An exploration of the experience and social construction of ageing: Perspectives from older adults in a healthy ageing program and those from Western Australian and Welsh communities

Sasha A. Stumpers

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An exploration of the experience and social construction of ageing: Perspectives from older adults in a healthy ageing program and those from Western Australian and Welsh communities

Sasha A. Stumpers

This thesis is presented in fulfilment of the requirements for the degree of

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USE OF THESIS

The Use of Thesis statement is not included in this version of the thesis.
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Statement of Confidentiality

Ethical clearance from the Edith Cowan University Ethics Committee was granted in December 2007. The confidentiality and privacy of the information were protected at all times, including in all correspondence between the researcher, research supervisors, and other colleagues involved with this research. All identifying information from participants used throughout this thesis was protected by non-identifying codes (i.e., numbers). All raw data included in the thesis (i.e., verbatim quotes) were carefully scrutinised for information that could render participants identifiable.
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Abstract

In recent years, a strong focus has emerged towards developing and implementing guidelines, policies, governmental strategies and research agendas that best support a growing ageing population (United Nations, 1983, 1990, 1991, 1999, 2001, 2002, 2012; United Nations Programme on Ageing/International Association of Gerontology and Geriatrics, 2007; United Nations/Department of Economic and Social Affairs, 2008; World Health Organization, 2002, 2004a). Locally in Western Australia (WA), nationally and internationally, this attention has culminated in a focus on promoting the notion of “healthy ageing” (Commonwealth of Australia, 1999; Commonwealth States and Territories, 2000; Office for Seniors Interests and Volunteering, 2006; U.S. Department of Health and Human Services, 2000; Welsh Assembly Government, 2005) based on the World Health Organisation (WHO) definition of health as “a state of complete physical, mental and social wellbeing; not solely the absence of disease” (World Health Organization, 1946, p. 2). However, policies and theoretical understandings based on healthy ageing narratives have been questioned in regard to their underlying assumptions continuing to medicalise, problematise and objectify the ageing experience (Biggs, 2001; Cardona, 2008; Estes, 1993; Estes, Biggs, & Phillipson, 2009; Holstein & Minkler, 2003, 2007; Powell & Biggs, 2000; Sabelli, Patel, Konecki, & Nagib, 2003). This propensity to precondition a highly intra-personal, variable, and socially located experience (Estes, 1993; Estes et al., 2009; Featherstone & Wernick, 1995) prompted the need for further examination of current conceptualisations of the ageing experience as it is lived and experienced by older adults themselves. Moreover, a dearth of understanding remains about how older adults socially construct and attach meaning to their ageing experience. For these reasons, the purpose of this research was to explore how older adults socially construct meaning around their lived experiences of ageing whilst drawing attention to dominant rhetoric about healthy ageing in wider society.

To explore the different ways in which older adults make meaning of their experiences of ageing, a qualitative methodology, guided by the theoretical underpinnings of phenomenology and social constructionism was used. Semi-structured interviews were conducted with 59 older adults (23 males and 36 females aged between 50 and 89 years) in order to collate a diverse, but in-depth and rich sample of descriptions of the lived experience of ageing. Participants were recruited according to four purposive sample groups. Consequently, this research project presents insight into the lived experience of ageing from across four distinct contexts, three of which were located in WA including 17 participants from a healthy ageing program; 12 participants who have withdrawn from a healthy ageing
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program; and 15 participants from a community sample. The fourth sample comprised of 15 participants from a community sample in Wales, United Kingdom (UK). A thematic analysis approach was utilised to analyse the data exploring participants’ experiences of ageing and investigating how participants constructed meaning in ageing across each of the four contexts.

