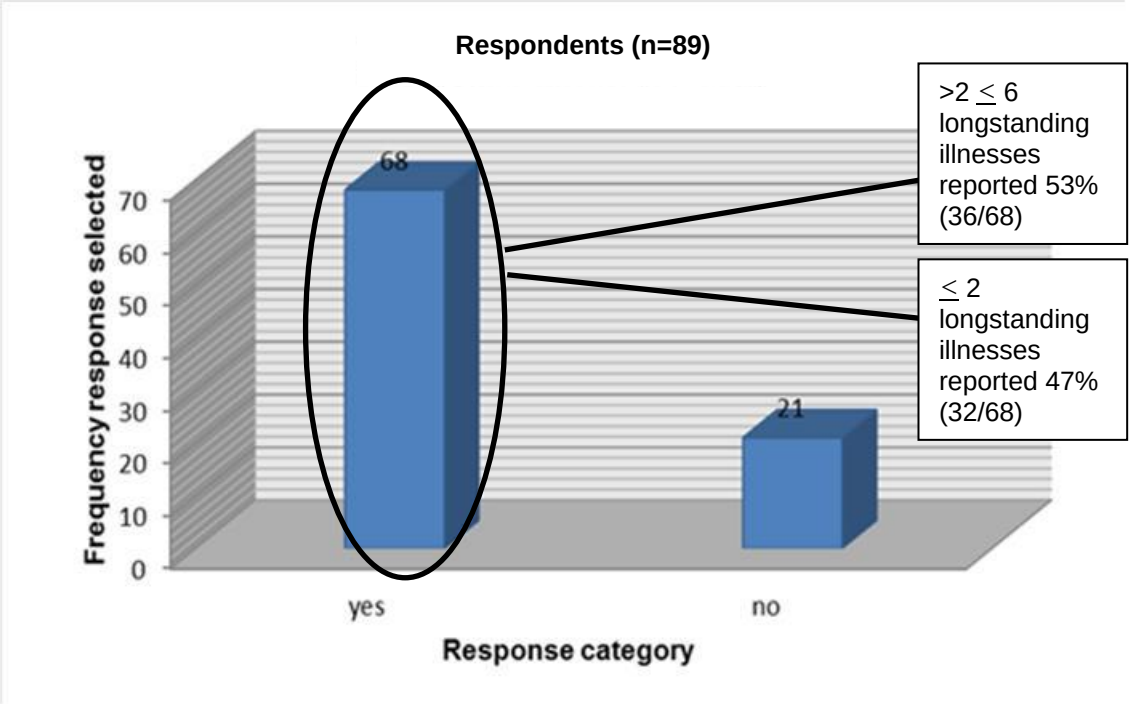


Table 8: Diagnosed Disease (from Review of General Practice Records n=116)

Diagnosis	Frequency All %	Frequency Male %	Frequency Female %
Angina	33 (n=38/116)	42 (n=16/38)	58 (n=22/38)
Previous Myocardial Infarction (heart attack)	12 (n=14/116)	50 (n=7/14)	50 (n=7/14)
Heart Failure	21 (n=24/116)	50 (n=12/24)	50 (n=12/24)
Hypertension	61 (n=71/116)	34 (n=24/71)	66 (n=47/71)
Atrial Fibrillation	23 (n=27/116)	41 (n=11/27)	59 (n=16/27)
Pacemaker	4 (n=5/116)	80 (n=4/5)	20 (n=1/5)
Cerebral Vascular Accident (stroke)	12 (n=14/116)	71 (n=10/14)	29 (n=4/14)

Transient Ischaemic Attack	12 (n=14/116)	50 (n=7/14)	50 (n=7/14)
Peripheral Vascular Disease	15 (n=17/116)	65 (n=11/17)	35 (n=6/17)
Cancer	30 (n=35/116)	57 (n=20/35)	43 (n=15/35)
Diabetes	8 (n=9/116)	44 (n=4/9)	56 (n=5/9)
Hyperthyroid	3 (n=3/116)	33 (n=1/3)	67 (n=2/3)
Hypothyroid	11 (n=13/116)	23 (n=3/13)	77 (n=10/13)
Osteoarthritis	57 (n=66/116)	35 (n=23/66)	65 (n=43/66)
Rheumatoid Arthritis	4 (n=5/116)	20 (n=1/5)	80 (n=4/5)
Osteoporosis	14 (n=16/116)	19 (n=3/16)	81 (n=13/16)
Parkinson's Disease	3 (n=3/116)	67 (n=2/3)	33 (n=1/3)
Dementia	11 (13/116)	46 (6/13)	54 (7/13)
Asthma	11 (n=13/116)	38 (n=5/13)	62 (n=8/13)
Respiratory Disease	26 (n=30/116)	40 (n=12/30)	60 (n=18/30)

The results in figure 9 show that 76% (n=68/89) of participants reported having at least one activity-limiting health problem, and the majority reported having more than two, demonstrating that multimorbidity, defined by van den Akker et al (1996) as the occurrence of two or more diseases in an individual, is common. Not shown in figure 9 is that in the group with >2 longstanding illness females outnumbered males by nearly 2:1 (22 to 14), meaning that 55% (n=22/40) of all female participants reported having two or more longstanding limiting diseases, as opposed to 35% of all male participants (n=14/40).

Results in table 7 illustrate hypertension (61%) and osteoarthritis (57%) as the most prevalent diseases in this cohort and shows that females carry not only the brunt of these diseases but also the majority of disease burden. Combined, these findings tend to support those claims outlined within chapter 2, that although females are more likely to survive to the age of 85, they do so with greater prevalence of disease than their male counterparts (Olshansky et al

1991). However, neither set of figures portrays anything subjective about how individuals experience or cope with or manage disease. This limitation, as argued in chapter 2, may result in unfounded assumptions being made about the level of health demands an ageing population will place on our economy.

6.3.1 Self-Rated Health

One of the most frequently used and widely adopted measurements of global health status consists of a single item that asks respondents to rate their health, usually on a four- or five-point response scale (Krause and Jay 1994; Jylhä 2009). Since the 1950s, the added benefit of subjectively assessing quality of health through the use of self-rated health (SRH) questions within health surveys has been recognised (Singh-Manoux et al 2007), the validity of which comes from consistently demonstrating that better SRH not only predicts better survival and function, but also lower use of services (Bond et al 2006).

Recognising the strength of including SRH questions, structured interviews contained the global self-rated health status question: '*How do you rate your current health against what you had expected it to be like at this age?'*, with the addition of a comparative self-rated measure of health: *'How do you rate your health compared to others your age?'*. Results were positive, with 46% (n=40/87) of responding participants rating their health as 'better than expected at this age', although again gender differences were apparent with a 18/22 male/female split determining that 47% of all male participants were in this category as opposed to 45% of all females. Findings for comparative measures were similar, with 70% (n=62/89) rating their health as 'excellent, very good or good when compared to their contemporaries and a 30/32 male/female split determining 75% of all male participants were in this category, as opposed to 65% of all females.

Two main conclusions are drawn from these results. The first supports literature from chapter 2 pertaining to disability paradox, whereby despite high levels of multimorbidity as illustrated in figure 9 and high prevalence of disease in table 7, participants still self-rate their health positively, supporting the point made toward the beginning of this chapter that individuals do think beyond disease when determining their own health. The second conclusion drawn supports

literature which states that females not only live longer and in poorer health than their male counterparts, but also self-rate their health less favourably (Eurostat 2003 cited IN Bond and Cabrero 2007, p.128).

In terms of strength of association with more objective measures of health, such as prevalence of disease and mortality rates, then subjective measures of self-rated health have been shown to have significance. However, Jylhä (2009) suggests that the reason for this strength of association is not clearly understood.

Data emerging from in-depth interviews suggests that the concept of individuals comparing their own health against that of their contemporaries is naturally occurring in everyday language. In the following response from Alan it is possible to conceive that in older age groups, given that many of the contemporaries and friends known to participants have died, it is not entirely surprising if such comparatives seldom fail to be favourable:

> "As I say I'm eighty-seven --- and I say some --- well such and such a one [counting on fingers] oh he'll be dead now and I remember this one they'll be dead and then this one all people my age that I knew --- so I must be doing alright [laughing]
> *R: Do you spend a lot of time thinking about that?*
> Well that's all I've got to do now --- ye don't I don't spend time think about it --- it's just if ya lying down or if ye cannit sleep ya sometimes think about what happened to the lads I used to hang round with and that --- ya brain everything its going all the time"
>
> (Alan, p.3, ll.111-119)

Where other favourable comparatives existed, feelings of sympathy were also commonly expressed:

> "Well --- one thing mind I've been a healthy person all my life and illness and that because when I talk to people my age and younger who have

arthritis and rheumatism and permanent illness I feel sorry for them because I've got no permanent illness and that
R: How does that make you feel?
Well sorry for them --- but I feel good yes I think so"

(Frank, p.17, ll.843-848)

Sympathy for those perceived to be in a worse state of health was also used by participants as a reason not to complain about their own health. Relatedly, participants also spoke of a sense of fear that the same thing could happen to them, with the fear of memory loss having particular resonance. The following from Coleen illustrates this:

"Well --- well I'm starting to have to think you know I'll say eeh I forgot that but everybody does as they get older --- but my memory's been pretty good
R: And is that something that is important to you?
It's most important.
R: Most important?
Oh yes
R: Why do you say most important?
Well there's one lady further along the road [pointing down the corridor in sheltered accommodation] and it doesn't matter who she sees she asks them what day is it --- … --- what am I doing today is anything on downstairs … bingo tonight because she used to call the bingo and everything now she hasn't got a clue where she is --- and ah hey it's sad to see so I think it's great that I can remember and she's a year older than me this lady
R: You say it makes you feel sad can you explain why?
Ah hey I feel sorry for her but you keep thinking when's that going to happen to me you know --- you cannot help it when you see it --- it does make you think about if it happened to you --- … and this same lady broke her hip --- well --- I was thinking about her all the time and I thought hey this could happen to me just like that it could happen to anybody --- and at the time I had hurt my back and … people cannit be

here all the time and things happen to you and I thought I'm just going to write a little note --- just in case I pop my clogs through the night for whoever finds me"

(Coleen, p.13, ll.561-599)

In contrast to feelings of sympathy, superiority was also expressed by one of the male participants, who perceived his health not only as better than those his own age group, but also those in a younger age group too:

"R: How do you feel about being this age?
Bill: I'm very happy --- I am fit and well
R: … You feel happy?
Bill: I feel on top of the world … I mean I look at other people who are younger than me and I feel superior to them
R: Superior?
Bill: Of course I'm that kind of bloke
Brenda: A bit conceited
Bill: Yes a bit conceited
R: So you turned eighty-seven last week?
Bill: Yes three days ago and I feel really chuffed … I'm fit and healthy and then Brenda told me that you were coming to see me and I was even more chuffed"

(Bill, pp.44-45, ll.1688-1724)

Continuing to explore his expression of superiority, it became apparent that Bill had a strong belief that he had invested a great deal of time, effort and willpower into maintaining his health, something which he had started from a young age during his time spent in the army where there was "discipline, exercise and rationing of food":

"R: If there was one thing I could take away from this interview … what health means to you and what age means to you what would you like for me to have in my mind as I go away?

Bill: There's an old saying what I'm thinking of a healthy mind and a healthy body the main thing is to live what I call a balanced life nothing in excess good exercise good diet we learned that in the army keep within yourself if you know what I mean

R: … Could you explain?

Bill: Within your own limits --- don't try to be better than anyone else --- you see there are some people who have the idea that you've got to achieve all the time higher and higher and it makes sometimes I think for dissatisfaction"

(Bill, pp.48-49, ll.1841-1856)

This theme of taking action and making choices to contribute to and maintain one's health [labelled healthy lifestyle], was readily expressed by other participants and as such is revisited in greater detail later within this chapter. The excerpt from Bill also introduces an awareness of the relationship between mind and body, where he speaks of a healthy mind but also of having a sense of being satisfied, a point which was echoed throughout many of the participant in-depth interviews, albeit expressed using interchangeable language including happiness and contentment. This area of exploration is emerging as an important one for 'ageing research'. However, the complex and diverse nature of meanings attached to such expressions makes this difficult, and some would argue that it is beyond the reach of quality of life scale (QOLS) or satisfaction with life scale (SWLS) alone, having more to do with the less tangible concept of wellbeing in older age (Fry and Ikels 2011), a concept which has presence throughout the chapters and one which will inform the final discussion.

In attempting to draw conclusions from data thus far, it would appear that comparatives of health demonstrate a natural convergence within the data, albeit with greater contextual richness from in-depth interviews as to why positive responses may be given. Global health status, or expectations of health at current age, did not appear naturally within in-depth interviews. However, as

this was a dimension of a particular theme, the essence of the question '*How do you rate your current health against what you had expected it to be like at this age?'* was repeated, although on this occasion no predetermined response categories were offered. The following extracts and ensuing discussion represent findings:

> "Well I'm eighty-nine on the eleventh of February I can't believe that this is possible that I'm eighty-nine now --- I can't believe it no so if I had thought about if I'd be healthy --- well I don't know what I would have said --- I'm not quite sure what I could have said if someone had said that to me I just didn't ever think"
>
> (Eileen, p.9, ll.401-402)

> *R: "Florence how did you expect your health to be at this age?*
> I've never thought about it [laughing] I've just got old
> *R: You got old --- do you ever call yourself old?*
> [laughing] No --- but I am
> *R: You said that really reluctantly what is it about that word old?*
> Well it's all in the mind isn't it
> *R: So what does it conjure up in your mind when you say the word old?*
> Someone else [laughing]"
>
> (Florence, p.13, ll.629-642)

> "…. What I expected my health to be --- I would never have thought I would even get to this age … no I never thought about getting old or nothing like --- it wasn't going to happen"
>
> (Gordon, p.28, ll.1374-1380)

> *R: "So when you were a young man you said you felt healthy and now you say you feel as healthy as you can be*
> Oh yes I'm getting on

R: So do you feel like you've changed?

… No I don't think so oh I'm getting on obviously

R: You're getting on --- is your health what you expected it to be at this age?

Well you know that's another thing I never even think about my age --- I never used to but now I say now so and so and so --- but I don't expect much

R: So you don't expect much?

No … well I don't know --- some things that --- no not really

[wife in background: you know fine well you'd like to do more in the garden]

Oh well I mean yes gradually doing those things --- you automatically say well I've got this to do I've got that to do and you can't"

(Edward, p.8, ll.341-373)

"Yes I did think of what my health would be like at my age today [laughing]

R: You did?

Yes the day before [laughing]"

(Harry, p.19, ll.940-942)

Participant responses to this question appeared to cover two distinct elements. The first expressed that they had never thought about reaching the age they had. The second, possibly as a direct consequence of the first, showed participants having no apparent expectations about what their health might be like at their age. Participants who had considered health expectations reported doing so within a very recent time frame and, as demonstrated by Harry, often expressed this with humour.

Such findings suggest that, on the whole, in this age group the usefulness of SRH questions in isolation may be limited. Mossey and Shapiro (1982) concluded that as a predictor of mortality the association of SRH is weaker with

advancing age, and more recently Bond and Cabrera (2007) questioned the absolute relevance to morbidity as many older people positively rate health in the face of multimorbidity. Recommendations drawn from this include: undertaking additional research to address how older people perceive their health, interpret SRH questions and what they mean by their responses. It may be that current data reflects an older person's optimistic rating against low or indeed no expectations using widespread negative assumptions about health at their age as reference, rather than their actual health.

Building on this point, when examining participant conversations of health more closely, it was observed that for some, such as demonstrated in one of the very first quotes from David at the start of this chapter: *"… It means to me that I can run around or could run around and jump all that sort of thing …"* the use of past tense was common. This guided the researcher to then ask the question: *"when thinking about how you have described health --- are you healthy?"* In keeping with the findings from SRH within structured interviews, the majority of participants agreed that they were healthy, despite having a diagnosis of disease. This is revealed in the cases of Florence and Harry who, having rated their health as 'worse than expected' but 'good' in comparison to others their age, also indicated that they were not healthy and the reasons why they felt this:

> "When I first came to live here I knew everybody to talk to even maybe to have a coffee with you don't now because they've all got cars they're in their cars not walking up the street … we've got a one you know … well we've never had a car we got it about three or four year ago and it's a godsend to me now
> *R: Why would it be a godsend?*
> For walking going to the doctors I have to go to the Freeman on Wednesday for instance these sort of things even going out for a meal on Sunday it's … it's getting out and if we didn't have a car
> *R: Is it important to still be able to get out?*
> Oh yes
> *R: Why would that be?*

Because the point is if I didn't have a car I would get the bus but I wouldn't be able to go to places so far away I would have to be content to go wherever the bus went … but I couldn't just sit in

R: You say you couldn't just sit in what is it that makes you feel that you couldn't just sit in?

I don't know just sitting there all day in the house I mean one day I might have to but until that day comes I have to make myself do things you know

R: Why do you make yourself?

Because I think it's important --- I think it's important for your health

R: And are you healthy?

Healthy well not really well but you see when you get to my age you get these problems because I've prolapsed and one thing and another"

(Florence, pp.6-7, ll. 272-311)

R: "Can I ask when you say the word healthy what is it that you mean?

Exercise

R: So is it more to do with the physical?

I would say so yes,

R: And do you feel healthy?

No

R: No --- so what stops you from feeling healthy?

… Old age and perhaps the after-effects of a stroke it's my leg that's gone the worst

R: You said old age can you just explain a little more about that?

Well its self-explanatory eighty-eight isn't young any more --- it's old isn't it you can't do at eighty-eight what you've done at forty-eight … but I wouldn't be too bad if it wasn't the legs which had gone"

(Harry, pp.2-3, ll.72-101)

For others, however, data was more at odds, as was the case for Alan who, having rated his health as very good and better than expected, then

described feeling surplus to requirements and a burden as he no longer had his health:

> "Well I'm at a stage where I've not got me health I can't --- what do I do from now --- can't walk can't run can't play football can't go down the town or down the quayside or anything like that --- so I'm superfluous to requirements
> *R: Is that the way you feel?*
> Oh yes --- that's the way I am
> *R: How does that make you feel?*
> Well…….I haven't ever said so but I am a burden to my two daughters
> *R: Do you feel a burden?*
> I do…I would be much better if I was out the way they wouldn't have to worry about me"
>
> (Alan, p.13, ll.603-619)

All three of these extracts support claims made previously within this chapter, that health for many older people is centred around function, with the loss of function having a negative impact on perceptions of health. Loss of function was also expressed with a great sense of hopelessness and the cause of being a burden, a topic which is revisited in detail in the following chapter. However, many others reporting loss of function also talked of adaptation, as will be illustrated later in this chapter.

With many of these very emotive accounts around health, there remains a great deal of convergence between the data, the excerpt from Alan being one of the exceptions. However, what data from in-depth interview reveals is that for those with negative perceptions of their own health, such as Florence and Harry, age featured strongly almost as an accepted cause. Here, comparisons are drawn with previous literature which claimed that not only is the popular consensus to perceive ill-health as an inevitable feature of ageing, but also that older people themselves 'buy into' and indeed mirror this socially produced culture with expectations of ill-health as they age (Bond and Corner 2004).

The following comments from David and Gwen, both having self-rated their health as fair and better than expected, highlight this common point in context using words such as ‘accept’ and ‘natural’, responses used by many of the participants’ when asked the question *‘What does ageing mean to you?’:*

> “Well ageing is just what it is --- you’re getting old things your body is slowing up your arms ache your legs ache in fact you ache all over sometimes you don’t ache as much as others … life is funny it starts to fade a bit and you realise that you get high blood pressure the eyes go … you have to accept it”
>
> (David, pp.20-21, ll.1089-1145)

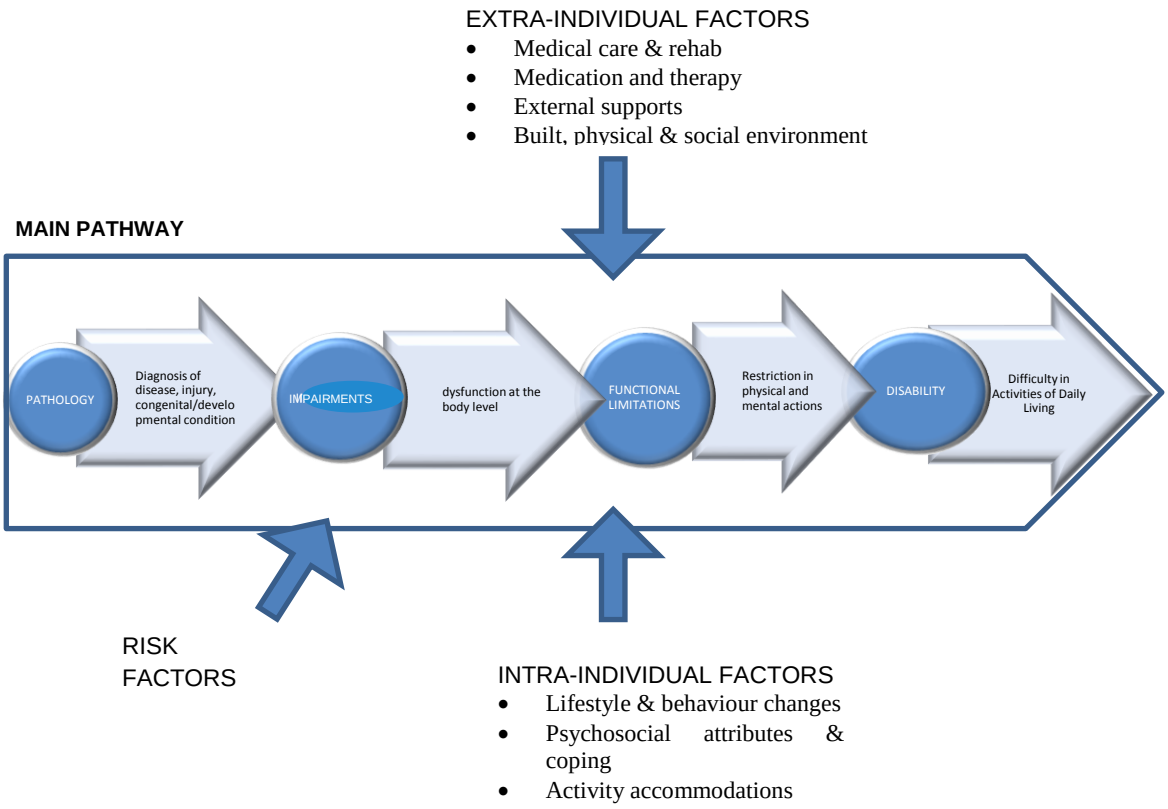
> “I’ve never felt my age I don’t say I feel it a bit now but I’m just getting tired terrible pain I get in my neck I don’t get a lot of chest pain but I get it in my neck … I’ve got rheumatism badly as you can see [shows hands] and now my ankles are swelling that one more than this one but it’s just natural
> *R: What do you mean by natural?*
> Well you can’t expect to be the same at my age can you --- I have the odd occasion I just don’t feel right some days you know but I think I’m still not bad I shouldn’t grumble”
>
> (Gwen, pp10-11, ll. 484-528)

A consequence of this ‘acceptance of symptoms’ may be the failure of older people to report them, despite the existence of effective treatment (Williams 1990 cited IN Bond and Cabrero 2007, p.117). This apparent trend of non-reporting of symptoms by older people is an important one which is considered later under the header ‘use of services’.

6.3.2 Disability

One of the most widely used practices to measure disease burden involves the investigation of disability. As a concept, disability is highly complex and although its history has been somewhat an either/or affair in applying contrasting medical or social model worldviews, in more recent times disability frameworks such as that from the World Health Organisation (WHO), have drawn from both perspectives (WHO 2001 cited IN Bond and Cabrero 2007, p.119). An earlier example of a socio-medical model of disability proposed by Verbrugge and Jette (1994) illustrates disability as a process [Figure 10], which takes into account personal ability and environmental demands as factors in the disablement process, resulting in disability being either 'intrinsic' (the difficulty of performing an activity without the aid of assistance) or 'actual' (the difficulty of performing an activity even with the aid of such assistance).