The data revealed that whilst participants described feeling that the dominant discourse in wider society caused them to anticipate ageing as a stage in life centred on experiencing decline and loss (e.g., a decline in mental functioning, or a loss of mobility), it was also evident that psychological, social and political aspects were of equal, or greater significance to the meaningful understandings they constructed about their personal ageing experience. Five major themes with related sub-themes emerged that were germane to this finding. Major themes included: 

- primed thought (consisting of sub-themes the “lucky” view, comparisons with others, healthy ageing, and decline and loss);
- connectedness (consisting of sub-themes the value of groups, supportive relationships, and religion and spirituality);
- social values (consisting of sub-themes generational interactions, ageism, and resource allocation);
- negotiating transitions in ageing (consisting of sub-themes life-stages and events, the dependence-independence continuum, the ageing body, and attitude and acceptance); and
- agency and influence (consisting of sub-themes meaningful roles, and personal control and worth). Cumulatively, these findings suggested that although research has often reported ageing in terms of aspects associated with declines and loss, to only attend to these areas would be to overlook significant psychological and social constituents of the ageing experience.

The findings of this research uniquely contribute to current understandings about ageing. Foremost, the findings support a more holistic understanding of ageing based on lived experiences and provide evidence that ageing is a socially constructed, and therefore modifiable experience. Specifically, the findings contribute to understandings about the systemic influences on constructed meaning in ageing, particularly the disjunction between policy constructions and lived experiences. Furthermore, with comparable findings occurring across the four distinct contexts of this research, especially between the local context in WA and the international context in Wales, highlights the significance and widespread relevance of the issues raised pertaining to participants’ experiences of ageing. Consequently, findings may be used to inform existing and future policy decision-making and models of best practice towards promoting healthy ageing. Moreover, the findings contend that a need exists to evaluate the way in which ageing policy is effectively translated into practice, that is, in a way that closely aligns with the lived experiences of ageing as had by individuals. In practical terms,
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The findings suggest it would be highly beneficial to ensure that healthy ageing initiatives implemented in the wider community embrace awareness, and put into practice actions that account for all factors contributing to a healthy ageing experience - especially psychological and social aspects as emphasised by participants. Despite the robustness of these findings, further research is needed and encouraged to maintain the development, growth, and momentum of such understandings about the ageing experience and this is particularly encouraged with populations from different socio-cultural contexts and settings, as well as a gendered perspective of the lived experience of ageing.
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Declaration

I certify that this thesis does not, to the best of my knowledge and belief:

i) incorporate without acknowledgement any material previously submitted for a degree or diploma in any institution of higher education;

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Sasha Alysha Stumpers 28 May 2012

Sasha Alysha Stumpers Date
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(ARC)/National Health and Medical Research Council (NHMRC) Research Network in Ageing

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Chapter 1: Introduction

This chapter introduces the wider context of this research. It begins by introducing the topic of population ageing and the associated political discourse concerning this topic. How the ageing experience has been constructed in theory and policy is then briefly reviewed. Next, the researcher’s journey leading to the culmination of an international research collaboration and collection of data to complement the Australian data is discussed. These preceding discussions lead to an outline of the rationale for this research. To this end, the necessity for exploring the lived experience of ageing from a social constructionist perspective is presented in conjunction with the importance of exploring healthy ageing in context. Specifically, the four participant groups of this research are described and the research questions delineated. The chapter concludes by discussing the implications of this research before outlining the structure of the thesis.

1.1 Research context

1.1.1 Population ageing.

Population ageing is characterised by an upwards shift in the age structure of the population resulting in smaller proportions of people at younger ages and larger proportions of people at older ages (Australian Bureau of Statistics, 2006, 2009; Australian Institute of Health and Welfare, 2007). This change in demographic circumstance has implications for social and economic planning as well as service provision and has raised ageing issues on the political agenda worldwide. Since the first international policy framework on ageing in 1982, the Vienna International Plan of Action on Ageing (VIPAA), the past few decades have seen a surge of political interest in ageing. Consequently, there is currently a strong political focus towards the development and implementation of guidelines, research agendas, policies, and strategies on how best to accommodate an ageing population. There is a particular focus locally in Western Australia (WA), nationally in Australia and internationally on research in the area of “healthy ageing” (Australian Bureau of Statistics, 2006; Australian Local Government Association, 2004a, 2004b; Department of Health Western Australia, 2009; Office for Seniors Interests and Volunteering, 2006, n.d.; United Nations/Department of Economic and Social Affairs/Population Division, 2010). However, policies, particularly those based on healthy ageing and “successful ageing” narratives in Western countries, have been questioned with regard to their underlying assumptions as well as for the way they dictate the ageing experience (Biggs, 2001; Cardona, 2008; Estes, 1993; Estes, Biggs, & Phillipson, 2009; Holstein, & Minkler, 2003, 2007; Powell, & Biggs, 2000). For example, how such discourses are used as
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tools to explain the ethics of “responsibility” for health care (Cardona, 2008) and in particular, how they set forth the preconditions for ageing successfully with this normatively desirable state vested largely within the individual’s power to achieve (Holstein & Minkler, 2003, 2007).