Figure 10: Disablement Process



(Verbrugge and Jette 1994, p.4)

The following from Cyril goes some way to illustrating in context the process within this framework, using what the authors term a valued domain, that being valued by the individual.

> "You see I used to go dancing --- I packed up when I was when I got thrombosis in me leg the balance went all wrong in me leg
> *R: Is that why you stopped?*
> That's why I stopped cos I couldn't get me balance but I decided I could still go to the dance halls to see everyone
> *R: How long ago did that happen?*
> I'd be over sixty-five it's about twenty year ago now … oh it must have been after I'd retired … and I said well I cannot come dancing anymore but we'll go and meet up with everyone --- and me wife could still dance … oh yes I cannot get me balance the balance had gone all wrong in me leg but we still went
> *R: And how long did you keep going to the dance?*
> She [wife] started getting she started getting --- getting arthritis osteoarthritis it was bad she could hardly move at times oh it was awful she had that for about ten years but of course everything else went wrong …"

(Cyril, pp.7-8, ll.330-362)

Here then at a pathological level the diagnosis of thrombosis resulted in Cyril having impaired balance and limited function, affecting his ability to dance (valued domain). However, using intra-individual factors, Cyril re-evaluated this valued domain to determine that the social aspect was also a valued domain; therefore, attending the dance to satisfy this also limited the effects of the disability. In addition to this example it is also possible to draw comparisons with psychological theories of ageing as reviewed in chapter 2, central to which is an individual's capacity to make sense and adapt to biological, psychological and social changes using processes to manage these such as selection, compensation and optimism (Baltes and Baltes 1990).

6.3.3 Measuring Disability

In terms of measuring disability, it is widely asserted that the most standard and cost-effective means of doing this is through questions about functional activities of daily living (ADLs) (Katz et al 1963; Kempen 1995; Kingston et al 2012). These questions require individuals to self-rate their ability in performing all personal care activities, using 'can do' not 'do do' on a four-point interval scale demonstrating degrees of difficulty, from:

(i) I am able to do this alone without difficulty
(ii) I am able to do this alone but with some difficulty
(iii) I am able to do this with the help of an aid or appliance
(iv) I am unable to do this alone

Due to criticisms that the use of ADL questions alone label those individuals with minimal difficulties as disabled, refinement of the questions includes the introduction of Instrumental Activities of Daily Living (I)ADLs), activities which require some level of cognitive ability, such as shopping, preparing and cooking a hot meal, managing medications and money (Lawton and Brody 1969). The combined use of ADLs and (I)ADLs is thought to benefit clinicians and researchers in best describing the range of disability in a wide population (Kempen 1995).

Harnessing this benefit, sixteen ADL/(I)ADL questions were asked of study participants within their structured interview, the results of the most commonly reported activity for the four response categories being shown in table 9 below.

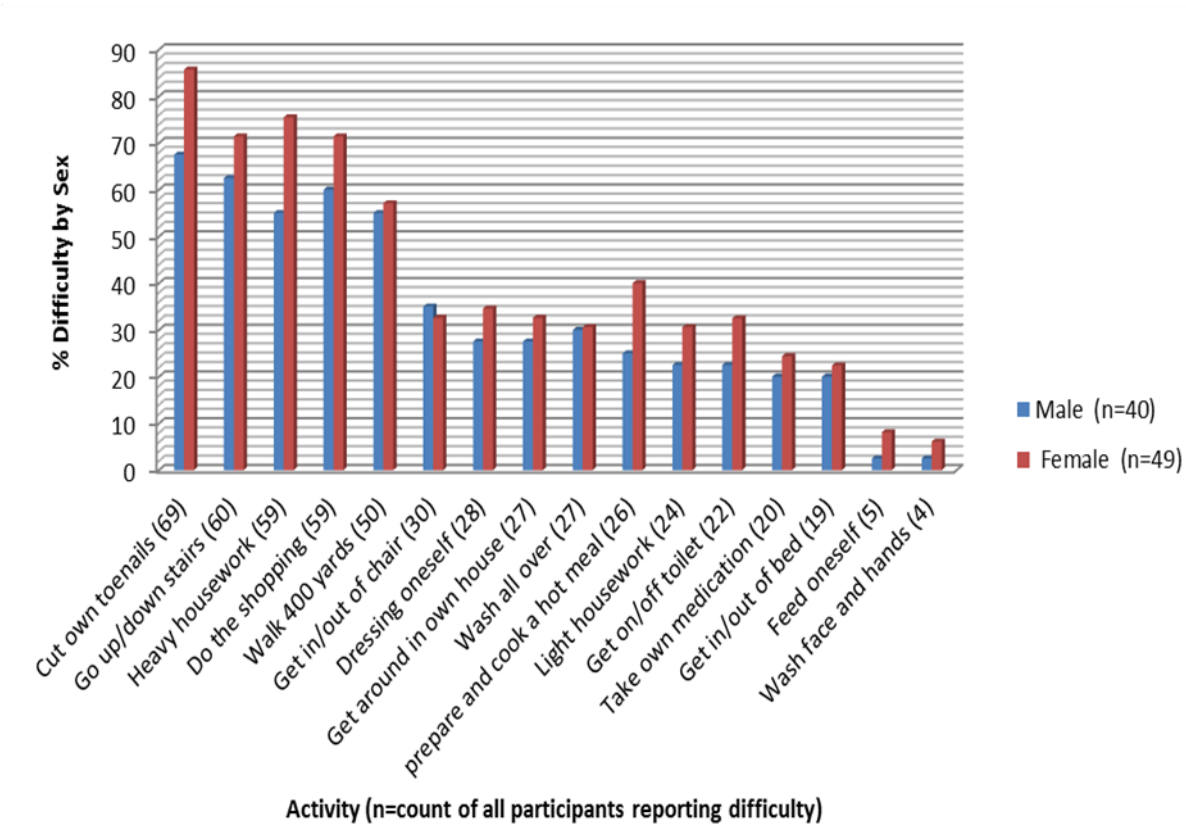
Table 9: Response Categories and Most Commonly Reported Activity

Response Category	Activity Most Commonly Reported	%
No difficulty	Wash face and hands	96 (85/89)
Some difficulty	Going up and down the stairs	37 (33/89)
Requiring the help of an	Getting on and off the	17 (15/89)

aid or appliance	toilet	
Unable to do alone	Cutting own toenails	53 (47/89)

The response of ‘no difficulty’ was then excluded and all of the remaining responses were used to rank activities from most commonly reported as causing difficulty to least commonly reported, regardless of degree of difficulty. Findings were cross-tabulated against sex, and here, as demonstrated in figure 11, females are shown to have greater levels of self-reported disability than males. These findings add weight to those presented for disease prevalence and also add to the evidence that females are more likely to survive to the age of 85 but in poorer health.

Figure 11: Activities Self-Reported as Causing Difficulty to Complete (Ranked and by Gender)



In addition to the four-point interval response scale previously identified, seven of the activities were identified by clinicians and social gerontologists within the

team as key activities representing a spectrum of ‘interval of need’ ranging from: requiring assistance with this activity less than daily; at regular intervals; and at any time during a 24-hour period. If participants reported that they were unable to perform any of these seven key activities alone they were also asked the cause of their difficulty, who provided assistance to perform the activity, how often assistance was received, and if the assistance received met their needs. The seven key activities were: ability to get on/off toilet; dress oneself; wash all over; heavy housework; prepare and cook a hot meal; do the shopping; and take own medication. Results indicated that where assistance was received this was mainly provided by the participant’s spouse or their children, regardless of interval of need category. The subject of provision of care within families is one which generated thick description during in-depth interviews, and this subject will be revisited in greater detail within chapter 7 of this thesis when considering social connectedness.

6.3.4 Use of Health Services

The burden of disease through factors such as multimorbidity, disability and dependency is keenly felt in use of health services, and the fear that this burden will increase beyond resources as the population ages was one frequently offered within the literature reviewed. Despite debate around ‘disability paradox’ and the validity of ‘Self-Rated Health’ tools, it remains clear that the projected increase in demand for health and social care provision requires careful attention (Jagger et al 2011). The point repeatedly argued here is the need for robust quality data.

Data from structured interviews and review of general practice records reporting participants’ use of health care are provided in table 10 [timeframe either in previous 4 weeks, 3 months and 12 months prior to interview].

Table 10: Use of Health Care Services from Structured Interviews[1] (n=89, n=86 where questions omitted for 3 participants in care home) and Review of General Practice Records[2] (n=116)

Timeframe	Service	%
Past 4 weeks	Home Care[1]	19 (n=16/86)
	Meals on Wheels[1]	8 (n=7/86)
	District Nurse[1]	8 (n=7/89)
	Attended Day Centre[1]	7 (n=6/89)
	Had contact with your General Practitioner[1]	27 (n=24/89)
Past 3 Months	Attended A&E[1]	6 (n=5/89)
	Attended Outpatients[1]	33(n=29/89)
Past 12 months	Been in Hospital as an Inpatient[1]	31 (n=28/89)
	Any Consultation with own General Practitioner[2]	95 (n=110/116)
	Any Consultation with Practice Nurse[2]	83 (n=96/116)

This data indicates that contact with own General Practitioner (GP) is a health care service commonly used by participants. Some caution, however, needs to be applied in attempting to draw any conclusions from this finding. In light of the different time-frames used to collect data it is difficult to compare against other data, although census information indicates that consultation rates within the past 14 days for those aged up to 65 years of age is 15%, as compared to 18% of those over 65 years of age (Bajekal et al 2006), suggesting that significantly more older people have consultations with their General Practitioner (GP) than younger age groups.

Systematic review of empirical evidence within the literature also suggests that gender differences in consultation rates exist, with women consulting more frequently than men, although with little evidence as to why there may be differences in health-seeking behaviour (Blaxter 1983; Hunt et al 2011), other than men adopting key social practices of masculinity and not wanting to be seen as weak, instead “toughing it out” (Tiduver and Talbot 1999).

Clearly from the evidence to date, care providers and practitioners have much to learn from investigating how individuals perceive their health and what cultural and social context they draw upon in the decision-making process to determine if their health is (i) compromised and (ii) requires consultation with their doctor. Undoubtedly the use of non-formal services and support is intrinsic to such exploration; and, although not discussed here, this important area is the focus of the next chapter. What is discussed here, is the relationship between participant 'beliefs' about age and expectations of their own health, as many of the participants indicated that symptoms were often explained away and accepted as 'normal' for their age. The impact of this was explored further through the theme 'health advice and medical contact', specifically with doctors, where a dimensional range of 'avoidance' [not wanting to bother or be a burden to their doctor] – to - 'actively seeking contact' [to gain re-assurance], with scope to move non-sequentially through this. Some of these aspects are now highlighted:

> " … I can remember like doctors I'm saying I haven't seen many doctors … I remember a doctor coming into the services he was just a boy I said he's not a doctor he's just a boy and I think the last time I saw him he was still just a boy and it must have been about 30 year later [laughing] … he was in my practice … and he said I'm doctor so and so and I says oh my God
> *R: So how did you feel seeing him?*
> Well I don't see them as it happens doctors --- I very seldom see them a doctor I'm lucky in me health --- it worries me sick if I've got to go and see a doctor
> *R: Why does it worry you?*
> I don't know because I never have to see them so if I've got to go and see a one then that means [gestures thumbs down] --- ye divn't want to join them [laughs pointing down to the floor]"
>
> (Alan, pp.3-4, ll.145-163)

> "Yes well as far as I'm concerned I am healthy --- aren't I --- I mean I never go to my doctors or I try not to he would pick faults with me [laughing]"
>
> (Edward, p.8, ll.379-380)

For both Alan and Edward it appeared that by avoiding contact with their GP, their perception of their health would not be challenged. In terms of Blaxter's 'Representations of Health' (1980) [Table 6], they were healthy as they were 'not-ill'. The findings also support the earlier reference to gender differences in consultation rates with doctors, in that the participants who spoke specifically of avoidance were male. Reasons for this were explored further, and in addition to challenging any self-perception of not being ill [as with Alan and Edward] for others the issue of not wanting to be a burden was introduced. In Ian's case, as given in the account below, this resulted in him delaying diagnosis and treatment for what turned out to be chronic industrial respiratory disease. This consequence of non-reporting of symptoms, as previously identified, is a major concern:

> "I found just lately when I've been getting in the bath getting out and cleaning it I find my breath short I've been getting a pain in my back but thought oh it's just another thing --- we all went out the whole family went out together to celebrate my eighty-eighth birthday we had a great time they were all 'come on dad' we had a great time … the next day when I woke up I said oh I must have a hangover but I didn't so I thought I had the flu you know it must have got on my lungs and chest … aye so that was at the back end of November December it started then instead of going to the doctors I thought I'd cure myself with lemon and honey and the odd drink but at the finish I had to go to the doctors because my chest was so bad I think myself I should have went earlier like but I don't like to put on to anybody"
>
> (Ian, p.15, ll.713-734)

For those participants ‘actively seeking contact’ the primary motivation seemed to be to gain reassurance. For some, such as Cyril, reassurance took the form of being told by a ‘legitimising agent’ [his doctor], that he was recovering after an acute episode:

> “So when I saw the doctor the other day he says to me try and get yourself fit by walking just walk slowly just a little bit and once you feel you’ve had enough sit down that’ll be enough for the day … your body will tell you when you’ve had enough walking … so I’ve been doing that”
>
> “Like the operation has been a success the doctor said everything’s a success it’s all healing very nicely”
>
> (Cyril, p.3, ll.131-134 & p.11, ll.541-542)

For others it was more in the form of legitimising symptoms through diagnosis:

> “Well I’ve had a cataract taken off this eye and I’ve had laser put on it twice but it’s made no difference well I was seeing this wife and she was checking my eyes and she says ‘oh your eyes haven’t changed in the last two years’ so I says oh I’m not happy about that cos I knew they had so I went to see my doctor again he wrote a letter [referred to outpatients] … I was in there a good bit trying this that and the other … anyway they give me that card saying that I was partially blind you know … [shows card stating registered partially sighted] … and that was her saying me eyes haven’t changed --- well that proved her wrong didn’t it”
>
> (Gordon, p.32, ll.1558-1585)

Gordon’s account also signifies a particular determination not to accept what he was first being told. This type of behaviour is perhaps not expected within this age group, possibly as a consequence of ageism or a continuation of not wanting to be a burden. Indeed for the most part within in-depth interviews participants talked of compliance and gratitude when speaking of encounters

with doctors, such as Doreen who, as identified in her vignette, has profound long-term health problems due to surgical complications:

> "I was in one hospital and had to go to the other to get this colostomy done and one of the doctors from the other hospital had been sent … this lady doctor and she says hello and I said hello she said 'I've met some patients in my time but I've never met anybody like you' what she meant I don't know [laughing] --- she meant I was never moaning and groaning you know I try to do as they told me"

(Doreen, p.3, ll.151-161)

Other participants, who would fit with the subject of compliance and gratitude, spoke of their doctor and nurse in terms of having faith in them. Here, health practitioners were described almost as divine keepers of health, without participants recognising any contribution they themselves may have in controlling this:

> *R: "Do you feel healthy at the moment?*
> I feel you know --- I've got a good doctor and nurse … I mean they see to my asthma and blood pressure all that sort of thing and if I've got anything --- if I'm worried about my leg there is the doctor they are they are very good --- I've got good faith in them"

(Florence, p.8, ll.370-376)

6.4 Luck Versus Healthy Lifestyle

In exploring the area of control over health further, the subject of fate was raised and here it was noted, as shown in Alan's excerpt when talking of avoiding his GP, that many of the participants talked of luck being responsible for their health and the age they had reached:

> "I think I'm lucky to have reached eighty-eight with the situation I'm in it's only the last twelve months that my legs have gone and that
> *R: You used the word lucky there*

I think I'm lucky --- yes

R: What do you mean by lucky?

Well having had the hiccups I've had in the past few ten twelve fifteen years I've recovered from them so --- I had six arteries by-passed and seven days after my operation of four and a half hours I was out in the pub having a drink"

(Harry, p.9, ll.414-430)

Interestingly, when talking of luck Coleen also expressed a feeling of sadness and the apparent inevitability of 'luck running out' with the passing of time.

"I think I'm very fortunate now to get to my age because I've got here with not much bother and now I keep thinking hey in three years I'm going to be ninety

R: Are you looking forward to being ninety?

No I'm not bothered about ninety --- who wants to be one hundred as well while we're on [laughing] … I don't care for birthdays … time is marching on --- my luck might run out …

R: How does that make you feel?

Sad --- because I'm nearing the end of my years"

(Coleen, p.11, ll.469-503)

As with Coleen, many of the participants who talked of luck went on to identify the limitations of this, which in turn introduced understanding around the role of the individual in determining his or her own health. The following from Harry repeats the previous quote from his interview [colour] but shows a continuation of the conversation to illustrate this point:

"I think I'm lucky to have reached eighty-eight with the situation I'm in it's only the last twelve months that my legs have gone and that

R: You used the word lucky there

I think I'm lucky --- yes

R: What do you mean by lucky?

Well having had the hiccups I've had in the past few ten twelve fifteen years I've recovered from them so --- I had six arteries by-passed and seven days after my operation of four and a half hours I was out in the pub having a drink --- that recovery was remarkable,

R: So was that recovery due to luck?

Well no … I was a healthy person to undertake it --- I was in a healthy state when I went in for the operation that wasn't luck the army taught me about discipline to be fit --- and after I retired I still played badminton and went dancing"

(Harry, p.9, ll.414-441)

Similar observations came from Harry where in his final remark he makes the point that an individual can influence his or her own health:

R: "What does it mean to you to be healthy?

--- Well I've got you today coming to see me … the times I've got to go un see the doctor I can count nearly on one hand --- I haven't had any breakages or anything like that so I've been lucky in me health

R: So you think luck has a lot to do with your health?

Luck well really --- it's just a word --- you can do something for yourself --- but if you haven't done it you've been lucky but ye can't have luck to go"

(Alan, p.3, ll.101-108)

6.4.1 Smoking

In exploring participant beliefs of how an individual, and they themselves, had contributed to influencing their health, the subject of smoking appeared frequently. The harmful effects of smoking were talked of, as was the fact of soldiers receiving tobacco as part of their rations with little awareness at the time of the damage it might cause. Data from structured interviews indicates that 61% (n=52/85) of study participants regularly smoked tobacco at some time in their lives, with the majority of these being male (58% n=30/52). When reporting current smoking habits of those who had ever smoked tobacco, only 17% (n=9/52) still regularly smoked. When talking around this subject during in-

depth interviews, the experience of watching family and friends die from smoking-related disease was not uncommon, and for those participants who had previously smoked the health benefits of no longer doing so were made clear:

> "We didn't really know it was bad for us … until I've seen them be ill with smoking and seeing oh oh oh you know people that … died of cancer --- God…. I saw more people like that after I'd given up and I'd say well thank goodness I gave it up"

(Alan, p.21, ll.1017-1021)

6.4.2 Exercise

For many of the male participants, influencing one's own health was centred upon exercise, discipline and physicality. As in the previous chapter, many of these beliefs were situated around working-life experiences and the physical nature of their work, including that of WWII and being in the services. Discussion then moved to comparing these experiences to those of people today and, as the following from Cyril demonstrates, participants expressed an awareness of the deleterious effect of a sedentary life:

> "I was a bus conductor for thirty five years now in those thirty five years I was upstairs downstairs outside the bus upstairs downstairs all day long an eight-hour shift … it was exercise but now you find anybody that's … everybody has got a very sedentary occupation in an office where they are just sitting at a desk all the time and that's not as healthy"

(Cyril, p.14, ll.657-666)

Modern-day technology was also given as a reason for people taking less exercise, with television singled out as culpable for some of today's health problems, such as childhood obesity:

> "I think television has been a bad invention --- I mean we are all becoming more couch potatoes less exercise ... I mean as a child I was never in the house … and I think that kept us healthier children these

days are more overweight because of television they sit in the house and they don't exercise enough"

(Harry, p.2, ll.67-70)

Environment and, in particular, lack of outdoor space and gardens were also identified as factors contributing to today's sedentary lifestyle. Interestingly, lack of a garden was also identified as a potential trigger for the deterioration of health in older people themselves, when downsizing property or moving to 'purpose-built' accommodation for older people which often lacks individual gardens.

It was also during these discussions that the relationship between physical activity and healthy mind was again realised:

"Oh I was always active always you know what it is I've got a daughter still playing badminton and she's sixty-four I've got a son now he's playing rugby he played for Gosforth before the Falcons then he played for that again then he played for the veterans he played until he was about fifty I've got a son who's still playing at fifty-five they take after their dad oh aye
R: And do you think activity is important to your health?
Oh definitely aye
R: What benefits do you think you get out of being active?
Well you know --- activity you haven't got to sit in the house you've got to get out and about you've got to keep your brain going and your mind going you know --- you've got to participate I get with the younger company I get with my family you know I'm not an old man I'm with them you know,"

(Ian, p.5, ll.227-243)

6.4.3 Diet

Both ‘smoking’ and ‘exercise’ were topics that featured most heavily during in-depth interviews with male participants. However, the topic of diet generated intensely rich data from both male and female participants, with both expressing beliefs around the benefits to health gained from good nutrition. These discussions often took a life-course approach, whereby the participants talked instinctively from their childhood experiences through to present time, revealing the importance of ‘good nutrition’ during the early years of life. This format of past life experience having an impact on current health is one which was employed in the previous chapter when examining work and transition to retirement. It also builds upon some of the literature referred to in that chapter, whereby research was emerging which considered childhood experiences and their impact on current health and wellbeing, although as also suggested at that point, the limitation of such research was its reliance on objective measures.

Dietary data from in-depth interviews unearthed two broad descriptions: good nutrition as quantity of food and good nutrition as quality of food. In terms of characterising quantity, this was often expressed in terms of going hungry or not. Interestingly, in the next excerpt from Florence the subject of good nutrition was introduced by her whilst being asked about her sibling’s longevity:

> “… So apart from my sister they were all well above ninety
> *R: How does that make you feel?*
> I’m proud of it … well we were always well fed well what I mean is we never wanted for anything really … we didn’t go hungry
> *R: Is that important?*
> Oh yes it’s important --- that’s what I hear --- I mean yes I do I think its essential good food”
>
> (Florence, pp.5-6, ll.236-253)

In relation to quality, childhood diet was commonly described as ‘healthy’, ‘home-cooked’ and ‘wholesome’:

R: "You say your mum went out to work and the money she was able to earn at that time was very little and she had two daughters and you were all living with her parents and you talked about getting the best food
Yes it was what she spent most of the money on every day we used to walk home from school and we had a good healthy meal …
R: What do you mean by healthy?
A home-cooked meal vegetables potatoes and meat and rice pudding --- we didn't have any fancy puddings that we have nowadays"

(Eileen, p.3, ll.126-142)

"Well grub and that was more wholesome I mean they have too many additives in stuff nowadays you know when you have certain things you have now you can taste the powder additives on some ... oh aye fresh bread in them days was fresh as I say anybody was passing would be [sniffs the air] phwoar they're baking their new bread … the smell of bread but it's not the same smell as what they used to make then your flour and that was richer --- everything was richer I mean everything that you would get off the farms in them days was really from the land now I think there's too much additives in too many different things you know nothing tastes as good as it did in them days no --- I mean a lot of people would say I'm wrong that's because they haven't tasted anything better"

(David, pp.12-13, ll.659-675)

Conversation with participants again moved towards comparing their diet with that of children today, where the overriding feeling suggested a poorer diet having detrimental effects on health and, as Gwen states, happiness:

R: "Is there any one thing which you have learned in your life --- information or piece of advice you would give to someone?
As I say the only thing I can say thinking about the kids now the way they are getting fat and all the rest of it they should eat proper food I mean I still have fish three or four times a week with salad things like that they

don’t eat the right stuff --- if you’re healthy you’re happy and if you eat properly you’ll be healthy
R: So do you think they are connected being healthy and happy?
I do I mean honestly pet if you’re not eating the right things you can’t feel fit all the time and if you’re not fit you’re not happy --- you’re not you know”

(Gwen, p.21, ll.997-1009)

When questioning the perceptions of a declining modern day diet further, responses commonly drew in wider social factors such as changes within the modern family, women going out to work and the take-over of large supermarkets versus the closure of local stores.

Overall, participants seemed highly attuned to the notion that good health was not attributable to one thing in isolation, but rather to the interplay between factors such as exercise, nutrition and lifestyle choices. Keeping in mind that many of the participants would have been of retirement age around the time that the 1986 WHO: Ottawa Charter for Health Promotion was introduced, prompting a major shift in moving the responsibility of health away from providers to individuals themselves, participants demonstrated an understanding of individual responsibility through healthy lifestyle.

However, such awareness seemed almost perplexing at times when participants remarked that against current health information, most of the home-cooked food they had eaten during childhood and into adulthood would not necessarily be considered healthy:

“Well we were eating what we shouldn’t eat … now by rights we shouldn’t be here at all … like pot pies and meat puds … you know ... a lot of meat --- rabbit pies and broth
R: Did you change what you ate or continue with that?
Well continued --- we all did really”

(Coleen, p.12, ll.519-536)

Dietary intake was also considered as a key component within structured interviews. However, the primary outcome of data gathered here was the comparison of two methods of data collection, namely: food frequency questionnaire (FFQ) based around broad recall of the previous 12 months food intake; and the repeated multiple pass recall (MPR) based around measurement s of food intake from the past 24 hours on two separate occasions. The rationale for this comparison was the lack of validated findings around the use of dietary assessment tools in those aged 85 years and older. The findings of this work are published in Adamson et al (2009) where it was concluded that the MPR is preferable as a means of assessing dietary intake in this age group.

6.4.4 Choice and Control

Debates related to health promotion, government guidelines and individual responsibility are in no short supply when reviewing literature. Successes such as that linked with reducing rates of smoking in the older male population, particularly in the non-manual group, are countered with continual unease from those, such as in sociological perspectives of chapter 2, who view the shift in responsibility as an opportunity for health care providers to blame individuals for making bad life choices that in reality they may have very little control over due to inequalities, and absolutely no control over in the event of genetic factors or health risks related to their sex (Townsend and Davidson 1992).

Research from Calnan (1989) using data from two large-scale community surveys in southern England also postulates that tools used to measure individual beliefs about control over health, such as Multi-dimensional Health Locus of Control (MHLC)[3], show little in the way of influence over health-related

[3] Based upon Rotter's concept of internal-external locus of control - whereby those with internal locus of control hold a belief system that considers their actions have an impact upon destiny and those with external locus of control believe they are not the masters of their own destiny (Rotter 1966 cited IN Bowling 2001 p.159).

behaviour. Here the author suggests that there are other areas of exploration which:

> "Look at investigating beliefs about the behaviour itself … and develop an instrument which is more sensitive to lay beliefs of health and its control…and find explanation about patterns of health related behaviour".

(Calnan 1989, p. 135)

Interestingly, the author goes on to identify the development of research using work history, beliefs about work and employment status in relation to health behaviour, citing many studies which have shown subtle relationships between beliefs about control over work and health-related behaviour. This provides further support for investigations such as that presented in the previous chapter.

This notion of choice and control in relation to improving health was also picked up on by some of the participants, particularly Anne as indicated in her vignette, due to her work as a doctor in women's health in some of the less affluent areas of Newcastle upon Tyne:

> "Of course before the National Health Service only the men with insurance could get to see their family doctor --- the wives and the children didn't they just couldn't afford it … they got their health information from neighbours old wives their mothers… well of course now there's the health services and better housing better feeding isn't there food and all the rest of it
> *R: And do you think that influences health?*
> Well that and hopefully education has helped but I gather --- you see I'm out of touch now but I gather there are still some very poor disadvantaged people who don't have the same as the rich people --- of course I don't meet them now…"

(Anne, p.6, ll.286-302)

6.5 Summary

The aim of this chapter has been to explore perspectives of health within the context of ageing. This was done using data which first considered the complexity of defining health. The evidence showed that one single definition of health is impracticable due to the fact that definitions are historically, culturally and socially situated, however in Western society the medical model has been relied upon to provide knowledge of health. Despite attempts by this model to move away from health being not merely the absence of disease, the literature informed us that much of what is measured and used to drive policy and service planning is centred around medically defining and measuring the prevalence of disease and disease burden, with age-related disease being no different (Salomon 2004, Collerton et al 2009, Jagger et al 2011).

Situated within Western influences and cultures, the participants of this study tended to first subscribe to social norms, talking around physicality and absence or presence of disease when asked about health. However, further exploration revealed that individuals interpreted this 'knowledge' differently in terms of beliefs about their own bodies and what health was to them. For some this meant being able to perform a particular function, such as getting out of the house and, although linked with physicality, the gain of social functionality was also uncovered. Ultimately, findings suggest that although lay health beliefs may share some common characteristics, such as those outlined in Blaxter's 'Representations of Health', primarily these beliefs are complex and multifaceted, as individuals have free will to apply their understanding of knowledge to their own situation and define health accordingly.

As a result of complexities in defining health, and with the additional factor that the extent to which 'knowledge' is applied by an individual and how they measure health against this is changeable, it is perhaps unsurprising that tensions were revealed between perspectives. Findings at times appeared inconsistent or at odds. Specifically, findings from objective and subjective measures of health were used to exemplify this, and whilst objective review of medical records and diagnosed disease showed multimorbidity to be the norm, many of the participants self-rated their health positively and performed highly in

(I)ADLs. Such a paradox is considered within a wealth of literature, however key findings put forward from in-depth data within this chapter, whilst acknowledging the use of SRH as a useful predictive health tool (Jylhä 2009), and (I)ADLs as a means of measuring disease burden (Katz et al 1963; Kempen 1995; Kingston et al 2012), first question the validity of SRH within this age group in terms of understanding what is truly being measured, and then query the untapped potential to gain understanding from those individuals who demonstrate resilience in successfully adapting in their everyday life despite changing health needs and high levels of disease.

Regarding the first point, results from in-depth analysis indicated that participant responses appear to be influenced by widely-held attitudes synonymously linking increasing age to increasing ill health. This conclusion was arrived at by considering that participants' initial explanations about health, as influenced by the medical model, did not necessarily change over time. However, due to the passage of time and taken in context, participant expectations or 'measurement' of their health against this point did appear to have shifted over the life-course, becoming influenced by the belief that declining health is a factor of increasing age. This may account for some participants rating their health positively against low societal expectations of health in older age. Similarly, for participants who did not rate their health positively, age was given as an accepted key explanatory factor for 'symptoms'.

Regarding the second point, whilst results from disease count and (I)ADLs support claims within the literature of chapter 2 that females live longer but with a greater proportion of disease and disability, it does little to fully harness what can be learned from those who experience difficulties but successfully draw upon resources available to them in order to manage their own health, such as non-formal support and help from spouse or children in performing (I)ADLs. It is the opinion of this study that this is an area of vital importance to overall research aims, and therefore this theme is drawn upon within the context of the following chapter, which considers social connectedness.

Debate also considered the use of formal health services, where despite high GP consultation rates when compared to younger age groups, many

participants spoke of not reporting treatable symptoms to their GP, instead accepting these as a ‘normal’ part of ageing. Further factors for non-presentation to their GP were revealed from the data, such as not wanting to be a burden, and avoiding any potential challenge to their own, more positive, health beliefs by seeking out medical perspectives. Related to this, Conway and Hockey (1998) suggest from their research that those societies where old age is stigmatised as a period of increased ill health, avoidance or rejection of the label of ill health also serves to deny old age itself. Again, these findings raise concerns around deep seated beliefs which link increasing age with failing health and decrepitude.

Sex differences were also apparent when considering use of services, with females having higher GP consultation rates than males. This occurrence is possibly as a direct result of the previous findings, which showed females to bear the greatest load for disease prevalence and burden. However, literature also pointed toward health beliefs having different meaning for men and women. Here Kandrack et al (1991) suggest this dimension of health requires further consideration when exploring health perspectives.

Finally, the chapter presented findings from data which demonstrated an awareness and responsibility held by this population group with regards to having influence over their own health, with participants also acknowledging the contribution of luck. Debate recognised that inequalities can impact upon an individual’s ability to make healthy lifestyle choices, however even where internal control is perceived, healthy choices do not always follow. Here there appeared to be great potential for generating further understanding of the issues surrounding perceptions of health and patterns of behaviour, by drawing from the past experiences of individuals within this age group and examining behaviour and values developed over the life-course, such as that presented within the previous chapter.

In conclusion, at the onset of this chapter it was identified that the investigation of health would be debated within the context of two broad categories, namely ‘disease prevalence and disease burden’ and ‘luck versus healthy lifestyle’. However, overarching findings indicate there is much to be gained from

investigating perspectives of health of the older person and incorporating these into medicalised perspectives and assessments upon which resource allocation and planning of care are based, as only then will these truly represent the divergent needs and gender issues of this population group and contribute to ‘ageing well’. This is not to say that such tools do not have a key role to play, but greater confidence should be sought in what is actually being measured and what meanings are being interpreted based upon what beliefs individuals are drawing upon when responding. It is argued that this population group is ideally situated to assist with this due to their wealth of as-yet untapped life experience, with many overcoming hardship, high prevalence of disease and disability, and yet reporting good health and remaining independent within their own homes.

CHAPTER 7: SOCIAL CONNECTEDNESS

> "When I get with the younger company… when I get with my family … I'm not an old man"
>
> (Ian, p.5, ll.241-243)

7.1 Overview

The previous two chapters showed that individuals aged 85 years and older have great resilience when faced with major life challenges or age-related transitions. Whilst individual experiences are unique, commonalities were also apparent in the strategies drawn upon. These include interacting or engaging with other individuals within their surrounding environment, be that at work or in social groups as examined in chapter 5, or with care services and family as introduced in chapter 6. This supports those who criticise theories of disengagement with advancing age, first outlined in chapter 2. Although it would be naïve to claim that social engagement remains unchanged over the life-course for all individuals aged 85 years and older, it is equally ill-advised to suggest that 'change' signifies disengagement culminating in social isolation. Rather, ageing is more generally linked to the presence of a social network consisting of higher-quality relationships and more supportive contacts (Cornwell et al 2008).

Throughout the relevant literature and, according to Smith (2010), dating back to the work of Durkheim in 1897, there is much debate about the concept of social networks and about the support and positive impact that being embedded within these can have upon individuals' health and wellbeing, in terms of doing better and living longer (Living et al 1999 cited IN Krause 2001, p.283; Grundy and Slogett 2006). Much of this literature goes on to address the wider concept of social connectedness, which provides an encompassing theme as a means of 'being involved' or 'belonging' (ASTRA 2008; Cornwell et al 2008; PHAC 2009; Visser et al 2010). Adopting this broader concept, the aim of this chapter is to focus upon the significance of social connectedness and the relevance of

its components - social networks and support - towards influencing perceptions of ‘ageing well’.

7.2 Social Networks

Social networks as defined by the European Union Public Health Information System (2009) are the ties or personal relationships an individual holds with family, friends, neighbours, colleagues and significant others. According to a review by Willmott (1986) it is not necessary for all of the individuals within a network to be directly in touch with each other; however, networks where individuals are connected are more close-knit or dense and tend to consist of ‘informal’ contacts such as family and close friends.

Much is reported about the differences between social networks of individuals in younger and older age groups. Younger individuals typically have larger social networks and greater opportunity for connectedness (Baltes and Mayer 1999 cited IN Askham et al 2007, p.197). This is often attributed to limiting factors associated with advancing age (Ajrouch et al 2005), which include retirement and declining health as covered in chapters 5 and 6 of this thesis. The death of relatives and friends is also identified as an age-related factor impacting greatly on the social networks of older people, and will be explored later within this chapter.

Previous chapters also identified the impact of inequalities such as social class, financial resources and gender on an individual’s ability to ‘age well’ in terms of successfully managing transition to retirement and influencing perceptions of health and lifestyle choices. Again, although not discussed in detail here, these factors are acknowledged as influencing individual opportunities for social connectedness. Wenger (1989), drawing upon the findings of Mugford and Kendig (1986), reported sex differences in social networks, with women having larger networks than men. This would appear to contradict claims made within chapter 5 that men are advantaged in having greater opportunity to establish and maintain social interactions due to an uninterrupted work history. However, the work of Aiken (1989) goes on to attribute this to women having a greater tendency not only to form social interactions but also to maintain these

relationships, strengthening their bonds through the expression of feelings and emotions.

The overview of this chapter touched upon ‘gains to health’ from social networks, through the potential to provide resources such as access to information and support (Cornwell et al 2008). However, not all networks are viewed as supportive by older individuals. Where viewed with suspicion, older individuals may feel awkward or unsafe in asking for help. In turn this can result in potential ‘helpers’ also feeling awkward and ultimately withdrawing from the network (Wenger 1989). It is also possible to suggest that the presence of cognitive decline may heighten this problem, as an individual’s capacity for understanding may be affected.

In examining social networks, Wenger and St Leger (1992) analysed data from two longitudinal studies: the Department of Health and Social Security funded North Wales study (1986); and The Northern Ireland Study (1991). Putting forward 5 main typologies of networks characterised as:

(i) *‘Local family-dependent network’* close family ties often sharing a household with an adult child, commonly a daughter, few peripheral connections to friends and neighbours, tend to be small networks, the older person is usually in poor health and often widowed.
(ii) *‘Locally integrated network’* close relationships with family and friends, often neighbours, long-established residence and active community involvement past or present, larger than average network.
(iii) *‘Local self-contained network’* has arm’s length relationship or infrequent contact with relative, is often childless and relies upon neighbours; community involvement is low-key and networks are smaller than average.
(iv) *‘Wider community focused network’* absence of local relatives is common, high involvement in community/voluntary organisations, high levels of friends and neighbours with a clear distinction between the two, this network is larger than average, often associated with retirement communities.

(v) *'Private restricted network'* absence of local relatives other than spouse, few friends and little community involvement, restricted contact with neighbours, networks are smaller than average.

(Wenger and St Leger 1992, pp.222-223)

Already through the data, it is possible to make some rudimentary assessment to assign most of the participants of this study, with one possible exception to be considered later, to type (ii): *'Locally integrated network'*, suggesting that perhaps this network is a key feature in the survival of this cohort. Although limitations of sample size make this claim tentative, it is possible to conduct a more detailed examination of the social network in which the individual is embedded in order to gain perspectives on value and support offered.

7.3 Support

Consistent definition of 'support' within the literature is elusive. In its most simplistic form, support is described as the potential for an individual's social network to provide help (European Union Public Health Information System 2009). According to Krause (2001) there is a lack of consensus because the concept of support is so unwieldy that definitions, possibly including that given here, are too narrowly focused. Such lack of clarity appears to have resulted in researchers adopting various methods of measurement, with little attempt to identify to which definition they adhere. As a solution, the work of Barrera (1986) is offered in providing classification of support into three main groups: 'Social Embeddedness'; 'Received Support'; and 'Perceived Support', each of which are now outlined.

7.3.1 Social Embeddedness

In quantifying the first of these three support classifications, Barrera suggests measuring frequency of social contact with others. Similarly, during structured interviews participants were asked how often they had engaged in a range of social activities, including contact with others, in the previous four weeks. The possible response options were: every day; every week; once; or not at all. Results showed that the main form of contact, reported by nearly two-thirds of

the sample (n=53/85), was receiving a weekly visit from relatives or friends. This was followed by telephoned (n=43/85) or been telephoned (n=40/85) once a week by a friend or relative in approximately half of the sample. For activities where contact with individuals other than family members was more likely, more than a third (n=31/85) had taken part in a club activity and nearly half (n=41/85) had visited a restaurant, theatre, cinema, art gallery or museum at least once in the previous four weeks.

7.3.2 Received Support

This second classification is said to be measurable in terms of amounts of care and assistance received, such as contact with formal care and help given. Findings from (I)ADLs included within the structured interview, as reported in the previous chapter, would correspond with this classification, particularly those additional questions around the seven key activities which identified who provided help and how often.

7.3.3 Perceived Support

This final classification of the three is suggested as having most influence over an individual's health and sense of 'ageing well' or wellbeing in later life (Krause 2001). Its description as the subjective evaluation of measurable support from the first two categories undoubtedly makes this classification difficult to quantify, although satisfaction rating scales do attempt this.

Again, data from structured interviews could make some inroads to capturing this subjective element of support, by asking participants the questions: 'does help received for (I)ADLs key activities meet your need?'; and 'is there someone you could call on for help should you need a lift somewhere urgently, or be ill in bed?' Around three-quarters of participants (n=68/89) considered that there would be someone they could call on, the answers to both questions being positive, with the majority of needs reported as being met all of the time or most of the time. However, this information has limited use in exploring which aspects of support may be most beneficial to an individual's health or sense of 'ageing well', and here it is argued that it is the particular strength of qualitatively derived in-depth data within this mixed method approach which enables true

exploration of this final classification. It provides a richness of detail which considers perceived support from the perspective of the individual and the meanings and values they attach to this.

As acknowledged in the previous chapter, support can be provided by formal and/or informal sources. Although the two are often blurred, or applied with fluctuating degrees of consistency, for the purpose of the ensuing discussion formal support is accepted as that which operates at an organisational, professional or institutional level (Allen et al 1992), while informal support is that which lies outside of this and is therefore often invisible. For the remainder of this chapter, the focus will be on informal sources of support, which the literature consistently documents as a primary resource for older people and central to which is the family (Wenger 1989; Silverstone and Horowitz 1993).

7.4 Ageing and Family Relationships

As suggested by Kinsella (1995 cited IN Connidis 2001, p. 8), one of the effects of living longer is lengthening the amount of time spent in familial relationships. Seeing children become adults, parents, grandparents and even great-grandparents is not uncommon, however from literature examining families in later life, the two most central intergenerational relationships involve parents and their adult children, and grandparents and their grandchildren (Connidis 2001). Data from in-depth interviews supports this claim, with much of the conversation around family being dominated by these two relationships. These relationships are now considered in detail.

7.4.1 Grandparent/Grandchild Relationships

On relationships between grandparent and grandchild, Askham et al (2007) dismiss the stereotypical image of the passive elderly grandparent for a more dynamic one, arising as a result of wider social issues such as changing demographics and family structure, and increased teenage pregnancy. Here typologies of grandparenthood are presented that afford positive gains to grandparents, such as gaining a sense of being valued. In contrast, Aiken (1989) presents a range of feelings experienced by grandparents, from gaining a great sense of pleasure, pride, being valued and involved in the continuing

family lineage, through to a sense of feeling old and isolated from the present and the future. Data from in-depth interviews supports the view of Aiken in also demonstrating such a ‘range’.

The following from Harriett illustrates the more positive end of this range in describing her grandchildren as a pleasure. This excerpt also suggests that in spite of ‘bad press’ and one personal negative experience, her view of the younger generation was a positive one which she had formed mainly from her relationship with her grandchildren and their friends:

> “Well all the younger ones that I know have all been very good you know I mean I haven’t had any cheekiness off them except I remember John [husband] when he was going to his mums he used to call in in the evening about nine o’ clock or so and there was one time when he was going along and there were some young lads coming along behind and they knocked his cap off which went flying over the road and he had to go running after his cap he shook his hand but he couldn’t catch the lads he said if I had have caught them I would have belted them
> *R: Did it upset him?*
> Oh no he was just cross yes he was just annoyed that they had done that and he had to run after his cap we never seem to have any trouble with the younger ones because a lot of the time you see in the news or the newspapers the younger ones seem to be --- there always seems to be bad press around them I’ve noticed that but the ones I’ve known by my grandchildren that they never annoy me and my grandchildren are a joy never any problems
> *R: No problems at all?*
> No they are just a pleasure to be around”
>
> (Harriett, p.7, ll.317-346)

Illustrating the other end of the range, Florence, whilst talking about how people live today and how she thought the world was better with more opportunities for her family, revealed a sense of disconnectedness and isolation from the world, which was brought into focus whilst thinking about her grandchildren:

R: "Why do you think that today's world's better?
Oh yes for all I'm not in it I still think the kids like my grandchildren have got better opportunities than I had
R: What you've just said there Florence 'for all I'm not in it' do you not think of yourself in today's world?
I'm in the world alright but I can't use it --- I can't do things --- you see New Zealand for instance I've been there four times… but I can't do it now I daren't trust myself in an aeroplane because of my veins and I can't use the computer and things like my grandchildren do because I don't understand them --- so that's the difference we're [self and husband] in it but I don't feel in it"

(Florence, pp.20-21, ll.994-1020)

Some of the less positive feelings expressed here by Florence may be associated with her family living in another country, however as later discussion around 'proximity of family' within this chapter will examine, the assumption that increased distance correlates to a less fulfilling relationship is not generally valid.

In addition to supporting a range of feelings similar to that put forward by Aiken (1989), data from in-depth interviews also revealed some novel gendered divergence in what contributed positively to the relationship with grandchildren. For grandmothers this tended to centre on the function of providing a caring role, perhaps unsurprising when considering the findings of chapter 5, suggesting that caring as a characteristic is heavily associated with the female sex. This was clearly expressed by Coleen in her vignette when talking of how privileged she had felt in being able to provide care for her grandchildren to enable their mothers to go out to work, a function she believed to have been made possible by her good health. Although the previous chapter would suggest that this relationship between 'function' and 'health' was perhaps more reciprocal, in that the function also contributed to Coleen's lay perceptions of good health, a viewpoint which gains importance by Coleen having stated that she would have felt useless had she not been able to fulfil this function.

For grandfathers the sense of relationship with grandchildren concerned acting in a position of authority or as an advisor, possibly paralleled by westernised cultures of gender inequalities and leanings toward patriarchal head of household, previously outlined when discussing the challenge of assigning social classification by occupation. The following account from Cyril typifies the dynamics of this relationship:

> " I've got five grandsons marvellous the whole lot of them they all come and speak to me 'hello granddad how are you how you getting on' and then talk about what they are doing and what I think and I listen to them but I listen to them and take notice in what they are doing and if I don't see anything wrong in what they are doing well I would just say smashing carry on doing it but if I think there was anything wrong in what they are doing then I would tell them I would just say I think you're wrong in there somewhere and I would go and think about it and when I had thought of something to say I would just tell them and hopefully they might decide that there's something in that"
>
> (Cyril p.20 ll978-987)

7.4.2 Parent/Adult Child Relationships

Relationships between parent and adult child have again undergone classification attempts within the literature. Here, results of one international study suggest a framework comprising four main areas of analysis in this relationship: (i) proximity; (ii) interaction (frequency and type); (iii) obligation or duty; and (iv) familism or loyalty and closeness of the relationship (Harris 1975 cited IN Troll et al 1979, p. 78). Similar to before, the subjective natures of the final two elements of this proposed analysis are inherently more difficult to examine, albeit more rewarding if achieved (Troll et al 1979).