Therefore, despite rhetoric of a more positive approach to ageing (i.e., successful ageing theory and healthy ageing policy), much of the existing literature focuses on the outcomes of ageing based on assumptions about older adulthood that tend to problematise, medicalise, and objectify the ageing experience primarily as a physical process of change (Biggs, 2001; Cardona, 2008; Estes, 1993; Estes et al., 2009; Holstein & Minkler, 2003, 2007; Powell & Biggs, 2000; Sabelli et al., 2003). Furthermore, while the dominant view on ageing in the western world has been the decline of health status and a focus on functional limitations (Brickman et al., 1982), this approach discounts other more positive factors which impact the ageing process and is neglectful of recognising the highly intra-personal, variable, and social nature of the ageing experience (Estes, 1993; Estes et al., 2009; Featherstone & Wernick, 1995). This “decline and loss” view on ageing has implications for promoting and improving life quality in older adulthood and is especially of concern considering the changing distribution of the population locally in Australia (i.e., with one in four Australians expected to be over the age of 65 years by 2056) (Australian Bureau of Statistics, 2008) and more globally across the western world with the proportion of people aged 60 years and over increasing faster than any other age group with an expected growth of 223% between 1970 and 2025 (Australian Bureau of Statistics, 2010b; United Nations/Department of Economic and Social Affairs/Population Division, 2010; World Health Organization, 2002). For these reasons, there is a need to re-examine current conceptualisations of ageing, particularly from the perspective of older adults. Prior to exploring what ageing means to older adults themselves, it is first necessary to examine how existing conceptualisations of the ageing experience are influenced by current theory and policy in the field.

1.1.2 Constructing the ageing experience: Theory and policy.

Theoretical understandings of ageing provide a framework for constructing meaning about the ageing experience. With various physical, psychological and social changes surrounding the ageing process, a fundamental question in the study of ageing has sought to understand how people come to terms with these changes (Coleman, Ivani-Chalian, & Robinson, 1998; Estes et al., 2009; Jamieson, 2002b; J. Reed, Stanley, & Clarke, 2004). Despite the development of many influential psychosocial theories, the medicalisation of ageing has dominated the discourse on ageing, consequently influencing how ageing issues are prioritised at a political level (Brickman et al., 1982; Bury, 2001; Estes, 1993; Estes et al., 2009; Estes &
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Binney, 1989). A main concern with this biomedical approach to ageing is the concurrent consideration of ageing as a problem. This is reinforced further by policy that implies absence of disease to be the primary indicator of ageing successfully (Cardona, 2008; Peel, Bartlett, & McClure, 2004; Phelan, Anderson, Lacroix, & Larson, 2004). In addition, much of the developmental literature on individual ageing makes use of standardised instruments for recording people’s self-concept and self-esteem. Although providing valuable information on outcomes in ageing, these approaches have offered little insight into the process and meaning making involved in ageing (Coleman et al., 1998; Jamieson, 2002a).

The meaning that people assign to ageing is influenced by their own life experiences and social interactions with the world yet research predominantly focuses on objectivity in ageing. There is therefore a need to better understand the experience of ageing from older adults themselves. This requires adopting a broader focus to investigate individual ageing experiences, where meaning making becomes an important point of investigation. Such an approach would involve a focus on spontaneous messages about experiences and meaning generated by people in everyday situations, and of plans people make for changes in the self (Atchley, 1991; Coleman et al., 1998; Jamieson, 2002a). Personal stories and accounts of ageing and what it means to live a long time will develop understanding of how and what experiences in a person’s life affect their process of ageing and the decisions they make to adjust and adapt throughout this process (Jamieson, 2002a). Furthermore, the realities of an ageing population bring to question the relationship between the experience of ageing and ageing policy. The influence of context in shaping people’s views and experiences of ageing can be assessed in light of how policy is constructed and developed.