Literature also points toward increasing tensions in a parent/adult child relationship as the parent ages, primarily as a result of 'role reversal' whereby the adult child assumes a position of responsibility and caring over the parent

(Aiken 1989). Generally this is said to occur more commonly with daughters than sons, which the gendered nature of caring may go some way to explaining [chapter 5]. In considering 'role reversal', the advice and information for families tends to be skewed towards forewarning of tensions through loss of independence for the older person. Whilst not disputing that in some instances this may be the case, there appears to be an absence of more specific understanding as to why this may be so. Observations from Arber and Evandrou (1993) explain that what independence actually means to the older person is seldom addressed. Where such a focus has been included in research, three interrelated dimensions have been recognised:

> (i) 'physical independence' (being able to look after oneself),
> (ii) 'autonomy' (freedom of choice),
> (iii) 'reciprocity' (not being under obligation, not charity).
>
> (Sixsmith 1986 cited IN Arber and Evandrou 1993, p.19)

Considering independence within this more sensitive framework suggests that loss of physical independence does not mean outright loss of independence. As difficulties may be overcome through received support or adaptation if this is perceived favourably within the broader reciprocal relationship, or if the individual feels they have retained autonomy. This reasoning links to the previous chapter when discussing Verbrugge and Jette's (1994) model of disability and the potential for individuals to draw upon support or 'intra- or extra-individual factors' in order to adapt or protect 'valued domains'.

Participants who did imply role reversal in their parent/adult child relationships did not suggest feelings of threat or loss of independence, but more of a degree of acceptance. Alan provides a particularly good illustration of this when talking with a great deal of humour of the 'support' from his daughters. In this account it is also possible to speculate where Alan drew reciprocity from the relationship, in having financial resource to counter his physical dependency:

> "Every week Carol [Alan's eldest daughter] comes on a Wednesday and tells me what a filthy house I've got and she does me hoovering and

Susan [Alan's youngest daughter] is Little Lord Fauntleroy she comes on a Sunday and sits there [gestures to chair] for an hour and talks to me and she'll go and have a look at me bank balance and she'll go and have a look in me drawer where I keep me money --- and on many occasions she'll say Dad you've got far too much money in that drawer I'm gonna take two hundred pounds out because you don't spend it when you're old [laughs] --- so away she goes with two hundred pound --- but she doesn't take two hundred pound I know for a fact that --- because I've heard them talking on the phone the two of them costs me a fortune every time they come … --- I don't know how often she's done it quite a few times and had maybe a thousand pound at one time --- I think I think they have a bank in Tesco's between the two of them I love it --- every hapenny I've got its theirs when the time comes

R: How do you feel about them doing things for you in the house and 'looking after' your money?

Love it --- I'm very proud of it --- can you understand that how many children bother with their parents and look after them --- my children come to see me --- I never go to see them mind that's because I cannit you know [touches legs] --- I couldn't tell you where they live"

(Alan, p.12, ll.549-569)

Also implying role reversal, using the phrase being 'told off' by her daughters, Harriett suggested less a feeling of acceptance and more one of disregard, possibly as a means of expressing autonomy over her independence. In the following Harriett talks of continuing to walk outdoors to the back gate, something which her daughter felt she should not do when she is alone:

"Well I get told off --- but I still do it --- I say 'I have to do something' --- 'shut up' she says 'you used to tell us about not to do this and not to do that when we were little now we can tell you off' so the roles have reversed a bit

R: How does that make you feel?

I just laugh and let them get on with it"

(Harriett, p.19, ll.918-924)

Where tensions did emerge around role reversal they tended to be explained through feelings of frustration at the lack of autonomy, or awkwardness from the lack of reciprocity in the relationship. In the following, Gordon - registered blind due to macular degeneration - exemplifies this in speaking about now having to rely on his children since the death of his wife. Particular attention is drawn to Gordon's attempts to exert some autonomy over his diet, which is felt to be unhealthy by his children:

> "It's a loss since my wife died like she was the only one who could read letters and that but now I cannot read any letters because I cannot see … I cannot read any letters --- when I'm eating my dinner I cannot distinguish what's on the plate she says [daughter] that's your potatoes there's cauliflower there --- the meat's over there but I'm just picking it up and I don't know what I'm getting first --- I'm just eating it
> *R: And how does that make you feel?*
> Oh it makes me feel awkward I'd rather just eat things I don't have to cut up like a tin of Irish stew or soup I can just eat that with a spoon but they keep on at me because it's not healthy --- I thought it would never come to this you know"

(Gordon, pp.26-27, ll.1288-1303)

Perhaps what is lacking in the framework from Sixsmith [p.189] is consideration of issues such as financial resource, culture, gender and class, all of which will have some bearing on how these dimensions play out in determining at what point independence becomes threatened.

7.4.3 Multigenerational Households

In considering reciprocity within parent and adult child relationships, the literature suggests that this is most often magnified when examining multigenerational households. The idea being that in contrast to the assumption that adult children are always the care provider in this situation, commonly they

have move back in with older parents for emotional or financial support through major life events, such as the breakdown of a marriage (Aiken 1989; Coward and Cutler 1991). Or may never have moved out (Connidis 2001).

This latter point reflected the living arrangements of Florence and her husband, whose youngest son had never left home. Florence talked openly about how her son contributed financially to the household and how in return she 'cared' for him, along with her husband. Similar to Coleen in caring for her grandchildren, Florence made frequent reference to the importance of this role, stating that she would be lost without it, using her ability to fulfil this role as a means of confirming her health, which she described as fitness:

> "Well I'm pretty fit --- I can look after three people you know
> *R: You say you look after three people can you just say who they are?*
> Yes myself of course my husband and my son who is sixty-three who's retired
> *R: Is it important to you to look after your husband and your son?*
> Oh yes it's important
> *R: How --- what does it mean to you?*
> Well really it means everything because all my family there's eight of us they've all gone apart from one so you know yes yes they are very important --- I cook everything more or less for them then of course the washing and ironing I do that for them but I have to sit down for the ironing [laughs] but I do it yes yes without that I would be lost
> *R: You would be lost?*
> Yes because I enjoy it … sometimes I get a bit you know [puts on miserable face and laughs] but by 'n' large I enjoy it"

(Florence, pp.1-2, ll.6-57)

Investigating the literature around multigenerational households in greater detail, Laslett (1972) suggests that there is a myth perpetuated by communities and held within individual conscience that caring within extended families has always been common-place. The significance here is that if high expectations from good intentions are not met, families can be left with feelings of guilt

(Connidis 2001). This may be exacerbated by comments such as ‘this wouldn’t happen in the good old days’ and ‘people used to have more respect for their elders’. On this point literature within chapter 2 can be recalled, as the increased mortality and lower life expectancy of the past would suggest that multigenerational living was somewhat of a rarity:

> “Well I never met any of my grandparents they all died before I was born they died well I’ve got no idea when they died people are living longer now old people are living longer and I say well my parents would never have seen any great-grandchildren although my mother lived until she was ninety five when she died I would like to live as long as she did”
>
> (Cyril, p.19, ll.915-919)

For the few participants who did talk of childhood experiences in a multigenerational household, they spoke less of their parents providing care for grandparents, and more of necessity and deprivation. As in the experiences of Frank and Eileen [vignettes]. This finding is one supported by the literature, with Troll et al (1979) suggesting that historically multigenerational households were usually the result of economic necessity, whereas now older individuals have greater choice or autonomy to live independently and little desire to give this up and become entangled in the domesticity of their children’s lives.

With increasing age however, choice and autonomy of the older parent can become eroded, where from the literature the impact of fearing or actual deterioration in health most promotes the desire to live together, or at least be in closer proximity (Kinsella 1995 cited IN Connidis 2001, p.8; Troll et al 1979). Such was Doreen’s experience, who after the death of her husband and the deterioration of her own health had moved in with her daughter. During her in-depth interview, Doreen frequently spoke of her dependence on her daughter, expressing regret at not being able to help with the cleaning or decorating. Although recollection of the three interrelated dimensions of independence is noteworthy, since some negotiation seemed to have occurred through Doreen still being heavily involved in choices regarding how the house should look:

> "I try to keep it right I know I can't do the cleaning right but choosing things you know I do that
> *R: So that's still important to you to be involved?*
> Yes yes yes you know I like to choose that's how I help June [daughter] you know we both look and say do you like this do you like that but I get to choose"
>
> (Doreen, p.10, ll.540-550)

It is through these details that Doreen's support network tends to differ from that of the majority of other participants who, as recalled, matched to type (ii): *'Locally integrated network',* coinciding more with type (i): *'Local family-dependent network'.* The network type is suggested by the literature as linked to a greater risk of loneliness due to individuals generally being more frail and dependent, and having limited contact with age peers (Wenger and St Leger 1992). However, as apparent in her vignette, Doreen and her daughter were involved in church activities which included individuals from Doreen's age group, the benefits of which are returned to in this chapter. The fact that Doreen's daughter had never married is also given as a limiting factor of conflict within this network type.

7.4.4 Proximity of Family

Despite evidence suggesting that advancing old age promotes the desire to live in multigenerational households, or at least for families to live in closer proximity with the assumption that older people living with their family are at the most supported end of the spectrum, closer examination reveals that proximity does not determine level of support. Here findings illustrate a range of relationship support, which correspond to that within the literature of: 'close/distant' through to 'distant/close' (Wenger 1989; Esonandler 1992; Connidis 2001). The following from Frank demonstrates this:

> "You see my family look in on me and I have quite a few ups and downs with the family now [since death of his wife] my daughter is very nice to me --- by the way she's my step-daughter you know she's very nice to

me she lives nearby but she doesn't really speak to me my son who is blood relation he doesn't live far and he comes down and he brings my dinner down on a Sunday and that oh but then there's my two granddaughters one lives in Huddersfield [approximately one hundred miles away] well just beside Huddersfield and the other one lives in Gosforth [under five miles] and since I lost my wife I was worried [as related on step-daughter's side] oh they've been the life and soul of me they keep me going my granddaughters … I speak to them on the phone and they come up when they can and that one's [points to photograph] coming up on Monday to see me they got my central heating in they got my windows in new electrics in new carpets all over the house new units in there [points to kitchen]"

(Frank, pp.18-19, ll.892-910)

For Frank the use of telephone contact seemed to provide a useful resource in maintaining relationships at a distance, although it should not be assumed that telephone contact is used more frequently with decreased proximity, only that it becomes more essential (Rossi and Rossi 1990).

7.4.5 The Effect of Changes within Families

The above excerpt from Frank also introduces the impact that 'family changes', such as a breakdown in marriage, can have on support networks. In the following, Harry who describes his family as 'close-knit' suggests that whilst this adds to his sense of wellbeing in providing a source of 'enjoyment', it also brings a negative side when things change:

R: "How often do you keep in touch with your family?
Oh it's a very close-knit family
R: Do you think that's important?
Very important very important
R: Why is it important can you explain what you mean?
Well when you find that your children aren't on drugs and are not criminals it's very gratifying that you've brought up these children to at least know what's right and wrong and they come and see you and cheer

you up and of course they've all got their own families now one's just had triplets and that's a great enjoyment when they come

R: You say cheer you up.

Oh yes they wear you out --- but they cheer you up of course you have your worries too they have their problems so their problems are your problems and that can increase your worries as well as your pleasures broken marriages and things like that --- you become concerned --- but I don't want to dwell on that"

(Harry, p.12, ll.557-586)

Harry was reluctant to expand upon this situation. However, in the following words from Ian, this impact is clearly felt:

"I was brought up with the family … a huge crowd of us we were brought up together it was very you know we were very friendly all of us you know what a big community we were you know and it was bred into us you know … right through a family a community we we're close-knit together now I feel as though I could weep you know I get upset

R: You get upset?

Aye I got upset the other day Monday my youngest son's ex-wife came up you know they parted and I loved her [Ian had disclosed at another point in the interview that at the time of his wife's death eighteen years ago, his daughter-in-law had played a central role in supporting him along with his own daughter] … my daughter has met her a few times down London where she lives now met her down there and she says she'll have to come up to see me so she came up last week and we went out together for a meal and when she left I broke down ---"

Ian continued to talk about the effects of the marriage breakup and of his adult grandchildren now living in London with their mother:

"… You know but they [the grandchildren] seemed to drift away and it's not like it used to be

R: And how does that make you feel?

> Well you've got to live on your own and get on you know this is the way the world is now --- one time I used to go if there were any dos on weddings and that now they kind of forget to ask …
> *R: Why do you think that is?*
> I don't know they're getting a bit they're getting a bit stand-offish they want to keep on their own side you know --- it's difficult"

(Ian, pp.18-19, ll.875-943)

7.5 Beyond Family

Wenger (1989) suggests that rather than the term 'family' researchers should think more in terms of 'kinship' and include relationships which extend beyond the traditional nuclear family, focussing instead on how the individual constructs family in the sense that:

> "Family is what people feel and perceive it to be"

(Askham et al 2007, p.186).

Connidis (2001) recognises that restricting definitions of family to nuclear family ignores those individuals who remained single or never had children, yet they are still part of a family network. O'Brien (1991) argues that researchers have a tendency to 'lump together' those defined as single with little thought about relationships that these older people may have established with, for example, their nieces and nephews. Complexity also exists in the inferences which can be drawn for older individuals categorised by researchers as married with children, since many have outlived their adult children (Connidis 2001). This latter point is even more pertinent when considering those who have lived longer, from whom much investment over time has gone into forming close relationships with friends; their contributions as a source of support should not be overlooked.

7.5.1 The Role of Friends

The label ‘friend’ encompasses many meanings from short-term casual acquaintances to a long-term deep commitment (Matthews 1986). Undoubtedly, for the individuals involved, these differing styles of friendships hold diverse values throughout the course of a lifetime. This was made evident by in-depth interview data which spoke first of childhood friendships. These appeared to be equally divided between describing acceptance of discipline and respect for others along with a sense of freedom to play, both characteristics suggested as being lost on ‘the youth of today’. After this time, attention turned to friendships and camaraderie formed during adulthood from war time or, as considered within chapter 5, the workplace and social activities. It was in these later ‘adulthood’ friendships where detailed accounts of significant enduring or past relationships were found. An example, was given in the account from Coleen in chapter 5 when talking of the support gained from work colleagues when her first husband died and how friendships then developed outside of work and continued to provide support throughout her life, on the death of her second husband.

It is said that for older individuals in particular, the advantages of feeling attached to a supportive network consisting of friends, and more specifically age matched peers, brings with it a range of benefits which contributes to a sense of belonging and wellbeing (Jerome 1989; Aiken 1989). Indeed when asking participants to describe perceptions of quality of life, friendships were often readily included in the response:

> *R: “What are the things that give your life quality?*
> Well having faith and friends you know good friends I mean --- if I’m not well and that they tell you ‘now don’t hesitate you know’ and tell you ‘if you want anything you know any help and that’ and I mean if people got together and were more helpful to each other and things like that you know”
>
> (Doreen, p.5, ll.270-276)

R: "If I was to say quality of life to you what would your meaning be?
Quality of life … a good family and lots of good friends"

(Coleen, p.19, ll.836-842)

Throughout, friendships were commonly described as offering additional physical and or emotional support to that provided by family. What was unique was the experience of sharing social activities with peers who often share histories and similar values.

7.5.2 The Role of Groups and Clubs

Clubs and societies often provide a meeting place wherein a collective set of standards, often favouring stoicism, are used to confront and cope with some of the losses and transitions of ageing. Already, under the heading of 'social embeddedness', this chapter has presented quantitative data pertaining to frequency of participants' involvement with social activity groups. However, the perceived importance of such activity is made evident here by Eileen, who accounts for this in not only maintaining health but also increasing longevity:

R: "So you think improved healthcare and food have enabled people to live longer --- do you think there is anything else to account for people living longer?
There are all these centres and clubs people can go to keep their mind occupied
R: And do you think that's important?
Oh yes
R: Why do you think that's important?
Well otherwise if you don't do anything or don't see anyone you would just sit there and vegetate and become a turnip [laughing]"

(Eileen, p.13, ll.619-632)

Frequently throughout chapters 5 and 6, participants talked of the need to keep busy and active, to have purpose and function. According to Ekerdt (1986)

satisfying these needs through taking part in club activities, enables older people to shun society's ageist attitudes which views them as a burden. Although Bernard (1991) identifies a drawback in that clubs, societies or luncheon groups tend to be set up for older people by well-meaning individuals or organisations, usually in response to perceived social isolation. One of the problems, aside from oversimplifying the complexity of social isolation and perhaps confusing living alone with loneliness (Troll et al 1979), is in the expectation that all older individuals wish to socialise in a constructed group separate from main society. From in-depth data this is made very apparent by Frank:

> "At night I go to the bingo at the local club … and on Tuesday night it's a Karaoke night there now I don't sing because they don't want the people to go away [laughing] and on Wednesday night I meet my friend who I met in 1988 and we went on holiday in California … now we go out on Wednesday night to the local club again and we'll have a drink in the bar then at 11 o' clock get a taxi home --- Thursday I go to a different working man's club and I play dominoes talk to the people and that and I get a taxi to all these places and I leave the club about quarter to eleven after having a pint or two Friday I go to the local club again and I meet six angels
>
> *R: Angels?*
>
> Yes I'm in the company of quite a lot of ladies --- I met these angels at a garden festival in 1990 and I was sitting next to these women … and I made a good friends … they call themselves Frank's angels and they are my angels mind a lot of people are jealous [laughing] … I'm 88 they think when you get old you stop in or sit in a club for a bunch of old folk but I don't want to do that I don't want to stop in and watch television never mind what's on … yes and it doesn't matter you can still be feeling out of sorts I mean you don't have to be a hundred percent to go out you can still go out …
>
> *R: Do you think that [going out] is essential?*
>
> Yes … you see people are saying 'how are you Frank' 'oh I'm fine' 'what have you been doing today' and we talk and from that I can learn a lot people will come up and say 'oh what do you think of that that's

happened today' or 'what do you think of that' you know and we stop and talk about it"

(Frank, pp.11-13, ll.541-617)

7.5.3 Community and Neighbours

A sense of community and neighbourliness emerged as a significant theme from in-depth interviews, although more often talked of with some reference to its passing:

"… People used to swap around you know I mean somebody used to maybe breed rabbits you used to get a cheap rabbit off them when I'm talking about cheap we're talking about coppers but coppers was all you got in them days you know
R: Do you think that people looked after each other a bit more?
Ah yeah at one time you could go out your front door you didn't lock it or your back door you didn't lock it you didn't lock your windows or anything like that you had no fear of anyone coming in and burgling you there was more trust and everything in them days
R: Why do you think people trusted each other more then?
Well we all knew each other it was a way of life you see you were brought up that way at school and at work and you were brought up to work you found very few loafers in them days"

(David, p.13, ll. 712-725)

In spite of a perceived decline, additional findings from the data revealed that perceived levels of support from community and neighbours formed an integral part of some participants' networks, particularly where no close family existed, or where family members worked or lived some distance away. The nature and intensity of this support varied from general enquiries of wellbeing, watching over homes when they were empty, holding spare keys, to providing care or running errands. The following excerpt from Eileen illustrates much of this 'variation' in context. However, what is also shown is the increased intensity of

this support, shown in her time of need after the death of her husband and after her family had returned to their everyday lives 'when things had settled down':

> "Some time after my husband died after things had settled down the neighbour he said Eileen if you ever want anything at any time just knock on the wall and I'll be there for you … then I've got the two people over the road who are my carers and they've got my key --- the lady on the corner there she used to have a shop a flower shop and she says if I want anything and when I go on holiday I draw my curtains so she knows I'm away so if anything is unusual she would come over and knock at the door and she would know where to get the key yes and there's another lady down there people are very very caring"
>
> (Eileen, p.19, ll.919-935)

Considering that all of the participants of in-depth interviews had lived within their communities for fifty plus years [including Coleen who had recently moved into sheltered accommodation but remained within the same neighbourhood], it is not unrealistic to conceive that participants valued the familiarity of their surroundings as an important part of their identity, often talking of life experiences using their home, surrounding locations, and landmarks as major components within the dialogue (Scharf et al 2003).

7.6 Place

Place or the living environment is, according to Cox (1987 cited IN Aiken 1989, p.242), the house, apartment or room in which an individual lives and the neighbourhood or community in which these are situated. Along with the following data, literature seems to provide a clear consensus that for the majority of older people, home - within their own familiar dwellings and communities - is not only the place in which they would prefer to grow old (Sabia 2008) but is also more critical to health than in any other age group (Rubenstein 1989; Peace et al 2007b). Here, Brenda and Bill talk of their home as a source of pride and a place which offers them independence:

Brenda: “Quality of life is very improved for people who live in their own house or home yes
Bill: Yes it gives stability
Brenda: Yes it doesn’t have to be grand but it has to be a home
R: What do you mean by a home?
Brenda: I think it’s somewhere that gives people a certain amount of inner security and pride --- because you’re not depending on other people you’re not obliged to other people
R: And is that important to you?
Brenda: Oh yes this house to me is my security
Bill: A sanctuary
Brenda: Yes”

(Brenda and Bill, pp.24-25, ll.955-978)

For Gordon also, who still lived in the same house in which his parents had lived, becoming acutely attuned to and familiar with his environment had enabled him to hold onto the independence he valued, despite his macular degeneration, the recent death of his wife, and relationship tensions with his adult children:

R: “Do you have any fears?
The worst thing I can think of is not being able to get about or losing my sight altogether
R: Why does that worry you?
Losing my sight altogether like --- it’s bad enough now like not being able to read the letters and that but as long as I can see what I can see now and I know exactly where everything is in here [his house] then I should be okay”

(Gordon, p.31, ll.1513-1522)

As a concept, ‘ageing in place’ is also attractive for UK policy development, due to the potential for cost-effective solutions to housing with an ageing population remaining within their own homes (Sixsmith and Sixsmith 2008). The use of

household aids and adaptations can be of benefit; for example, questions pertaining to this in structured interview considered 11 household adaptations and found that hand rails and grab rails were most commonly in situ and perceived to be effective by participants. However, such a drive to 'age in place' presents challenges for practitioners and researchers in understanding the complex link between the individual and place. Once understood, however, there are opportunities for developers to recreate these 'values of home' in care settings for those individuals who do not or cannot remain in their home (Rowles and Chaudhury 2005).

Reasons for moving into care settings are undoubtedly complex and varied. Oswald and Rowles (2006 cited IN Peace et al 2007b, p.126) suggest these 'third moves', as termed by the authors, are most associated with complex undertones of deteriorating health, inability of the individual and/or the family to cope, and lack of choice. In this context 'first moves' referred to moving to a place which provides desired post-retirement amenities and 'second moves' included those to be nearer family.

Research which attempts to categorise variables associated with this 'need' to move into a care setting consistently highlights the lack of close relatives, particularly a spouse, as a primary reason (Connidis 2001). Other findings suggest that in the absence of a spouse, the presence of at least one daughter can significantly reduce the chance of going into a nursing home (Freedman 1996). Whereas others reflect more upon gender disparities, identifying that older women who have never been married along with widows who are less likely to re-marry than widowers, are most likely to move out of their communities into care settings (Rossiter and Wicks 1982; Murphy et al 1997; Connidis 2001). Claims which perhaps can be combined with those from chapters 2 and 6, in stating that women outlive men but with a greater burden of disease.

Due to sampling limitations, exploring 'place' from the viewpoint of those residing in care is limited. However, in-depth interviews were able to explore the emotions attached to thoughts of moving into care. In the following, Gwen

draws on her experiences of visiting her sister-in-law in a care home and concludes that she would rather be dead than move into a care home herself:

> "Oh no I hope I go quick I hope my heart gives out quick there's one thing if I had to go in a home I'd top myself
> *R: Would you?*
> I went and visited my sister-in-law for a year every week to the home she was in and seeing her sitting around they don't do it right in those homes
> *R: What do you mean?*
> Well they should have little groups not sitting around on their own they should have tables round tables where they can sit together and talk instead of sitting around it's terrible terrible
> *R: And why do you think that?*
> That's the only home I've visited mind I don't know if they're all like that you know and it was a lovely home spotless but they sit them there and they're sitting --- a few times I've took them to the toilet --- there's nobody there --- I would hate it I'd have to be carried there I can tell you I would never go in never that's my only hope that I can live in my own place
> *R: Do you think most people would prefer that?*
> I think so --- I don't know there are those people who like to be among loads of people yes they can be quite happy in places like that I couldn't honestly I would hate it hate it I hope that I can always stay in my own place mind as I say I'm eighty-nine in April I can't expect to live a lot of years I might live a couple if I'm lucky but I hope I can stay here"

(Gwen, p.16, ll. 744-775)

For other participants who had experienced family members moving into care, or, as more commonly expressed, had been 'taken into' care - suggesting some external force - criticism was widespread. Drawing upon her professional experiences, Anne suggested that much of what is believed of care homes by her generation, in being separated from their communities, is a legacy of the workhouse. Where even as late as the mid-1960s many of the care homes for older people were sited in old workhouse buildings (Ritch 2009).

R: "Prior to the introduction of National Health Service where did people get their healthcare from?

I suppose neighbours old wives you know their mothers --- I think that happened tremendously --- from the community who else could they get it from unless they were put in a workhouse and then they were hidden away from all that --- mind I suppose that still happens when people go into a home"

(Anne, p.7, ll.326-332)

Given the benefits attached to being embedded within a supportive social network comprising of family, friends and neighbours as located in community and place, then moving into a care home and being separated from this is understandably perceived as a potential threat to what is valued, causing disruption and unfamiliarity (Hodgetts et al 2010). This is not to say that all care settings fail to provide opportunities for retaining social connectedness; however the need is heightened for researchers, care providers and developers alike to understand the value of these support structures.

7.7 Death of Others

Literature in chapter 4 highlighted that a consequence of longevity is to experience bereavement. As the participants of this study have shown when talking through their emotional experiences of pain, loss, and adaptation to new roles within the vignettes of chapter 4, Coleen's experience of the death of her group of lifelong friends in chapter 5, the somewhat positive slant that Alan drew from the death of friends in reminding him of his own health in chapter 6, and the bereavement experiences of Eileen and Gordon in this chapter, they are no exception.

In contrast to what might always be assumed to have negative outcomes, we are informed that the time after bereavement can often be filled by increased contact with friends and family (Hockey and James 1993), again to illustrate this attention is drawn to a previous quote from Eileen when expressing a sense of increased social connectedness from the support of her neighbours after the

death of her husband. In addition, the liberation and newly gained independence for those who have experienced a long period of isolation whilst providing care for a dying relative can be positive in bringing about increased opportunity for social connectedness (Murphy et al 1997; Connidis 2001). Although findings from in-depth data also suggest that liberation and newly gained independence may require time, as made clear by Cyril, first in his vignette and then in chapter 5, where he talked of loss of identity and purpose after the recent death of his wife, for whom he'd provided care.

Despite these more positive associations with bereavement, the death of family, friends and associates, particularly of those who offer support or companionship, can not only pose a significant threat to an individual's social connectedness, but also their risk of social isolation and loneliness (Jivorec et al 1984; Heikkinen and Kauppinen 2011) and possibly, as the following from Ian shows, their will to live:

> "When my wife died I couldn't even boil water you know … I didn't know how to cook I couldn't make gravy or anything … and I'd known her since she was twelve years of age … she did everything … when she died it was a big miss we were married fifty two year you know and I knew her for sixty year altogether and did my life change --- I didn't want to go on --- I miss her a lot I used to cry a lot --- I used to cry a lot I miss her --- I never went out never went out of the house … it was my daughter who got me out … she said 'dad you've got to get out and about you can't bring her back you know' she was the one who got me out you know got me back you know back --- but it took me a long time … she's been dead thirteen years and it took me about ten years to stop grieving"
>
> (Ian, pp.17-18, ll.798-870)

With regards to the will to live, evidence demonstrates an increased relative risk of mortality, lasting some six months after bereavement of a spouse (Jagger and Sutton 1991).

All told, both the literature and data from this study signifies that the subject of bereavement, widowhood or loss of others is one which deserves greater exploration by researchers and indeed consideration from practitioners, in terms of its impact upon social connectedness, support, loneliness and increased mortality, rather than taking the simplistic view that it is a normal occurrence with, or indeed a factor of, advancing age (Aiken 1989).

7.8 Summary

The aim of this chapter has been to focus upon the significance of social connectedness and the relevance of its components upon 'ageing well', identified here as social networks and support.

Social networks were first considered in the context of exploring differences between those of younger and older age groups, examining some of the limiting factors associated with advancing age (Ajrouch et al 2005). This included retirement and changing health, with links being made to the relevant data in previous chapters. Gender differences were also touched upon, with findings suggesting that females are more likely than males to form and maintain social relationships across the life-course due to their tendency to invest greater emotion and expression.

Continued exploration of networks then moved toward characterising five main types, noting from Wenger (1989) that not all networks provide support. It was suggested earlier that most participants could be located within type (ii): *'Locally integrated network',* characterised by close relationships with family and friends, long established residence and past or present active community involvement. From this the question was raised of considering through further research the relationship between an individual's successful survival beyond the age of 85 years and this network type.

The concept of 'support' was recognised as being elusive, with researchers seeming to apply variation in meaning to the term, so that the meaning often was determined by study participants themselves. Nevertheless, a definition of informal support was provided and a rationale was offered for the emphasis

being given to that data considered within the domain of perceived support as proposed by Barrera (1986). Here recommendations tended to support those within the literature who suggest that exploration of perceived support, although most difficult to quantify, should be pursued as it is this focus which reveals most about what aspects of support influence an individual's health and sense of 'ageing well' (Krause 2001). Central to this are the themes of family and the environments in which these relationships are played out.

Aside from relationships with a spouse, the most commonly occurring relationships within the data related to those between parent and adult child, and grandparent and grandchild. Within these relationships, the literature states that due to demographic change and change to family structure, the roles of the older person no longer adhere to those perpetuated by myth and ageist attitudes of the passive elder in receipt of support (Askham et al 2007). Findings from in-depth interview data not only demonstrated this but went further, illustrating a range of highly complex dynamics of support within these relationships. Examples here included support provided by the participant: in caring for an adult child who had never left home; caring for grandchildren; having financial resource. The benefits were felt not only by the individual in receipt of the support, but also by the provider. This claim is founded on observation within the data of instances where participants described gaining a sense of purpose which they associated with increased good health and implied a positive contribution to their sense of ageing well. Gendered divergences around support were also revealed within these relationships.

On the whole, support from families was perceived positively by participants. Where 'tensions' were observed, such as those from role reversal, these were examined more closely through the literature from Arber and Evandrou (1993) who attempt to unravel meanings of independence and resolve tensions through redressing the balance of independence in the relationships of older people. Recommendations for further research in this area also draw comparisons with findings from the previous chapter when looking at models of disability and adaptation.

Consideration was also given to examining support in relation to the proximity of family. Here, findings from data and literature agree that there is a desire for families to live in closer proximity with advancing age; however the quality of support is not determined by this. Instead a spectrum of relationship support was revealed, ranging from 'close/distant' through to 'distant/close' (Wenger 1989; Esonandler 1992; Connidis 2001). In addition it is argued here that the presence of family, regardless of proximity, does not guarantee any relationship, let alone one which is supportive.

Threats to support, such as changes to family, due to marital breakdown or reduced fertility trends and the death of others were also considered within the data. Recommendations for researchers and practitioners to look beyond family were upheld, this being of particular resonance for those individuals who have never married, or are now widowed, and have never had children. Here the notion of 'kinship' was preferred, to include relationships which extend beyond the traditional nuclear family, possibly from peer groups, clubs or societies. The contribution of these as a source of support should not be overlooked and may have added benefit to ageing well as a result of shared histories and similar values.

Support from community and neighbours also fits into this definition of kinship. In-depth interview data illustrated that as a source of informal support neighbours did indeed form an integral part of some participants' networks, particularly where no close family existed, or where family members worked or lived some distance away. As with family relationships, range within the nature and intensity of perceived support existed.

As previously identified, the environment within which these supportive relationships were played out featured strongly throughout in-depth interview data. In addition to proximity of family, an individual's surroundings or environment form an important part of their identity and sense of ageing well, through familiarity with their own home and communities, in which they have often lived for many years. This results in home being identified as the place in which older people would choose to remain (Sabia 2008) and also as more critical to health than in any other age group (Rubenstein 1989; Peace et al

2007). It was also suggested that ‘ageing in place’ is attractive for UK policy development, it being cost-effective for an increasingly ageing population to remain within their own homes rather than purpose-built housing being provided (Sixsmith and Sixsmith 2008). However for some older individuals the necessity of moving into care settings is a reality, which from the data was often associated with unfamiliarity, disruption and removal from community.

In conclusion, the findings of this chapter argue that further research into social connectedness, here being examined within social networks and support, has great relevance for an individual’s perspective of ageing well, providing understanding as to the nature of support offered by close personal relationships in helping an individual successfully to negotiate age-related transitions such as retirement, physical deterioration and the death of a loved one, in addition to other sources of stress.

CHAPTER 8: SUMMARY AND DISCUSSION

8.1 Overview

This thesis was motivated by recognising that addressing the challenge of population ageing will require detailed knowledge of the diverse perspectives of older people themselves. At a time when those aged 85 years and older are not only identified as the fastest growing sector of an ageing population but are also assumed to be the most demanding of care, it is important to explore what is understood by 'ageing well'. The necessary perspectives must include listening closely to the voices of individuals from this unique group of people, and must thereby develop greater awareness of their needs, beliefs, values and attitudes. The central assertion is that there is much to be learnt from doing so, which will create opportunities to understand how these factors influence the decision-making processes of very old people in terms of their health, health-seeking behaviours and 'ageing well'.

Review of the literature in chapter 2 made it clear that there is a gap in current knowledge, whereby little is actually understood about this population group. It has been under-represented in previous research, partly because of societal neglect but also because the group is highly diverse, posing distinct challenges for the researcher. Therefore, much of what is used as the basis for planning future health and social care resources is founded upon assumption and ageist attitudes, rather than good quality evidence. This study was undertaken as a response to this need for better information, by exploring perspectives of 'ageing well' in community-dwelling adults aged 85 years and older. The central statement of the thesis is that the findings generated have validity, and add general value and originality to what is already known. Taking this forward, a primary question for exploration was identified as:

- What are the influences that contribute to our ability to 'age well'?

Two further derived questions resulting from this inquiry were:

- What potential does exploring ‘ageing well’ from perspectives which include those of the older person offer for policy and practice development?

- What are the benefits to knowledge when widening the methodological approach beyond empirical perspectives in order to investigate ‘ageing well’?

The aim of this final chapter is to assess how successfully the different elements of the thesis have been addressed. To do so, the chapter first reviews the methodological approach. Next, major findings from the data are summarised and drawn together through discussion of their connections in relation to the three areas identified for exploration. The chapter then moves to reflect upon limitations of the study and extend beyond its scope in providing implications for further research. Finally, an overall conclusion is offered which is drawn from the evidence presented within this work.

8.2 Summary of Methodological Approach to the Study

This study applied a convergent parallel mixed methods approach comprising two strands of data collection from two theoretical paradigms: (i) quantitative, being that derived from structured interviews with participants of ‘The Newcastle 85+ Pilot Study’; and (ii) qualitative, being derived from in-depth interviews with a sub-group of these same participants. This approach was selected for its strength in providing a broader understanding of the subject, by using more than one method to investigate a complex, multifaceted social issue (Brannen 2005).

8.3 Summary of Main Findings

Three main findings which advance our understanding of ‘ageing well’ in community dwelling adults aged 85 years and older were presented across data chapters 5, 6 and 7.

From chapter 5, we learned that past life experiences have relevance to ‘ageing well’ for individuals aged 85 years and older. Similarities were established with

other literature considering the relevance of past life experiences to ‘ageing well’, such as Martin and Martin (2002), Cho (2011) and Gale et al (2012). The advance represented by this study is its inclusion of in-depth exploration. Here, relevant past life experiences determined as having meaning and value by the individuals themselves, rather than the researcher, were discoverable. This enabled the ensuing discussion to move beyond what is common to much of the other literature, that being to debate the effects upon ‘ageing well’ from what are essentially objective measurements of past life experiences, such as, years in education, childhood age at parents’ death or divorce.

Past life experiences of work and retirement were highly represented themes throughout participant in-depth interviews, so these were selected to facilitate the discussion within chapter 5. In doing so, it became evident that the participants attributed their development of lifelong skills and capabilities in managing, negotiating or adapting to challenging life events to their exposure to hardship, discipline, loss, social constraints, changes in finances and opportunities, thereby assigning gains from these experiences was essential to the idea of ‘ageing well’. Gains from the past life experiences of work and retirement also extended to nurturing those values held as important to life and ‘ageing well’, such as belonging, camaraderie, support, independence, resilience, keeping busy, having a sense of purpose and not being a burden.

Chapter 6 strengthened the main finding of chapter 5, in that those same skills developed from the past life experiences of work and retirement, such as listed above, were now used to meet the challenges of changing health needs in maintaining independence and resisting the feeling of being a burden. Chapter 6 also presented us with our second main finding that the planning of health and social care resources for those aged 85 years and older needs to expand beyond empirical perspectives and ageist attitudes to include lay health beliefs. This finding emerged from discussion that first drew upon a vast body of knowledge concerning the complexity of defining health as being dependent upon which perspective, or lens, that was selected to view the concept. Here it was argued that the disease-based biomedical approach, which has dominated Western definitions of health for some time, is not always congruent with that of the older person.

This observed disparity between ‘professional’ and ‘lay’ perspectives of health was also present within the literature, some of which facilitated the exploration of data in this study, including self-reported health [chapter 6] and the disability paradox [chapters 2 & 6]. The originality of the data in this study was in considering that the health beliefs of this unique survivor cohort are as diverse as any other population group and therefore warrant individual attention. The argument here is that research which systematically and arbitrarily excludes those over the age of 75 years [chapter 3] cannot be assumed to provide solutions for those aged 85 years and older. Therefore, restricting financial support and the planning of health and social care resources to findings from empirical investigations may result in the development of services that do not meet the needs, the aims, or the desires of the older person.

Finally the third main finding from chapter 7, was understanding that social connectedness in those aged 85 years and older is a mediating factor of informal support and a significant influence on ‘ageing well’. Once again, the discussion of this chapter pulled through some of the key themes from previous chapters, such as belonging, and adaptation, thus creating links across the data. To exemplify this, where talk of belonging had previously been located within the workplace, particularly for the male participants, it was now placed firmly within their community, family or social groups. Where adaptation was used to focus conversations around the challenges of retirement and changing health, it was now used to describe how participants responded to sources of informal support becoming threatened or lost through the death of key individuals, or changes to long-established links with a community, environment or living arrangements.

Data examined within chapter 7 also re-introduced the concept of participants not wanting to be a burden. Rather than merely adding to the illustrations of this, an element was uncovered which challenged the overriding assumption that informal support within participant relationships was simply one-way. Many of the participants were observed to provide informal support within their relationships as well as being in receipt of this. In an attempt to tease out the relevance of data to ‘ageing-well’, literature was used that has considered the

effectiveness of supporting relationships through the balance between physical independence, autonomy and reciprocity (Sixsmith1986 cited IN Arber and Evandrou 1993, p.19). In doing so, it became apparent that whilst concepts of belonging, having support and being cared about all influenced factors of 'ageing well', feelings of providing support and caring for others were equally crucial. Exactly what level and type of 'providing support' satisfies this influence is unique to the individual.

Although a summary of the three main findings from the data, as provided above, is crucial in bringing together the elements of this thesis, the intention of this chapter is not simply to repeat previous discussions around the 'fit' of this data within its relevant literature, as done in chapters 5, 6 and 7. Rather, the following aims to demonstrate how these findings can be developed, and their convergence interpreted to respond across those wider issues identified for exploration.

8.4 Overarching Discussion in Response to Research Questions

As identified in chapter 2, this thesis subscribes to the principles of critical gerontology, which attempts to move beyond what is considered as 'already known' about ageing. This same value, alongside the mixed method principle of met analysis, underpins the discussion around the interpretation of data from this study, a value that fundamentally attempts to explain the convergence and significance of data in relation to the topic, here being 'ageing well', and not merely amass it (Ray 2003):

> "Knowledge is more than an accumulation of so-called facts … it is about explaining things and drawing associations"
>
> (Biggs et al 2003a, p.1)

For consistency, the three areas identified for further exploration are now addressed in turn.

8.4.1 Defining the Influences that Contribute to Our Ability to 'Age Well'

> "Study the past if you would define the future"
>
> (Confucius)

Findings from this study agree with the bulk of opinion from the literature outlined in chapter 2, stating that concepts such as 'ageing well' consist of many interrelated factors or influences. From a biomedical perspective these factors tend to be focussed on physical ability and the absence of disease, such as presented by the empirical data within this study. However, the above discussion around the main findings of this study have also gone some way to demonstrate that factors and influences of 'ageing well' are powerfully shaped by past events, as experienced by the individual within the course of their everyday lives. In considering what is exclusive about those aged 85 years and older, the following sections discuss what was discovered from this study.

Across the findings, influences that were observed to be inextricably linked to 'ageing well' are interpreted through three overarching and interlinked grand themes: 'interplay between control and autonomy', 'capacity for adaptation' and 'having a sense of purpose'.

Interplay Between Control and Autonomy

The first theme, and perhaps the most challenging in terms of providing a succinct account due to its far-reaching nature, is 'interplay between control and autonomy'. It is known from previous discussion that some factors which influence our ability to 'age well' are resolutely beyond our control, such as genetics, whilst others, such as healthy life choices, environments and outdoor 'spaces' are problematic due to the added complexity of inequalities (Townsend and Davidson 1992). However, key areas of the data which illustrated this interplay were often expressed by participants as having 'choice' and tended to appear as conflict between what was expected of an individual and what level of freedom the individual perceived they had within this. How an individual learned

‘the rules’ of this appeared to be deeply rooted in their past life experiences, the cultures and social norms they had been exposed to, and the values inherited.

In chapter 5, when examining participant perceptions of control regarding ‘choice’ of paid work, this point was made all the more evident when explored by gender. For male participants, control could be located within their conversations recalling the expectation or ‘traditions’ of their going to work in long-established industries within their communities. Still, control tended to fit with the individual desires of many of the men, even being recognised within their communities as marking a transition from boyhood into manhood. As for the female participants, control in many cases appeared to jar against individual desires and be more hard-hitting in nature. Expectations of unpaid domestic work tended to dominate the life histories and narratives of many of the female participants, described almost as a sense of duty for their becoming a wife, a mother, a carer, or for some an unpaid worker within the family business [vignette of Florence chapter 4]. If paid work was entered into, then choice was often limited to that deemed appropriate to a woman, such as retail or secretarial positions, with interruptions to fulfil domestic responsibilities. In chapter 5 we were also introduced to the controlling forces around retirement. Described through legislation and incentive packages these forms of control, appeared at first glance more directly associated with men, due to their more complete history of paid work. However, for women who undertook paid work these controlling forces took on an additional element in the expectation that their retirement would be synchronise with that of their husbands. Interestingly, these same controlling forces or societal expectations did not extend to non-paid domestic work. Here the data indicated that it was not uncommon for females, once retired from paid work, to take on the role of providing care or even that the expectation of providing care would be the catalyst prompting retirement. It was also learned from the literature that whilst retirement might be assumed to have little impact for females who had not been in paid work, this was not always the case, as their husbands’ retirement is bound up with triggers to other social responses which expect women to change their day to day routines to accommodate the needs of their husband. For the females then, the period of retirement is linked to increased potential for domestic work demands.

From chapter 6 controlling forces related to health could be observed to reflect tensions between the dominating biomedical model, society's ageist attitudes, and lay health beliefs. Unravelling the connections between these components revealed that many of the 'first response' definitions of health offered up by participants located health in the absence or presence of disease, demonstrating the widespread adoption of the biomedical paradigm. Additional expressions of awareness around the uptake of promotional health advice, for example relating to nutrition, exercise, smoking and alcohol intake, rather than relying on chance or 'luck' alone, suggested that participants placed value on the contribution of empirical investigation. However, the actual control participants' described in subscribing to this advice is heavily debated through the literature, from the viewpoint that the impact of inequalities is not considered (Townsend and Davidson 1992). Here, the main tenets of this argument states that such an oversight vindicates providers of health care and government, providing them with an opportunity to 'victim blame' when health targets and outcomes are not met.

When asked to apply their own 'first response' definitions of health, many of the participants appeared to lower expectations of their own health because of their current age. This manifested in some of the participants rationalising symptoms of ill health and disease as 'normal' to the ageing process, rather than seeking medical attention. It is not unrealistic to suggest that this is as a result of lay health beliefs being shaped not only by the influence of biomedicine but also by ageist attitudes and the continual portrayal of old age as a time of senility and decrepitude within the communities and cultures to which the participants themselves belong. Examining this further, comparisons can be made with a study of women residing in a deprived community in Scotland, where although aged only in their late 40s to early 50s many of the women attributed symptoms of poor health to advancing age (Blaxter 1983). Explanations for this were led by the opinion that whilst the lay health beliefs of these women reflected an understanding or knowledge of symptoms gained through a biomedical lens, this knowledge was conditioned in terms of where it 'sat' within the characteristics and expectations of their 'community'. Here, early childbearing age heavily influenced this process in terms of symptoms of ill health often being attributed to this one event. In turn this process also provided the

rationale which controlled help-seeking behaviour. This has great similarity to the model put forward for the participants of this study, although here findings are not limited to females. Where the findings of this study depart in similarity is in the added controlling influence of ageism. Here, claims that older people attempt to deny the stigma of old age itself (Conway and Hockey 1998) were used to describe data where participants rejected or downplayed symptoms of ill health whilst attaching great importance to having a purpose or function and not being a burden. Regarding this latter point, comparisons are again made to an earlier study from Blaxter (1990 cited IN Bond and Cabrero 2007, p.116), where the definition of health, particularly in the case of older males [chapter 6], was very much represented and expressed through having a 'function', although once more the study presented within this thesis does not limit this finding to one gender.

Finally, in chapter 7, controlling influences were considered in the debate of data and literature which holds that it is society's expectations of families to provide informal support to older relatives, or even that older relatives live with their families (Kinsella 1995 cited IN Connidis 2001, p.8; Troll et al 1979). Such expectations are held through the evidence which demonstrates that being embedded within a supportive network impacts positively upon an individuals' health and wellbeing, in terms of doing better and living longer (Living et al 1999 cited IN Krause 2001, p.283; Grundy and Slogett 2003) [chapter 7]. However, evidence across the chapters suggested that for many families and older individuals these expectations are reinforced by the fear that the only alternative, should families fail, is for older relatives to move out of the communities they have been part of for most of their lives and into care. The consequences of these beliefs are costly to the dynamics within long-held relationships, whereby older relatives may feel they have little choice other than to surrender any sense of agency, giving rise to situations of role reversal as illustrated through the data, or the infantalisation of older people (Aiken 1989).

The above provides examples of where the dialogue of participants in this study indicated some element of influence from controlling forces during their lives. Their reactions to these are demonstrated through varying degrees of autonomy, ranging from defiance - : Anne going to medical school [albeit still

bound by interruptions to work to raise her family]; Gordon refusing to accept what one health professional said about his eyesight; Harriett continuing to walk to the back gate despite her daughters insistence that she desists from doing so to acceptance: Ian sticking with his work at the shipyards due to the financial rewards; Cyril no longer being able to go dancing; Alan resigning himself to his daughters now taking charge of his finances. Such a 'range' of responses to controlling forces does not appear to be uncommon within the literature, however, opinion appears to be somewhat divided, with some research suggesting that one side of the 'range' is synonymous with more positive outcomes, such as 'ageing well', whilst the other is more negative. Examples of this include a study of older people moving into care, where those with a 'more combative nature' were concluded to do better than those who accepted controlling forces (Marcoen et al 2007), also, Cairney and Krause (2008 cited IN Martin et al (2011, p.104) claiming that life events where individuals perceive low levels of control have an increased risk of negative outcomes, such as stress. Lastly, a multivariate study using data from over 84 countries by Verne (2009 cited IN George 2010, p.335), found the combination of perceived control and choice to be the strongest predictors of 'happiness', over health, finances and marital status. The essence of the contrasting opinion was first raised within chapter 5 of this thesis, in presenting evidence stating that one side of the range does not necessarily equate to positive outcome. Using the example of perceived control of timing of retirement it was suggested that this did not necessarily result in success (Holcomb 2010). In some of the narratives from chapter 6, participants talked of 'controlling' their lifestyle choices around 'good values' and the advice of health promotion, and yet a deterioration or critical health event had resulted. For the most part the findings of this study tend to position themselves with the opinion that perceived control <u>is not</u> always the determining factor which is most associated with positive outcomes. This comes from data revealing that despite some of the study participants having apparent low levels of autonomy or choice [in the face of controlling structures of their environment, gender, culture, society and also the losses associated with increasing age], they nevertheless perceived a sense of 'ageing well'. Here this is argued through the complex relationship between the three overarching themes providing a process from which to manage the interplay, or conflict, between control and autonomy.