Social living influences policy, and policy development and prioritisation influences social living, making them seemingly symbiotic. As a result, when investigating social constructions in ageing it is difficult to disentangle the associated policy context of a particular time. Currently, the construction of ageing has primarily focused upon outcomes in economic terms such as activity and productivity (Estes et al., 2009; S. Katz, 2000). This can result in homogenizing older adults with attempts to produce a generic older person facilitated through the marketing of ageing as a product considered achievable through investment in particular lifestyles and practices (Cardona, 2008; Estes et al., 2009; Featherstone & Wernick, 1995; S. Katz, 2000). This is implicitly implied in much of the current policy on ageing and has led to a focus on health promotion and prevention (Australian Institute of Health and Welfare, 2003; Australian Local Government Association, 2004a, 2004b; Commonwealth States and Territories, 2000; J. E. Lang, Moore, Harris, & Anderson, 2005). In response, it has been
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suggested that research should focus on aspects of healthy ageing (Commonwealth of Australia, 1999; Commonwealth States and Territories, 2000; Prime Minister's Science Engineering and Innovation Council [PMSEIC], n.d.; United Nations Programme on Ageing/International Association of Gerontology and Geriatrics, 2007).

Recent support for promoting healthy ageing and current local, national and international policy development in the area (Commonwealth of Australia, 1999; Department of Health Western Australia, 2009; Health Department of Western Australia, n.d.; J. E. Lang et al., 2005; United Nations Educational Scientific and Cultural Organization, 2006) provides impetus to explore and gain understanding about what motivates people to make lifestyle modifications to improve their health and in particular, why older adults decide to participate in programs aimed at promoting healthy ageing. While literature exists on definitions of healthy ageing (Cardona, 2008; J. E. Lang et al., 2005; Peel et al., 2004; Peel, McClure, & Bartlett, 2005; D. M. Reed, Foley, & White, 1998; Sabelli et al., 2003), the experience of being involved in a healthy ageing program in relation to how the person involved constructs and experiences ageing has not been investigated. Equally important is exploring the reasons why some older adults choose not to continue in programs or interventions that may have positive outcomes for their health. Furthermore, to fully appreciate the impact of healthy ageing policy on people’s experiences of ageing it becomes relevant to ask those involved in a healthy ageing program about their ageing experience.

Therefore, decisions around policy development and service provision are reflective of popular discourses associated with ageing and these discourses and social attitudes are likely to affect the individual experience of ageing (Cardona, 2008; Estes et al., 2009; Peel et al., 2004; Ranzijn, 2010). Subsequently, it is necessary to understand how the current ageing experience is constructed and conceptualised theoretically and in policy in order to understand these discourses. With the lived experience of ageing traversing locally, nationally and internationally relevant policies as well as individual experience, a critical exploration of the multiple systemic influences on the lived experience of ageing is also required. The current publicity around population ageing and the associated social and economic burdens depicted because of this phenomenon, highlights the currency and importance of exploring the lived experience of ageing. Moreover, recognising the recent surge of political interest in ageing issues, and realising the dearth of understanding on the lived experience of ageing, provided the foundation from which this research evolved.
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1.1.3 The researcher’s journey: Navigating local, national and international contexts.

Exploration of the literature for this research topic raised awareness of the current social commentary on ageing, and immersion in the research further facilitated the researcher’s knowledge of key organisations and research bodies involved with ageing issues. It is during this process that the researcher joined the Australian Research Council (ARC)/National Health and Medical Research Council (NHMRC) Research Network in Ageing Well. It is through this network that the researcher became involved with the Emerging Researchers in Ageing (ERA), an initiative of the Australasian Centre on Ageing at the University of Queensland. Attendance at the annual conference of the Australian Association of Gerontology (AAG) in collaboration with the ERA provided an introduction to international research in ageing and in particular, research conducted by Professor Judith Phillips and colleagues in Wales in the United Kingdom (UK). This became a defining moment in this research journey as opportunities for collaborative work emerged.