Capacity for Adaptation

This leads the discussion to the second overarching theme: 'capacity for adaptation'. When viewed through a wide-angle lens of science, the continuing ability and capacity for humans to adapt is one which has secured the on-going survival of our species (Westendorp and Kirkwood 2007). When narrowed to the life-course, this focus suggests that individuals are often able to adapt to and overcome, many age-related challenges (Marcoen et al 2007). As the data from this study has shown, alongside relevant literature, the capacity to adapt is not lost with increasing age. This was illustrated through empirical data from SRH and (I)ADLs where, in the face of multimorbidity, participants paradoxically reported positive states of health, and where some performed highly in everyday tasks of living, presumably as a result of adaptation [chapter 6]. The in-depth interviews within this study added a layer of description from which to examine this assumption, where using interchangeable terminology such as: 'coping'; 'managing'; 'levelling out'; and 'accepting', participants gave personal accounts of overcoming age-related life events and losses, using the skills, attributes and mastery of the resources and support available to them. In exploring this, use was made of the work of Baltes and Baltes (1990) who considered adaptation, through the use of selection, optimisation and compensation [chapters 2 & 6]. Also useful was a model of adaptation to disability from Verbrugge and Jette (1994) which suggests the use of extra-individual and intra-individual factors in order to achieve this [chapter 6], and finally work from Sixsmith (1986 cited IN Arber and Evandrou 1993, p.19) [chapter 7] around the meanings older people attach to independence within relationships, in trying to achieve a balance between physical independence, autonomy, and reciprocity. Related directly to these works, Marcoen et al (2007) make the point that the health, attitudes and coping strategies of older people are diverse. Therefore, more research is required to consider what factors might facilitate or inhibit an individual from adapting. This thesis has already put forward an argument to implicate the impact that past life events, and the controlling forces and cultural values of the societies in which older people are situated, have on the capacity to adapt in those aged 85 years and older. However, it is believed that further deconstruction of some of the

examples from the data offers additional insight into an area identified as requiring increased understanding.

Reflecting again upon an account given by Cyril, [chapters 4 & 6], we see that despite no longer being able to fulfil his long-held pastime of dancing, due to a deterioration in his health, after recovery Cyril had re-attended the tea dance. When this was discussed in chapter 6, the perspective of the disablement process was primarily utilised to rationalise Cyril's adaptation, by his drawing upon intra-individual factors to re-evaluate his valued domain towards retaining social contact. Here, through data derived from in-depth interviews it is possible to tease out some of the contributory elements which facilitated this adaptation. Throughout his in-depth interview Cyril had not only described himself as very physical, but also very sociable. Upon his physicality being challenged Cyril appeared to draw upon his social skills and the 'gains' he felt from camaraderie to adapt to his new situation. These same 'skills' were also observed to be in current use by Cyril in trying to come to terms and adapt to the death of his wife and a further deterioration in his own health using his social connections, such as the 'Fellows of Services' organisation [chapters 4 & 5]. If however, Cyril had not developed such a strong value for social interaction and connectivity his 'story' of adaptation may have been very different, having lost physical ability through deteriorating health.

Other examples of successful adaptation from those highlighted within the thesis include that of Florence [chapters 4 & 5] who, after working unpaid within the family business and then raising a family, set out to enter paid work. However, the death of her mother impelled her to retire and take over the responsibility of caring for her father, who came to live with her and her family. Although at first Florence speaks of regret in having to leave her much-loved job, she adapted to this challenge, talking of fulfilling a sense of duty to her father. Using insights from her in-depth interview, such as coming from a large family of eight siblings with strong values of family responsibility and caring instilled from an early age, values which may also have been used to resolve earlier conflict of control when asked to work unpaid in the family business, we can begin to understand how Florence used these as effective adaptation strategies. Indeed, in chapters 6 and 7 Florence goes on to suggest that her

health is still defined by her ability to care for her family. It is also not unreasonable to suggest differences in strategies of adaptation when comparing the situation of Florence to that of Anne, an only child who described herself as lonely and having to be self-reliant, who ‘defied’ controlling forces to pursue a career in medicine.

Attention is now directed towards narratives from participants where, at the time of in-depth interview, the process of adaptation in the face of a challenging event seemed less ‘complete’. Take first Alan, who talked of selling his car as he could no longer afford to run it after his retirement [chapter 5]. Keeping in mind this event had occurred some 20 plus years ago, Alan still clearly identified this event with his loss of independence and his ability to get out and about, despite a recent deterioration in health. Perhaps influencing his capacity for adaptation was the fact that Alan was an extremely proud man who talked of his responsibility as a father figure to his siblings from a very young age [chapter 4], and in chapter 5, Alan spoke of a fear that deterioration in his health meant he was a burden on his family. Therefore, blaming giving up his car for his of loss of independence may have served his purpose. A more extreme example is found in chapter 7, where Gordon, after the recent death of his wife and his own deterioration in health, appeared to be struggling to adapt to the informal support he now received from his family. Gordon’s response to this appeared to be to assert his independence through his environment. Gordon’s in-depth interview revealed that he had endured many hardships throughout his life, some of which had been alleviated when as a child he and his family had moved into a new home, a home in which he still resided [chapter 4]. In the face of recent challenges, Gordon appeared to be using his mastery of this environment to begin to adapt or work through these, despite being partially sighted and having limited mobility. One might speculate that without this, agency would have been threatened or surrendered over to his well-meaning family.

Overall, the examples above may provide some resistance to the opinion that increasing age is a time of loss and decline, as perhaps for those who reach the age of 85 years and beyond, the capacity to adapt becomes stronger, through creative application of the wealth of knowledge and experience available to

them, having ‘seen it all before’. In essence, the examples throughout this thesis illustrating capacity for adaptation are the personal narratives of how participants became part of this unique survivor cohort.

Other works, although limited, support the crux of the findings outlined above in describing that recently experienced life events may not be as important for ‘ageing well’ as the inclusion of life time trauma. Suggesting that an individual’s general outlook on life in older age results from a long series of experiencing challenging life-time events, with the perception of emotional support offsetting stress and promoting active coping with health-related events in later life (Martin et al 2011). The historical reference to holocaust survivors in this thesis also illustrates how, in the face of little or no control, some survived who had the capacity to adapt, by whatever means available to them. In longevity, those having the greater capacity to successfully adapt not only survive but ‘age well’.

Having a Sense of Purpose

The third and final overarching theme, ‘having a sense of purpose’, is perhaps the most straightforward to illustrate from the data. Participants often gave accounts of the characteristics which they perceived as making up their identities, or how they made sense and gained value in who they are. These included: gaining a sense of purpose through work, hobbies and productivity; reciprocity within relationships with family [being a wife, a husband, a mother, a father, and so on] and friends; and connectivity to social groups, communities and wider networks. However from the literature reviewed in chapter 2, we also gain the sense that these roles and identities fade increasingly with the passage of time, more often due to society’s view of older people as a homogeneous group defined by chronological age alone (Aiken 1989).

These attitudes and expectations of society alongside the transition to retirement, changing health needs and loss of connectivity to others, as explored within the data, may then pose a threat to an individual’s sense of purpose, where it is advocated that the capacity to adapt, find a new purpose and not be a burden is heavily implicated in achieving a sense of ‘ageing well’. The previous example of Florence finding a sense of purpose in her identity as

a carer is a clear illustration of this. Other examples from chapter 5 relate to those participants assigned to the category of paid work, such as Ian, who expressed the need to keep busy and active during retirement, or from chapter 6 where participants such as Frank spoke of function and its relevance to health, or specifically from chapter 7 where Cyril spoke of his role as advisor to his grandchildren.

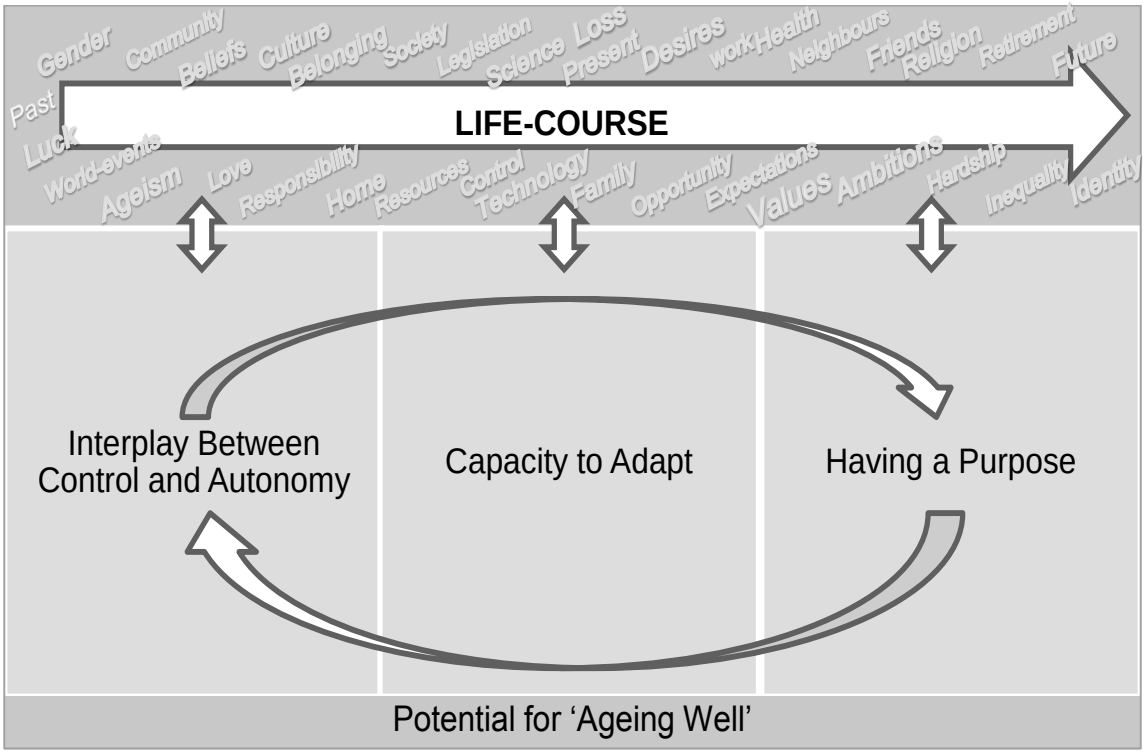
The primary point to be drawn from these descriptions is that longevity and 'ageing well' are not one and the same. It is from having a sense of purpose, which fits with our own values and desires that individuals might 'age well'. This corresponds with the conclusions of Godfrey et al (2004) who suggest that older people strive to construct meaning and purpose in their lives from the context of the whole of their lives and not just the attitudes and challenges they face now. In taking a critical approach to this however:

> "… Opens up the distance between what older people are told are choices available to them and what they might desire"
>
> (Etes et al 2003, p. 152)

The 'Process'

In drawing the three overarching themes together, 'ageing well' is presented [Figure 12] as a process of continually responding to life-course events, through the adjustment to challenge and taking advantage of opportunities. If effective, this process can counter the effects of controlling forces such as environment and gender, as well as absorb those losses commonly associated with increasing age. The ability to do this effectively is nurtured and modified from one's past life experiences. What does this say about 'ageing well'? Ultimately, an individual strives to strike balance [offsetting losses and harnessing the potential for gains] in order to attain a sense of purpose, which might also be described as a passion for life or will to live. Therefore, these overarching concepts of continually finding harmony or balance for that individual, increase the potential for 'ageing well'.

Figure 12: 'Ageing Well' Process



8.4.2 Identifying the Potential for Policy and Practice Development Gained by Exploring 'Ageing Well' from Perspectives Which Include Those of The Older Person

> "All our knowledge has its origin in our perceptions".
>
> (Leonardo da Vinci)

By including the perspectives of older people to explore 'ageing well', this study informs the development of policy and practice in the following areas.

Chapter 2 of this work discussed the government's response through British policy and reform in recognition of an ageing population. Specifically, attention was drawn to the Government White Paper released in 2012 and a 2013 report from the House of Lords highlighting the importance of focussing on the population aged 85 years and older. Despite differences of opinion as to where we are in terms of addressing the needs of an ageing population, there was

agreement as to what concepts were to be championed, namely, independence and wellbeing, both of which relate to 'ageing well'.

Whilst accepting that in developing reforms, governments and reporting bodies consult with those organisations that would aspire to represent the needs of older people, it is suggested here that claims of 'representation' should not be automatically accepted as fact without challenge. The rationale here is that over time and with shifting power dynamics what may once have been representative can become self-serving, with the views of those claimed to be represented becoming muted and their perspectives lost:

> "… With the promotion of some meanings at the expense of others"
>
> (Ray 2003, p.34)

Therefore it is a central recommendation of this work that the voice of those aged 85 years and older be explicitly included in policy development, in terms of gaining their views on services, and their desires and aspirations for life. It is simply not acceptable to assume that the needs of this population group match those of policy makers, professionals, researchers and 'representing' organisations, nor that research findings from other 'older cohorts' [usually only up to the age of 75 years] are used to represent this group. This is typically done, implicitly or explicitly, on the grounds of a perception that those aged 85 years and older are difficult to include in research. That this is in fact possible, is demonstrated by this study. Until such a time that this recommendation is taken on-board then policy and reform will be fundamentally flawed.

Linked to this central recommendation, recent government reforms also suggest putting individuals in charge of their own care (DOH 2012), but how can this approach be seriously considered without first gaining some understanding of, or at the least acknowledging, lay health beliefs which regulate help-seeking behaviour? As we learned through the findings of this study, lay definitions of health are often in conflict with that of the biomedical perspective - resulting in a paradox - so to rely on some format of self-report alone would be ill-advised. It is also unrealistic to contemplate such an approach without recognising the

influences and controlling forces of societal values and predominantly negative attitudes towards ageing.

In acknowledgement of the complexity around influences affecting how an individual comes to understand their health, it is reasonable to suggest that policy needs to move beyond the focus on morbidity and mortality and toward recognising that an individual's health is far more than this. According to Conway and Hockey (1998), such a challenge would need to brace itself for the threat that the de-professionalisation of healthcare would bring, which they describe as becoming a 'health-care battle ground for control'. This appears to fly in the face of government reforms as to where the control of care should sit, as set out above. Cynics might argue that this somewhat David and Goliath scenario will ultimately effect little change of control. Others, however, consider that good practitioners will be interested in combining the biomedical perspective with that of the individual in order that public health decisions are sensitive to actual needs (Sen 2002).

The findings of this study also identified that participants living their everyday lives and managing their health needs often did so through informal sources of support available to them, such as family and social networks, which are undoubtedly difficult to quantify. In the government's approach to value the contribution of carers, this study would question how then can this be achieved without looking beyond empirical measures? However, in recognition of the value that empirical evidence brings to this in terms of providing demographic data illustrating decreasing rates of fertility and increased longevity upon which we can make some judgement about the demands of future services, and with regard to filling the gap currently plugged by family and support networks [chapter 2], this study advocates the development of mixed methods approaches. Incidental to this is the impact these same demographics will have on the numbers of individuals entering into professions providing formal-support, such as nursing.

According to Hagberg (2006), those aged 85 years and older are long-lived and have gathered a wealth of experience, which should be considered as an additional resource in dealing with responses to population ageing. Although

challenging, it should not be considered impossible to apply this principle to specific areas. One example is retirement and pension reforms, whereby data from this study which illustrated function or purpose as essential to ‘ageing well’, could be explored to provide information upon which to set realistic targets to extend working life, supporting those who call for real investment to recognise and harness the value of the mental capital of older people in society (Kirkwood et al 2008). This goes one step further to that already being proposed in shifting focus away from life expectancy (LE) toward healthy life expectancy (HLE) in order to inform EU targets [chapter 2], currently stated as being difficult to meet in all EU countries (Jagger et al 2008).

Specific to the development of practice, the cultural beliefs and values of the individual should be explored and included in the design of programmes of healthcare suited to need, rather than being based upon the assumptions of health care professionals and researchers, or the performance-related target-setting strategies of government. The skills and resourcefulness of many of these older individuals could be embraced to design and share with others small-scale interventions to get through the day (McNellis Carey 2006). The potential for including the perspective of the older person to explore ‘ageing well’ may also address the lack of cohesive advice said to be given to families, where it is noted that only upon reaching the point of crisis do families tend to come into contact with professionals (DOH 2012). Here it is not unreasonable to draw links to those deep-seated forces of control within society such as fear of failure, as discussed earlier, and suggest that these contribute to the difficulties of engaging older people and their families in research and practice development, since professionals are often viewed with suspicion. It is also possible to postulate that such matters remain unchallenged by official sources due to concerns around increased demands upon limited resources. Crucially however, including the perspectives of older people might also help us to discover what older people understand about those factors central to government reforms, such as ‘independence’, ‘dignity’ and ‘respect’. From a historical perspective, the sentiment of many of these ideas can be located in person-centred initiatives, although described through different terminology such as mutual respect and sharing of power, which have been around for over 50 years:

> "… Modern concepts of person-centred care is derived from a client-centred counselling approach developed by Carl Rodgers in the late 1940's"
>
> (Dow et al 2006, p.5).

Much of what is current to ageing and health can be traced to the societies and practices of the 18th century (Yallop 2013), where concepts linking mind and body are evident and connect to health not being merely the absence of disease, with controlling forces and values dictating expectations and idealised behaviours of older individuals. In the 18th century, a key emphasis was on the virtues of what was known as 'cheerfulness', a substantive notion combining both wellbeing and behaviour, in keeping old age at bay. This can be related to today's presentation of virtuous older people within the media [chapter 2], where those outside of this may perceive themselves as 'unsuccessfully aged' and a burden on society.

Overall, this suggests that many of the challenges for policy and practice have remained unchanged and are comparable to that of any other social group, that is challenges of being accessible and sensitive to varying degrees of social, physical, economic and environmental characteristics and abilities (Godfrey et al 2004). Given such a 'constant' arguably adds to the evidence which challenges current beliefs about knowledge of ageing and those 'traditional' approaches to investigating the needs of an ageing population.

8.4.3 Benefits to Knowledge When Widening The Methodological Approach Beyond Empirical Perspectives in Order to Investigate 'Ageing Well'

> "The mind that opens to a new idea never returns to its original size."
>
> (Albert Einstein)

The findings of this study argue that there are profound advantages to knowledge when researchers explore ‘ageing well’ beyond the confines of empirical perspectives. Through embedding this argument in previous discussions around the monumental shift during the ‘period of enlightenment’, which challenged what was individually and collectively known and understood of the world around us, from religion and folklore to empiricism and science (Hamilton 1992) [chapter 3], the potential of this is arguably strengthened. since this period however, the central problem is in the continued domination of empiricism, which is now believed to hold more compelling evidence in terms of what is accepted as true, whilst other forms of enquiry have become devalued. Consequently, such standing has resulted in the trend for the collection of data through empirical methods alone becoming a substitute for thinking about the problem (Wilson 2000). Furthermore, we see many of the theories and models of ageing which control and influence policy and practice, such as successful ageing (Rowe and Khan 1998) [chapter 2], positioning themselves with biomedical perspectives and failing to address how older people balance those losses and gains generally associated with increasing age (Aldwin et al 2005).

A vast quantity of the literature along with the findings from this study assert that the meaning and experience of old age, and indeed what contributes to successful ageing or ‘ageing well’, need to be viewed within the wider social and cultural context of people’s entire lives and include their perspectives of the lived experience. The significance here is in the central claim that:

> “Ageing does not occur in neutral environment which can be separated from society, expectations, ageism, and all of the baggage from previous life stages”
>
> (Godfrey et al 2004, p.227)

Therefore, the knowledge gained from widening our research approaches in terms of capturing older people’s perceptions of their aspirations, their health and ‘ageing well’ should not be belittled just because these perceptions do not match those of professionals, younger age groups, or wider social attitudes.

This study advocates the development of mixed method research and claims that the divide between positivist and interpretivist approaches is falsely constructed to serve the purpose of those who subscribe to either one, rather than pursuing any real development as to how we might advance our understanding of 'ageing well' by challenging that which is considered as knowledge.

> "We need to remind ourselves that all theory and knowledge is partial and that other meanings are always possible … we lose perspective on the world outside our belief system"
>
> (Ray 2003, p. 34)

8.5 Study Limitations

Chapter 3 has already addressed strengths and limitations commonly attributed to the methodological approach used within this study, such as the paradigm debate of mixing qualitative and quantitative methods of exploration, the potential for conflict between data and the notion that more data should not necessarily be viewed as superior data (Morse 2003). The main tenets of criticism for the methods of inquiry were also provided, including quantitative approaches failing to recognise social structures such as class, gender and ethnicity (Craib 1992), the potential for interviewer bias throughout data collection and analysis (Holloway and Wheeler 2010) and method of data collection being inflexible to additional and perhaps vital information (Berg 2009). At the same time, qualitative approaches are susceptible to interviewer bias and interpretations of truth, relying upon the skills and abilities of the researcher to provide a transparent and reflexive account of the findings (May 2001). This makes methods of data collection and analysis time-consuming and difficult to conduct (Doody and Noonan 2013). However, the following considers additional, more specific limitations in the light of further experience as the thesis has developed, as reflected upon by this researcher.

The design of this study applied principles of convergent parallel mixed methods design, described in detail within chapter 3 as:

> "… The concurrent timing to implement quantitative and qualitative strands of the data"
>
> (Creswell and Plano Clark 2011, p.70)

The timing of data collection between the two strands of data in this convergent parallel mixed methods study was approximately 18 months, a time-scale driven by the fact that the researcher was contracted to a study grant which aimed to collect quantitative data within a given time-frame. Only when this was complete could qualitative in-depth interviews commence. Whilst many definitions of convergent parallel mixed methods within the literature suggest that the strands of data collection should be carried out simultaneously, this relatively novel approach to research is continually developing. Here some of the more recent literature, such as that from Creswell and Plano Clark (2011), suggests that timing is not so much about when the data is collected but rather when the researcher utilises the data from each strand. This accepted, this study complies with the principles of convergent parallel mixed methods. However, it is possible to consider that the timing of data collection between the strands may influence content and reflect priorities of what is current to an individual at that time, although the same may be said of any point of data collection.

In relation to sample size, it is to be recalled that the quantitative data in this mixed methods study, derived from 'The Newcastle 85+ Pilot Study', was used in order to give greater breadth and understanding to the debate, in terms of viewing the participants of this study in context. As 'stand-alone' research, the primary aim of the pilot study was to formulate recruitment and assessment strategies along with testing operational aspects to develop a main study. Therefore, quantitative data derived from this sample (n=116) is not offered, nor considered sufficient to draw inferences that can be used to describe with confidence the characteristics of this population group beyond this limited sample. That said, many of the results from the pilot study are comparable to the findings of the main study, 'The Newcastle 85+ Study'. Such findings include the identification of hypertension and osteoarthritis as the most prevalent diseases in this age group, the commonness of multimorbidity

(Collerton et al 2009), and ‘cutting own toenails’ being ranked as the (I)ADL which participants reported as being the most difficult to perform independently (Kingston et al 2012) [chapter 6]. In terms of qualitative data, chapter 3 informed us that sample size is determined by reaching the point of theoretical saturation, although debate indicates difficulty in identifying this point (Bulmer 1979). Therefore, some element of judgment from the researcher is required, which is often governed by practical realities (Mason 2010). Arguably, this would include meeting deadlines within a PhD.

The sample of this study was also limited in terms of being constrained to one geographical area of the UK, therefore its findings cannot be assumed as valid when applied to community-dwelling 85-year-olds beyond this geographical area. In reality, the selection of this geographical region was one of convenience, this being the location of the research institute. More specifically and as identified within chapter 4, the geographical area of the study had limited ethnic diversity, especially at very high ages, and those individuals living in care homes were underrepresented in recruitment. Further investigation with greater geographical and ethnic diversity, and which fully represents the population under investigation is required, although, from chapter 3 we are reminded that the issue of generalisability is more relevant to the quantitative strand of this study. It remains an important element of research need to address how family and community relationships relevant for ‘ageing well’ may differ between the various ethnic groupings and also in regions which have had different patterns of traditional industries and working lives. The focus of qualitative research lies with exploring new themes of ‘what’ rather than ‘how much’, examining the depth of these new themes and not the breadth (Polit and Hungler 1995; Bowling 1997) [chapter 3]. Therefore, the concern is with theoretical representativeness of the real concerns, issues, and life experiences of participants. Adding to this, Conway and Hockey (1998) explain that whilst qualitative findings cannot be empirically generalised, they provide a voice for oppressed groups such as those who are the object of ageist attitudes, where they would otherwise not have one. Therefore, despite its limitations, this study is a step in an important direction.

All data collection for this mixed methods study took place within the participants own homes. Whilst chapter 3 describes strengths of this design approach in reducing barriers to participation and addressing power dynamics between researchers and the researched, this environment is not one that the researcher can regulate. Therefore, the potential for interruptions to data collection due to unexpected visitors, telephone calls, and pets, are unavoidable and may influence proceedings.

Chapter 3 also provided discussion of global issues around 'truth', and reliability and validity in quantitative and qualitative methods of data collection. Therefore, as this mixed methods approach includes methods from both of these research paradigms, it is appropriate to consider their strengths and limitations alongside the findings of this study. Additionally, chapter 6 made specific reference to the validity of findings gained from some of the standardised tools. The main question was; as tools were not validated in this age group, do they actually measure what we believe they are measuring?

The concept of reflexivity is that aspect of the research that enables researchers to be critical of and examine their influence in the shaping of the research, through their culture, background, beliefs and values. This concept was first introduced within chapter 3 of this work and, although relevant throughout, it is the specific information and experiences of the researcher described in the 'Researcher Vignette' [chapter 4] that we are reminded of here. In accepting that some of these social characteristics and frameworks are value-laden, such as culture, gender and professional background, the influence of these need to be taken into account when considering my interpretation and discussion of the results. Similarly, the way in which the participants of this study perceived these same characteristics may have influenced the content of data collected, in 'setting the tone' for the interaction between researcher and participant, although such influence is arguably more significant for data collected from interviews that were in-depth than structured.

Whilst accepting the limitations of this study, it is considered that as the researcher I have demonstrated the necessary expertise to deliver a sound approach to the research, and manage limitations effectively in providing a

transparent account of them. Such expertise has been shaped by transferrable skills from nursing, management, and those developed during academic pursuits. Therefore, this researcher asserts that the findings of this study have relevance to the area of investigation, and are of a quality to add to overall knowledge. The following considers how these findings might be extended beyond the scope of this study in providing recommendations for further research.

8.6 Recommendations for Further Research

In addition to those recommendations already put forward in acknowledgement to limitations of this study [previous section], it is also fitting that a number of key recommendations have resulted from the exploratory and somewhat novel approach of this study in extending beyond that which has often been referred to as ‘traditional’. The intention here is that the findings of this study are built upon and continue to add general value to what is known about those aged 85 years and older, thus addressing the gap in current knowledge.

Specifically, recommendations include the continued exploration of the influence of past life experiences on an individual’s development of skills, resilience, and effective strategies to adapt to or accept difficult age-related transitions. Although based on the results from this study, this recommendation departs from the vast amount of literature in this area to state that such exploration should not be limited to the impact of past life events which can be objectively measured against outcomes in later life. Examples of this include childhood experiences such as age at death of a parent or parental divorce, years in education, and fiscal resource as in the work presented from Martin and Martin (2002) [chapter 5]. Rather, it should include methods of a more subjective qualitative nature to capture an individual’s life history, allowing them to set the agenda of what past events have been significant and had lasting effect in shaping life skills and ability to use them, and their interpretation of why this is so. In short, what does and does not work to enable this survivor cohort to live their day-to-day lives.

Further research should examine more intently the characteristics of support networks, relationships and community of those aged 85 years and older in terms of gaining knowledge around support which is perceived to be effective and reciprocal [chapter 7]. Only when such knowledge is available can it then be operationalised to inform practice, serving as the basis for risk assessment and the planning of preventative strategies, and as a means of measuring the efficacy of interventions (Litwin 2006; Moyle et al 2010; Wenger 1989). Researchers should also be mindful to widen their focus of 'family' beyond that which is traditional and define it through the perspective of the older person.

Although the limitations of this study noted difficulties in terms of generalising to other geographical areas and the insufficient recruitment of individuals from care homes, its findings still offer direction for further research within these two domains. When expanding research beyond the geographical area of this study, consideration is also recommended to consider the potential variance of factors such as connectedness with families, the wider community and isolation for those individuals aged 85 years and older living within rural settings. Secondly, for those individuals who find it necessary to move into care homes [chapter 7], further research should include the exploration of the 'values of home', and its findings used to direct developers and care providers to replicate these same values within care settings (Rowles and Chaudhury 2005).

Evidence was also presented regarding use of services [chapter 6], with specific mention of the average number of consultations with a GP suggested as having a positive correlation to increasing age (Bajekal et al 2006). Further tentative comparisons within the literature found that individuals aged over 85 years consult their GP nearly twice as frequently within one year (Collerton et al 2009) than groups where no adjustment is made for age (McCormick et al 1995). Such evidence clearly requires further investigation, firstly to gain accurate calculations for projected use of services, particularly in light of the already keenly debated future burden on resources, which may in fact be underestimated, and secondly to incorporate approaches which attempt to understand lay beliefs that are instrumental in determining the 'why' and 'how' of an individual's help-seeking behaviour and use of services.

Further research is also recommended for the development of tools used to measure health, such as SRH [chapter 6], which although quick and easy to administer lack validation in terms of sensitivity to what is actually understood about what is being measured (Jylhä 2009).

With recommendations for further research offered within this chapter so far, the findings from this study argue compellingly that there is much to be gained from conducting in-depth gender-specific comparisons, particularly in areas around work and retirement [chapter 5], use of health services [chapter 6], and caring roles [chapters 5, 6 and 7]. An additional ageing 'gender specific' recommendation is for the continued exploration of evidence from empirical data, first presented within chapter 2, determining that females live longer than males but with greater levels of disease, as indications here suggest that these differences are flattening out.

Finally, given the current scarcity of good quality knowledge and accepting that despite outputs provided within this thesis and published as a result of this work [appendix N], the findings of this exploratory study are unlikely to be absolute, the main recommendations are (i) for the continued adoption of research approaches which enable the inclusion of the voice of the older individual and (ii) for further research itself. To explain, firstly in continuing to include the voice of the older person, possibly through the more widespread use of mixed methods, we can challenge what is already believed to be understood about older people and discover more about what is unique about this survivor cohort. Only then might we disseminate the benefit of this to future ageing population groups, whilst confronting ageist attitudes should findings broaden what is currently assumed of older people. Secondly, at various points this work has maintained that the participants involved in this study have been exposed to some of the most poignant historical experiences of recent times. Arguably these experiences have shaped their beliefs about the world in which they live, therefore future generations moving into this fastest growing sector of the ageing population will have been exposed to very different experiences throughout their life-course, including an increased familiarity with 'everyday' technology, initiatives emphasising lifelong learning, and legislative changes to

the labour force. It will be interesting to begin to build up knowledge as to what factors contribute to ‘ageing well’ across these generations.

8.7 Final Conclusion

Despite literature identifying those aged 85 years and older as the fastest growing sector of an ageing population, little has emerged in the way of good quality data upon which future resources for policy and practice can be informed. Instead, assumption and ageist attitudes have provided ‘solutions’ to determine the needs of this population group, a strategy which has served to perpetuate the negative image of older people and demonise them as heavy users of resources who contribute little, a feeling which is heightened particularly in a time of fiscal austerity. In addition, what little knowledge has been generated tends to reflect not only the Western bias toward empiricism as true knowledge, but also the opinion of the researchers conducting the research, with little or nothing in the way of including the voice and agenda of older people themselves.

This study has addressed this issue and demonstrated the benefits of challenging traditional approaches to knowledge, here by exploring the concept of ‘ageing well’ from perspectives which include that of individuals aged 85 years and older through a mixed methods framework. In doing so, the value of this study lies in its contribution to what is ‘known’ of those aged 85 years and older, what contributes specifically to their perceptions of ‘ageing well’, and how this might be harnessed to inform policy and practice, whilst also providing recommendations for further research and challenge to ageist attitudes.

Ultimately, ‘ageing well’ is offered not as a fixed concept, nor as an area of examination that should narrow its lens, stripping out everything to focus attention exclusively on older people. Rather, it is viewed as a fluctuating state of being, which is continually shaped and then re-shaped through the challenges of a life-course. The approach to this requires a wide-angle lens in order to capture the influences of culture, society, expectations, beliefs, values, and in effect, the ‘history’ an individual has inherited and lived through. Essentially, ‘ageing well’ is sensitive to all of the assurances and uncertainties

of the past, present and future. Therefore, such sensitivity should be explored and indeed opportunities exploited, to maximise the potential for ‘ageing well’ in future ageing populations.

APPENDICES

Appendix A: Letter of Ethical Approval

NHS

Gateshead and South Tyneside Local Research Ethics Committee
Room 148
TEDCO Business Centre
Rolling Mill Road
Jarrow
Tyne & Wear
NE32 3DT

17 March 2005

Full title of study:	***What Does it Mean to Be 85+? An exploratory Investigation to the meaning of health and age from the perceptions of the oldest old age group.***
REC reference number:	***05/Q0901/21***
Protocol number:	***1***

The REC gave a favourable ethical opinion to this study on 28 February 2005.

Further notification has been received from a local site assessor, following site-specific assessment. On behalf of the Committee, I am pleased to confirm the extension of the favourable opinion to the new site. I attach an updated version of the site approval form, listing all sites with a favourable ethical opinion to conduct the research.

Management approval

The Chief Investigator or sponsor should inform the local Principal Investigator at each site of the favourable opinion by sending a copy of this letter and the attached form. The research should not commence at any NHS site until management approval from the relevant NHS care organisation has been confirmed.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

[REC reference number]: 05/Q0901/21 **Please quote this number on all correspondence**

Yours sincerely,

Carole Moore
Administrator

E-mail: carole.moore@stpct.nhs.uk
Enclosure: Site approval form (SF1)

An advisory committee to Northumberland, Tyne and Wear Strategic Health Authority

Appendix B: Letter of Caldicott Approval

R+D ID: 2005OP003

NHS

For office use only			
Ref. no:		Date Received	

Caldicott approval form for use or release of service user identifiable data

(Please print clearly)

Title: What Does it Mean to be 85+? An Exploratory Investigation

Description of proposal: This Qualitative research study requests that service user identifiable data from the North East 85+ Pilot Study be utilised to facilitate the add on study to conduct face to face interviews with participants and ask them about their life experiences. GP permission and consent of the individual are also considered as essential within this approach.
The aims of the study are;

- To examine meanings, experiences and perceptions of the individual aged over 85.
- To identify emerging themes from the data to generate a theory of age and health from the individuals perspective.
- To link findings from this qualitative study to data from the North East 85+ study in order to promote deeper understanding.

Indicate which data items have been requested:

Forename: [x] Surname: [x] DoB: [x] Age: [x] Sex: [x]

Address: [x] Postcode: [x] NHS No. Other (Please state)

Name of organisation receiving data

University of Newcastle Upon Tyne

Person responsible for release of data :

Name: Job title:

Person responsible for receipt of data:

Name: Karen Barrass Job title: Clinical Research Nurse Manger

Contact details in relation to this form:

Name: Ms Karen Barrass

Address: Newcastle university, Institute for Ageing and Health, Newcastle General Hospital, Westgate Road, Newcastle upon Tyne, NE4 6BE

Telephone: 0191 2563391

Email: karen.barrass@ncl.ac.uk

Appendix C: Statement of Sponsorship

Newcastle NHS
Primary Care Trust

Statement of Sponsor's Responsibilities

Project ID: 2005OP003
Project Title: What does it mean to be 85+?

As Project Sponsor I agree to ensure:

- The research proposal respects the dignity, rights, safety and well-being of participants and the relationship with care professionals
- The research proposal is worthwhile, of high scientific quality and represents good value for money.
- The research proposal has been approved by an appropriate research ethics committee and Trust R&D Departments
- Intellectual property rights and their management are appropriately addressed in research contracts or terms of grant awards.
- Arrangements proposed for the work are consistent with the Department of Health Research Governance Framework (RGF)
- Organisations and individuals involved in the research all agree the division of responsibilities between them.
- There is a clear written agreement identifying the organisation responsible for the ongoing management and monitoring of the project.

Name ROBIN ANDREW KING

Role ASSISTANT REGISTRAR

Organisation UNIVERSITY OF NEWCASTLE UPON TYNE

Signature R A King Date 23 March 2005

V1 Oct 04

Appendix D: Sampling Matrix

PID	Gender	Lives Alone	Current Legal Marital Status)	MMSE≤21	In-depth qualitative Interview
P001	Male	Yes	Widowed	No	
P002	Female	Yes	Widowed	No	
P003	Female	No	Single	No	
P004	Male	No	Married & Living With Spouse	No	
P005	Female	Yes	Widowed	No	
P006	Female	Yes	Single	No	
P007	Male	No	Married & Living With Spouse	No	
P008	Male	No	Married & Living With Spouse (found to be widowed at time in-depth interview)	No	5
P009	Male	Yes	Widowed	No	
P011	Female	Yes	Widowed	No	
P012	Male	Yes	Widowed		
P013	Female	Yes	Widowed	Yes	Excluded as vMMSE
P014	Female	No	Married & Living With Spouse (found to be widowed at time in-depth interview)	No	14
P015	Female	Yes	Widowed	No	
P016	Female	Yes	Widowed	No	
P017	Female	No	Married & Living With Spouse	No	
P018	Female	No	Widowed	No	7
P019	Male	Yes	Widowed	No	1
P020	Male	No	Married & Living With Spouse	No	
P023	Male	No	Married & Living With Spouse	No	
P024	Female	Yes	Widowed	Yes	Excluded as vMMSE
P025	Female	Yes	Widowed	No	15
P028	Male	Yes	Widowed	No	
P029	Female	Yes	Widowed	No	
P031	Female	No	Married & Living With Spouse	No	
P032	Male	Yes	Widowed	No	
P033	Female	No	Single	No	
P035	Female	Yes	Widowed	No	
P036	Male	No	Married & Living With Spouse	No	8
P037	Male	No	Married & Living With Spouse	No	
P038	Female	Yes	Widowed	No	6
P039	Male	No	Married & Living With Spouse	No	16
P043	Male	Yes	Widowed	No	10
P044	Female	Yes	Widowed	No	
P045	Female	No	Widowed	No	

P048	Male	Yes	Widowed	No	17
P049	Female	Yes	Widowed	No	
P050	Male	Yes	Widowed	No	
P051	Male	No	Married & Living With Spouse	No	
P052	Male	Yes	Widowed	No	
P053	Female	No	Married & Living With Spouse	No	3/4
P054	Female	Yes	Widowed	No	
P057	Male	No	Married & Living With Spouse	No	9
P058	Female	Yes	Widowed	No	
P059	Male	No	Married & Living With Spouse	No	
P060	Female	Yes	Widowed	No	
P061	Female	Na-In Care Home	Widowed	Yes	Excluded as vMMSE
P062	Female	Yes	Widowed	No	11
P063	Male	No	Married & Living With Spouse (found to be widowed at time in-depth interview)	No	13
P064	Male	Yes	Widowed	No	
P065	Male	No	Widowed	No	Excluded as withdrew
P066	Female	Yes	Widowed	No	
P067	Female	Yes	Single	No	
P068	Female	No	Widowed	No	Excluded as withdrew
P069	Female	Yes	Single	No	
P070	Male	No	Married & Living With Spouse	No	
P071	Female	Yes	Widowed	No	
P074	Female	No	Widowed	No	
P075	Male	No	Married & Living With Spouse	No	
P076	Female	No	Married & Living With Spouse	No	
P077	Male	No	Married & Living With Spouse	No	
P078	Male	No	Married & Living With Spouse	Yes	Excluded as vMMSE
P081	Male	No	Married & Living With Spouse	No	Excluded as withdrew
P082	Male	Yes	Widowed	No	
P083	Male	No	Married & Living With Spouse	No	
P084	Female	Yes	Widowed	No	
P085	Male	Yes	Widowed	No	Excluded as withdrew
P086	Male	No	Married & Living With Spouse	No	
P087	Male	Yes	Widowed	No	
P088	Female	Yes	Widowed	No	
P089	Female	Yes	Widowed	No	
P090	Male	Yes	Widowed	No	
P091	Female	Yes	Married & Separated From Spouse	No	

P092	Female	Na-In Care Home	Widowed	No	
P093	Female	Yes	Widowed	No	
P094	Female	Yes	Widowed		2
P095	Female	No	Not Asked-Interview Terminated	Yes	Excluded as vMMSE and withdrew
P097	Male	Na-In Care Home	Married & Living With Spouse	No	
P099	Male	Yes	Widowed	No	
P102	Female	No	Married & Living With Spouse	No	12
P103	Female	Yes	Widowed	No	
P 104	Male	No	Married & Living With Spouse	No	Excluded as withdrew
P 105	Female	Yes	Widowed	No	
P 106	Male	No	Married & Living With Spouse	No	Later Withdrew (In-Depth Data Destroyed)
P 107	Female	Yes	Widowed	No	
P 108	Female	Yes	Widowed	No	
P 109	Female	No	Widowed	No	
P 110	Female	Yes	Widowed	No	
P 112	Male	No	Married & Living With Spouse	No	3/4
Totals	89	86			17

Appendix E: Recruitment Protocol

Recruitment Protocol

What does it Mean to be 85+?

- Identify potential participant from sample population of The Newcastle 85+ Pilot Study. (Excluding all those with severe cognitive impairment).
- Clarify GP permission to approach participant.
- Send first contact cover letter to participant along with information booklet.
- One week later contact participant by telephone or letter to arrange appointment.
- Ensure informed consent is given voluntarily following consent/assent protocol.
- Complete consent documents and copy for participant.
- Conduct interview (approx one hour)
- Conduct clarification of interview/further face to face meeting or telephone call if necessary.

Version 1 Jan 2005

Appendix F: Letter of invitation to Participate

Nurse Karen Barrass (now Davies)
The Institute for Ageing and Health,
Wolfson Research Centre
Newcastle General Hospital
Westgate Road,
Newcastle upon Tyne, NE4 6BE
Telephone: 0191 2563391

UNIVERSITY OF NEWCASTLE

Date
(name of potential participant) (address of potential participant)

Dear (name of potential participant)

You recently took part in a research study 'The Newcastle 85+ Pilot Study' investigating the health and well-being in people aged over 85 years. Thank-you for your valuable support with this study and I hope you enjoyed the experience.

I am writing to invite you to make a further contribution to the issues of ageing and health by taking part in a study where we aim to gain your personal experiences and views about life, health and ageing. This involves arranging an interview with you to take place within your own home at a time to suit you. The interview will last approximately one hour. This interview will not involve any further tests or investigations.

I have enclosed an information booklet with this letter to explain the study in more detail. Please take the time to read this.

I will contact you in the very near future to discuss the study and arrange an appointment should you wish to take part. However please do not hesitate to contact me before this time if you wish to do so. My contact details are included at the top of this letter and at the end of the information booklet along with ID photograph.

Although I consider your possible contribution to be very valuable to this research, please be assured that you are under no obligation to take part and that refusal would in no way affect your current care.

Once again, thank-you for your support.

Karen Barrass (now Davies)

Version 1 Jan 2005

Volunteer Information Booklet

‘What Does It Mean To Be 85+?’

(Working Title)

The Institute for Ageing and Health
University of Newcastle

You are being invited to take part in a research study. Before you decide whether to take part in this study, it is important you understand why you have been chosen, why this research is being carried out and what it involves. Please take time to read this information sheet carefully and discuss it with friends, relatives or your GP if you wish. If there is anything that is not clear or you need more information please ask. You will find our contact details at the end of this information sheet. This leaflet is yours to keep.

Thank you for reading this leaflet.

What is the purpose of this study?

It is becoming more common for people to live to age 85 and beyond. Previously little attention has been paid to the health and needs of individuals in this age group. The purpose of this research is to investigate the health and needs of older people from the knowledge, experiences and perspective of the older individual.

It is the aim that the information from this research will be used alongside information already gained within The North East 85+ Pilot Study to help professionals increase their understanding and work towards improving medical care and services for older people helping them stay healthy, independent and active in old age.

Why have I been chosen to take part in this study?

You have been invited to take part in this study as you are part of the Newcastle 85+ Pilot Study. Your G.P. has also permitted us to contact you to invite you to take part in this further research interview.

Do I have to take part?

It is your choice whether you volunteer to take part in this study. You do not have to do so; however your information is extremely valuable to us. If you do decide to take part, you will be asked to sign a consent form, a copy of which you will be given to keep. You can still withdraw at any time without having to give a reason. Deciding not to participate or withdrawal from the whole or any part of the study will not affect your usual or future medical care in any way.

What if I have health or memory problems?
The research team have a lot of experience of working with people of your age group. We understand that some individuals may have health or memory problems and might feel anxious about taking part in a research project. However, a family member or carer can be present at the interview to help. Remember your views are important.

What will happen to me if I take part?
If you do agree to help, a nurse will arrange to come and talk to you in your own home at your convenience. She will explain about the study and then if you agree interview you about your thoughts and experiences of your life and your health. The interview will last about one hour and thirty minutes. If you are agreeable the nurse may telephone you or arrange to visit you again to check with you she has understood and put forward your views clearly.

With your permission the interview will be tape recorded in order that the information can be anonymously stored for analysed at a later date. All tapes will be destroyed after this time.

Taking part in this study does not involve any additional medical tests or treatments and will not affect your usual care; if you currently receive treatment from your doctor or hospital this will continue unchanged.

What are the possible benefits of taking part?
While there are no immediate benefits in taking part in this study to you personally, we believe the information gained will improve what is known of the health and needs of

individuals in your age group. We also hope that you enjoy taking part in this study.

What are the possible disadvantages of taking part?
As this study does not affect the treatment you receive from your doctor, it is unlikely that you will experience any harm by taking part in this study. If you do find that taking part causes you any distress or concern, you are free to withdraw.

Will my taking part in this study be kept confidential?
All the information that you provide during the course of this research will be securely stored in either locked files or a secure computer database and kept strictly confidential. Only members of the research team will have access to personal details about you. No individual will be identified or identifiable in any publication arising from the research. Only you, your own GP and the study team need know of your involvement in this study.

What will happen to the results of this study?
The results of this study will be published as part of a final thesis towards an award of PhD at the University of Newcastle and possibly in academic and professional journals. The results will also be linked and compared to results from the Newcastle 85+ Pilot study. If you wish to receive copies of these publications you should notify research staff and they will make them available. In accordance with confidentiality no individual will be identifiable within any publication or report.

Who is organising and funding the research?
The research study is sponsored and supported by the University of Newcastle as part of a PhD thesis.

Who has reviewed the study?
The study has been reviewed by the Newcastle and North Tyneside Medical Research Ethics Committee, Newcastle Primary Care Trust and lead supervisors at Newcastle University

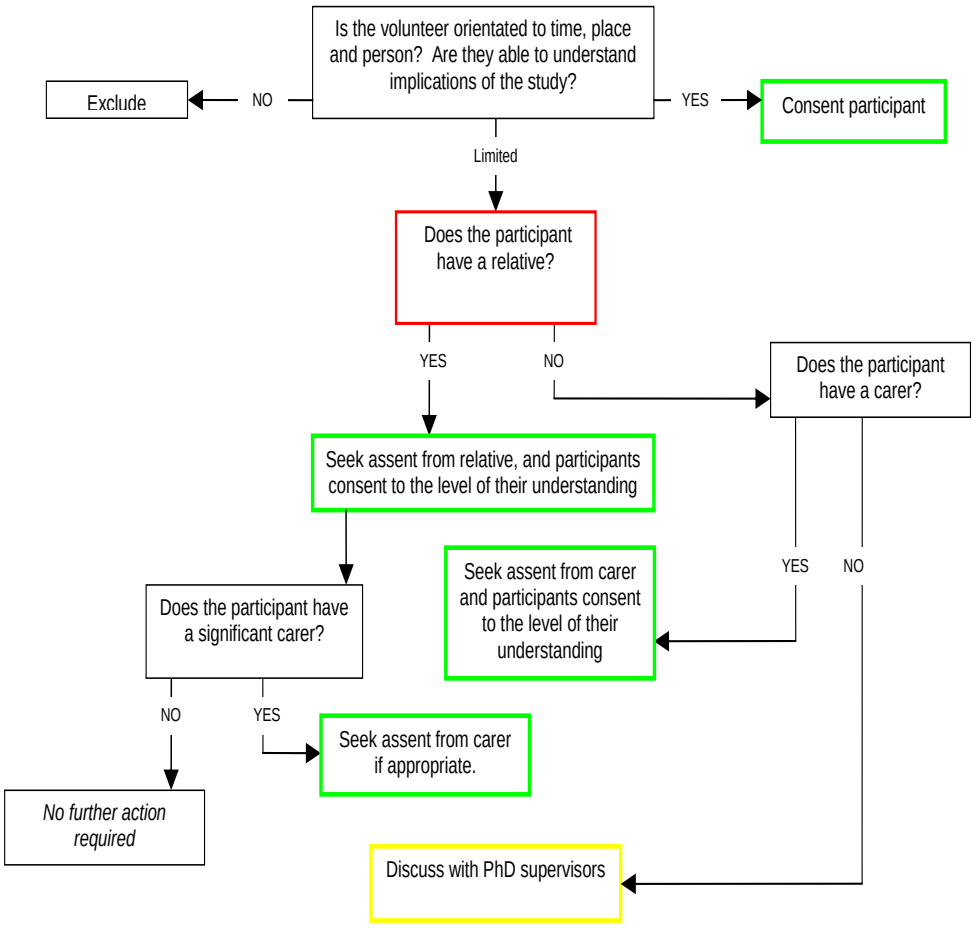
Whom can I contact for further information?
We will be happy to answer any questions you, your family or your carers may have about any aspect of this research study. Please call the number at the end of this booklet and ask to speak to nurse Karen Barrass (now Davies), or write to us.

Your information is very important to us; we very much hope you will agree to take part.
Many thanks.

Contact details

Karen Barrass (now Davies) MSc, BSc (hons), RGN.
Clinical Research Nurse Manager
The Institute for Ageing and Health,
Newcastle General Hospital,
Westgate Road,
Newcastle upon Tyne,
NE4 6BE
Telephone: 0191 4444417 (if no-one is available please leave your details on the answer machine and Karen will return your call)

Appendix H: Consent Protocol



Alerts

Discuss ALL concerns with PhD Supervisors.

Appendix I: Volunteer Consent Form

‘What Does it Mean to Be 85+?’
Volunteer Consent Form

	Please circle
I have read and understood the information sheet that has been given to me about the study.	YES / NO
I have been given time to think about the information and the opportunity to ask questions.	YES / NO
I have received enough information about the study and satisfactory answers to all of my questions.	YES / NO
I understand that my consent is voluntary, and I can withdraw from the whole or any part of the study at any time without having to give a reason for withdrawal.	YES / NO
I understand that withdrawal or declining to participate will not affect my usual care.	YES / NO
I agree that the interview(s) I give may be tape recorded, anonymised and stored by the researcher for future analysis.	YES / NO
I understand that once transcribed, anonymised and analysed tape recordings will be destroyed.	YES / NO
I understand that with my permission the researcher may arrange an appointment with my GP or Nurse on my behalf should I wish to discuss any matters further.	YES / NO
I agree that results from this study can be linked with the results from The North East 85+ Pilot Study.	YES / NO
The nature and demands of the study have been explained to me I fully understand and accept them.	YES / NO

I (name of volunteer)..……
of (address)……
……
agree to take part in this study. (What does it mean to be 85+?)

Signed:……Date……

Investigator Statement:
I confirm that I have explained the nature of the study and given every opportunity for ……..to receive and consider the information about the study.
Name…….……Signed…..……
Designation……Date…..……

Copied for volunteer ☐ *(Tick when completed)*

Appendix J: Consultee Assent Form

‘What Does it Mean to Be 85+?’
Relative/Carer Assent Form

We are asking ……..……..to take part in a research study.

We understand that they may find it difficult to make decisions about participation in this study because of memory problems. However we believe they can make a valuable contribution to this study. We would be grateful for your advice, based on your knowledge of …….now and when they were well, as to whether you think they would wish to take part in this study.

Please ensure you have read the accompanying information booklet which explains why we are doing this research and what we are asking them and you to do. If you find reading or understanding the information difficult, please ask a family member or someone close to you to help you.

Please ask the research team any questions.

Remember:

- That participation in this study is entirely voluntary and they or you may withdraw from the whole or any part or the study at any time without affecting their usual medical care.

- It is unlikely that taking part will have any direct benefit for them.

- There are no hazards or discomforts in taking part.

	Please circle
I have read and understood the information sheet that has been given to me about the study.	YES / NO
I have been given time to think about the information and the opportunity to ask questions.	YES / NO
I have received enough information about the study and satisfactory answers to all of my questions.	YES / NO
I understand that my assent is voluntary, and .(participant name). or I can withdraw from the whole or any part of the study at any time without having to give a reason for withdrawal.	YES / NO
I understand that withdrawal or declining to participate will not affect .(participant name).. usual care.	YES / NO
I agree that the interview(s) .(participant name).. gives may be tape recorded, anonymised and stored by the researcher for future analysis.	YES / NO
I understand that once transcribed, anonymised and analysed tape recordings will be destroyed.	YES / NO
I understand that with permission the researcher may arrange an appointment with .(participant name).. GP or Nurse on their behalf should I/they wish to discuss any matters further.	YES / NO
I agree that results from this study can be linked with the results from The Newcastle 85+ Pilot Study.	YES / NO
I understand that should I or .(participant name).. wish to claim against the University for any adverse reaction or injury arising from involvement in this study I/they will be entitled to do so without the need to prove fault on the part of the University.	YES / NO
The nature and demands of the study have been explained to me I fully understand and accept them.	YES / NO
To the best of my knowledge (participant name) would not object to participation in this study when well, and will not be caused any undue distress by participating.	AGREE/ DISAGREE

I (name of person giving permission)……
of (address)……
……
agree to allow ……...to take part in this study; What does it mean to be 85+? .

The nature and demands of the study have been explained to me. I fully understand and accept them.

Name……Signed.……
Relationship.……Date..……..……
On behalf of……

Investigator Statement:

I confirm that I have explained the study and given every opportunity for; ……(subject) and…..……(Relative/carer) to receive and consider the information about the study.

Name…..……Signed…….……
Designation……Date……

Copied for volunteer ☐ *(Tick when completed)*

Copied for relative/carer ☐ *(Tick when completed).*

Appendix K: Investigator Consent Checklist

CONSENT CHECKLIST FOR INVESTIGATORS

1. Has the consent protocol been adhered to? Yes/No

2. Has the volunteer/relative/carer read the 'volunteer information sheet'? Circle all who apply.

3. Have you given an oral explanation to the volunteer including: Yes/No

- this is a research study?
- participation is voluntary?
- the aims of the study?
- this study will form the final thesis of a PhD?
- the likely duration of the volunteer's involvement?
- the expected benefits to the volunteer and/or others? Yes/No
- what risks, inconvenience, discomfort or distress may reasonably be anticipated this volunteer? Yes/No
- that a refusal to participate or withdrawal from the whole or part of the study ma be given without reasons and will not affect the usual care? Yes/No
- that personal information will be treated as strictly confidential only available t the research team? Yes/No
- whom to contact and how? Yes/No

Yes/No

5. If you have answered NO or not answered any of the above questions rec why:……..
……...…… Yes/No
……...

6. Have you allowed the volunteer/representative sufficient time to consider matter, discuss with others if wished, or ask you any questions? Yes/No

7. In your opinion, has the volunteer/representative understood consented/assented to this study? Yes/No

8. Has the participant/representative signed and dated the consent/assent form? Yes/No

Investigator name:…….

Signature:…….Date:……

Version 1 Jan 2005

Appendix L: In-depth Interview Agenda

Prior to Interview
- Assign ID
- Ensure all equipment is present and functioning

Introduction
- General introduction
- Purpose of the research and intent of the interview
- Go through information booklet
- Answer questions
- Assess capacity
- Obtain consent/assent as directed by protocol
- Clarify demographics

Research Aims
- To explore influences on ageing well from the individuals perspective.
- To link findings with those from the North East 85+ pilot Study in order to further understand the topic.

Background
- Tell me about yourself

Family
- Tell me about your family

Health
- What is health?
- What does this mean to you?
- Experiences
- How have these experiences affected you?
- How have these experiences affected your family

Ageing
- What is ageing?
- What does this mean to you?
- Experiences
- How have these experiences affected you?
- How have these experiences affected your family?

Lifestyle
- Tell me about your lifestyle
- Experiences
- Do you think these have affected you?
- How do these compare with the lifestyle of others?

Social issues
- Tell me what you think are some of the main social issues
- Do you think these affect you?
- Do you think these affect older people?

Closure

- Recap or clarify any areas where appropriate
- Would they add anything to what has been discussed?
- ASK if they have any questions. Answer any questions.
- How have they found experience of interview?
- Clarify what will happen to data / Confidentiality
- Remind of researchers contact details
- Recap permission to re-contact if necessary
- Thank for time given

(Prompts for researcher; Can you tell me more about that?
Can you give me an example of that?
How do you feel about that / How does that make you feel?)

Appendix M: Timeline

HISTORICAL TIMELINE FROM PARTICIPANTS BIRTH (1918) TO YEAR OF NORTH EAST 85+ PILOT STUDY (2003)

WORLD /UK	YEAR (participant age)	NORTH EAST
• *WW I ends* • ***Spanish flu*** *hits Britain killing 200,000* • *women given vote if they are propertied and over age of 30*	**1918**	• ***Year of participants birth*** • *North East (Billingham) chemical works to create synthetic ammonia for bombs has to adapt as war ended*
• *Sex Disqualification Act: illegal to exclude women from specific jobs*	**1919** *(Age 1)*	
• *Women studying at Oxford University able to receive awarded degree*	**1920** *(Age 2)*	• *Motor buses and trams common place in North East towns*
• *Deprivation widespread unemployment reaches 17% in Britain*	**1921** *(Age 3)*	
• *conservative Government in power* • *Irish civil war breaks out*	**1922** *(Age 4)*	
	1923 *(Age 5)*	• *North East Coal mining reaches its peak employing around 170,000 in Durham alone* • *Ammonia produced by North East (Billingham) factory (Brunner Mond later to be known as ICI) used for fertiliser*
• *First labour Government*	**1924** *(Age 6)*	
• *Britain returned to pre 1914 monetary system*	**1925** *(Age 7)*	• *North East* ***Montague Pit disaster*** *A.J. Cronin based his novel 'The Start Look Down' on this*
• *TV first demonstrated* • *Samuel Report prompts miners' strike lasting only 9 days as lack of* • *general support*	**1926** *(Age 8)*	• *General strike North East miners*

		1927 *(Age 9)*		• *Newcastle Brown Ale produced* • *Lucozade created by chemist William Owen in shop on Barras bridge in Newcastle*
• ***All women aged 21 and older get the vote*** • ***Penicillin discovered*** *(Alexander Fleming)* • *First talking film 'Jazz Singer'*		**1928** *(Age10)*		• *Tyne Bridge built by Dorman Long opened by George V* • *Armstrong Vickers merge as unable to diversify since end of war* • *Flying Scotsman locomotive service London to Edinburgh begins operation*
• *Stock market crash - sparking* ***The Great Depression***		**1929** *(Age11)*		• *Domestos created and produced by Wilfred Handley in a Newcastle Byker workshop*
• ***Housing Act****: Government given go ahead to clear slums* • *Amy Johnson flies solo from UK to Australia*		**1930** *(Age 12)*		• *North East Shipyard closures in past decade = 19 with high job loss and heavy unemployment in region*
		1931 *(Age 13)*		• *Palmer shipyard at Jarrow launches its last ship: HMS Duchess* • *Jarrow unemployment reaches 80% due to slump in shipyard demand*
		1932 *(Age 14)*		• *Sydney Harbour Bridge completed by Dorman Long based on Tyne Bridge* • *5,000 workers employed by chemical works in North East Chemical factory (Billingham)*
		1933 *(Age 15)*		• *In North East: a further 6 shipyard closures from 1931 -1933*
• *Welsh mine disaster kills 266 people*		**1934** *(Age 16)*		
• *Penguin publishes paperback: books for the masses*		**1935** *(Age17)*		• *Mauretania returns to Tyne before being broken up in Glasgow* • *Newcastle airport opens*
• *George V dies, succeeded by Edward VIII* • *The first programmable computer invented the 'Z1', by Konrad Zuse*		**1936** *(Age18)*		• *Team Valley industrial estate opened to encourage light industries to North East area* • *Queen Mary liner sails from South Hampton and reaches New York in 4 days* • ***Jarrow march*** *in protest of 70% unemployment in North East*
• *George VI crowned after Edward VIII abdicates*		**1937** *(Age 19)*		

• *First plane built to carry 18 passengers* • *First IRA bombing in UK*		**1938** *(Age 20)*		
• *UK declares war on Germany (start **WWII**)*		**1939** *(Age 21)*		
• *Winston Churchill is Prime minister* • *Battle of Britain: Blitz 30,000 killed - 52 consecutive nights of bombing on London by Luftwaffe* • ***Penicillin purified and used as an antibiotic***		**1940** *(Age 22)*		• *Newcastle radio show 'what cheor geordie' begins ad ran until 1956* • *Air raid on Newcastle and bridges over Tyne destroys Spillers factory*
• *British battle cruiser 'HMS Hood' sunk by Bismarck* • ***National Service Act*** • *Battle ship 'King George V" built in Walker shipyard sank German Bismarck*		**1941** *(Age 23)*		• *King and Queen visit North East shipyards* • *The head of Greys monument statue Newcastle destroyed by lightening*
• ***Beverage Report: recommends welfare state, NHS and social security***		**1942** *(Age 24)*		• *Murton Colliery disaster: 13 men killed in explosion*
• *RAF Dam-busters raid breaks 2 dams*		**1943** *(Age 25)*		
• *D-day landings* • *Butler Act: free secondary education to age of 15*		**1944** *(Age 26)*		
• *British troops liberate Belson concentration camp* • *Germany surrenders (**end WWII**)*		**1945** *(Age 27)*		
• ***Introduction of state run universal contributory pension scheme*** • *Churchill declares cold war on Russia*		**1946** *(Age 28)*		
• *British coal industry is nationalised representing a major shift in industrial policy*		**1947** *(Age 29)*		• *North East: Stanley (Louisa) Colliery disaster: 21 men killed in explosion*
• ***NHS established***		**1948** *(Age 30)*		• *DHSS at Longbenton Newcastle : this service sector was to become a major employer in region in late 20th Century*
		1951 *(Age 33)*		• *Easington Colliery disaster: 81 men killed in explosion*

• George V II dies succeeded by Elizabeth II • Britain explodes first atomic bomb • London smog		**1952** (Age34)		• Andy Capp cartoon character created by Hartlepool artist Reg Smyth
• Edmund Hillary and Tensing climb Everest • DNA double helix discovered by Crick and Watson		**1953** (Age 35)		
• Churchill retires aged 80 • first broadcast by commercial TV		**1955** (Age 37)		• Newcastle win FA cup
• Suez crisis English pound collapses • First nuclear power station in Britain to supply electricity • Clean Air Act: as worsening pollution and London smog kill more than 4,000 people		**1956** (Age38)		• Last pit in Newcastle closes
• Britain tests first hydrogen bomb		**1957** (Age39)		
• Motorway opens with M6		**1958** (Age 40)		• Sparkie the talking Budgerigar hits headlines in Newcastle
		1959 (Age 41)		• North East Pit closures in past decade = 16
		1960 (Age 42)		• **City Council begins demolition of Newcastle City slums and redesign city**
• Beatles debut		**1962** (Age 44)		• Centenary of Blaydon races attracts 500,000 people to North East
• Robins Report: increase to state funded University fees		**1963** (Age45)		• Beatles write 'She Loves You' in Imperial Hotel Jesmond Newcastle
• RPM standard pricing abolished supermarkets undercut small shops and reform retail industry		**1964** (Age 46)		
• Comprehensive education system introduced • Britain abolishes death penalty		**1965** (Age 47)		• First section of A1M
• England defeat Germany in world cup		**1966** (Age 48)		• Darlington railway workshops close ending the industrial era and the loss of 2,150 jobs • from 1960 to 66: 6 shipyards closed in North East region

• *First ATM cash machines in UK* • *Homosexuality (for those aged over 21) and abortion are legalised*		**1967** *(Age 49)*		
• *Concord first supersonic airliner developed*		**1969** *(Age 51)*		• *Work starts on building Byker wall Newcastle housing* • *North East Pit closures in past decade = 73*
• ***Equal Pay Act***		**1970** *(Age 52)*		
• *Decimalisation* • *First British soldier killed in Northern Ireland troubles*		**1971** *(Age 53)*		• *53% of Tyneside employment now in service sector: manufacturing and heavy industry no longer dominant*
• *First VCR made by Phillips* • *Bloody Sunday: British troops kill 13 civilian civil rights protesters*		**1972** *(Age 54)*		• *Hartlepool nuclear power station commences supply*
• *Britain joins EU economic community*		**1973** *(Age 55)*		
• *Harold Wilson in power for Labour party* • ***Health and Safety at Work Act***		**1974** *(Age 56)*		• *Creation of Newcastle Metro system commences*
		1975 *(Age57)*		• *First oil piped from North Sea*
• *Concord first commercial flight* • *Punk rock*		**1976** *(Age 58)*		
		1977 *(Age 59)*		• *Queen silver jubilee: Royal yacht Britannia arrives on Tyne*
• ***Winter of discontent****: strikes paralyse Britain* • *First IVF baby born*		**1978** *(Age 60)*		
• *IRA kills Lord Mountbatten* • *Margaret Thatcher elected as prime Minister for conservative party*		**1979** *(Age 61)*		
		1980 *(Age 62)*		• *Newcastle Metro transport system opens its first section between the Haymarket and Tynemouth* • ***Consett steel works closed***

• *Brixton Riots: racial tensions between black community and police* • *Prince Charles and Dianna Spencer wed* • *Humber bridge opens*		**1981** *(Age 63)*		• *First Great North Run* • *63% of Tyneside employment now in service sector*
• *Economic recession leads to high unemployment* • *Britain at war with Argentina over Falklands*		**1982** *(Age 64)*		
		1983 *(Age 65)*		• *100th Miners gala at Durham*
• *IRA bomb conservative conference in Brighton* • *DNA fingerprint invented*		**1984** *(Age 66)*		• *North East Shildon wagon works closed* • *National miners' strike: violent clashes between strikers and police, after one year strike called off and pit closures go ahead*
• *39 Italian football fans killed by rival Liverpool fans*		**1985** *(Age 67)*		• *Newcastle FRH* ***first heart transplant***
• *Privatisation of major national industries*		**1986** *(Age 68)*		• *Nissan car producers opens in Washington Tyune and Wear*
• *Montreal Protocol: limits use of substances which damage the ozone layer* • *Thatcher elected for 3rd term becoming the longest serving PM for 150 years*		**1987** *(Age 69)*		• *The last ship ever to be launched on Tees and Smiths docks: the 15,000 tonne 'North Islands' with the loss of 1,295 jobs* • *North East Metro Centre opens: Europe's largest shopping complex*
• *First man (Colin Pitchfork) convicted using DNA fingerprint*		**1988** *(Age 70)*		• *Sunderland Shipbuilding ends with the closure of Austin and Pidegill*
• *96 football fans killed at Liverpool Station*		**1989** *(Age 71)*		• *Rail accident at Newcastle*
• ***Internet invented*** *by Tim Berners-Lee* • *Poll tax riots in London* • *Margaret Thatcher resigns*		**1990** *(Age 72)*		• *Western bypass opened*
• *UK and America goes to war on Iraq*		**1991** *(Age 73)*		
• *Chunnel between UK and France is opened* • *Black Wednesday: sterling pulled out of EU exchange rate*		**1992** *(Age 74)*		• *Tyne declared first class river*

• *First female priests ordained by C of E*		**1994** *(Age 76)*		
• *Mad cow disease leads to slaughter of many cattle*		**1996** *(Age 78)*		
• *Scotland and Wales vote for devolution* • *First Harry Potter book published* • *Hong Kong handed back to China* • *Tony Blair elected as PM for labour party* • *Dolly the sheep is cloned* • *Lady Diana killed in car crash*		**1997** *(Age 79)*		
• ***Good Friday agreement**: Peace treaty between UK and Ireland*		**1998** *(Age 80)*		
• *Britain decides not to join EU single currency*		**1999** *(Age 81)*		
• *New Millennium* • ***Biologists decipher entire DNA code for a human*** • ***Eva Morris dies aged 115 the oldest British person of all times***		**2000** *(Age 82)*		• *Newcastle hospital trust has lowest mortality rates in country* • ***Newcastle Gateshead initiative created to promote and regenerate the City***
• *America declares 'war on terror' after hijacked planes destroy the twin towers* • *UK foot and mouth disease sees the culling of millions of cattle and brings crisis to the countryside*		**2001** *(Age 83)*		
		2002 *(Age 84)*		• *River Tyne: Millennium bridge opens*
• *Invasion of Iraq* • *Concord is retired*		**2003** *(Age 85)*		• ***North East 85+ Pilot Study commenced***

Appendix N: Statement of Thesis Outputs

Davies, K., Collerton, J.C., Jagger, C., Bond, J., Barker, S.A.H., Edwards, J., Hughes, J. Hunt, J. and Robinson, L. (2010). Engaging the Oldest Old in Research: Lessons from the 85+ Study. *BMC Geriatrics* [online] biomedicalcentral, available: http://www.biomedcentral.com/1471-2318/10/64

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Papers under development

Davies, K., Bond, J., Kirkwood, T.B.L. and Brittain K.: Past Life Histories And Their Impact On Ageing: 'Work To Retirement' Explored Through The Voices Of The Very Old.

Davies, K., Bond, J., Kirkwood, T.B.L. and Brittain K.: Self-Rated Health: Interpretations And Application In The Very Old

Davies, K., Bond, J., Kirkwood, T.B.L. and Brittain K.: Perceived Control As A Determinant Of Ageing Well In Very Old Adults.

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