Facilitated by the ERA initiative, the researcher was successful in securing one of 25 placements in a yearly Masterclass held at the University of Queensland. Developed for early career researchers in the area of ageing, the Masterclass involved collaborative workshop activities and networking sessions with leading academics on topics relevant to ageing research. The Masterclass contributed to understandings concerning the importance of policy and governance in shaping research agendas. Importantly, acceptance into the Masterclass highlighted the national interest in this research and provided acknowledgement of the need for phenomenological research on the lived experience of ageing. That is, the importance of investigating the experience of ageing from the perspective of those who have experience with it (Barkway, 2001; Creswell, 2007; Liamputtong & Ezzy, 2005; Moutsakas, 1994; Patton, 1990) and focusing on how people construct their experience in the context of their own life world (Creswell, 2007; Flood, 2010; Patton, 1990; Zippel, 2010). Attendance at the Masterclass also led to involvement in an ERA International Exchange Program to extend this research.

International collaboration: Wales research exchange experience.

The ERA exchange program took place between the 18th of August and the 24th of October 2009 and was hosted by Professor Judith Phillips and colleagues at Swansea University in their Centre for Innovative Ageing in Wales, UK. A core feature of the centre at Swansea is its focus on international collaboration with well established research links with centres of excellence in ageing in Europe, North America and Canada. Professor Phillips’s position at the time as President of the British Society for Gerontology (BSG) ensured that the exchange
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facilitated relevant cross-institutional networking and collaborative work and the establishment of foundations for future partnerships in the area of ageing across research centres, universities and institutions of excellence. Specifically, links were made, and ongoing communications were facilitated between the researcher with colleagues and researchers in England, Scotland, Wales, Japan and Canada. These communications enabled the researcher to kept abreast of current research in ageing at an international level.

The opportunity to exchange thoughts and ideas with other researchers provided exposure to the quality of international work and research in the ageing field. For example, learning how the Welsh and English government systems operate allowed reflection on the operation of the Australian government, particularly highlighting Australia’s position concerning ageing issues on the international stage. Discussions with other researchers in ageing across the UK highlighted the importance of understanding the contextual role that social policy has in influencing people’s health. Of particular significance was the importance placed on examining the more systemic factors or “fault lines” within systems such as policy failure, especially the absence of promoting preventative approaches to health and wellbeing (J. Reed et al., 2004; Walker, 2009a, 2009b). This has particular relevance for Australia’s socio-political climate, which is currently investigating how to effectively support an ageing population and deciding which models of support to fund (Australian Institute of Health and Welfare, 2003; Bartlett, 2003; Commonwealth of Australia, 1999; Commonwealth States and Territories, 2000; Prime Minister’s Science Engineering and Innovation Council [PMSEIC], n.d.).

Another important outcome of the exchange was the opportunity to talk with older adults themselves about their experiences of ageing in Wales. These conversations culminated in the collection of qualitative interview data that complemented findings from the Australian data. This international data added depth, rigour and meaning to local understandings on the experience of ageing in WA. Moreover, this data allowed for the identification of practices and policy within Wales that can positively contribute to, expand on, and inform current models of practice and service delivery in ageing within Australia. Engagement in this research exchange, and the opportunity to collect additional data resulted in the further refinement of this research by investigating the ageing experience in conjunction with international lived experiences of ageing and related ageing policy.

Therefore, the current research having evolved from an identified need to explore the lived experience of ageing, led to the researcher’s participation in a Masterclass for emerging researchers in ageing and engagement in an international exchange program. These
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experiences provided opportunities to collect significant interview data; to assist in the conceptualisation and development of the current research; to disseminate this research to a wide audience; and to facilitate practical learning to influence policy and practice. In addition, these experiences built on the researcher’s knowledge and skill base in the area of ageing by means of practical experience of peak healthy ageing service delivery models and research centres operating in the UK, which subsequently informed understandings about models of practice and service delivery in Australia.

In summary, this introduction has focussed on the research context, specifically: population ageing; current conceptualisations of ageing by way of theory and policy; and the journey of the researcher in the research process. How these contextual factors have informed the structure, foundation and purpose of this research has also been discussed. The following section provides a summary of the research rationale and outlines the specific aims and questions of this research. This next section concludes by highlighting the contribution of this research to current understandings in the field of ageing, in particular, by highlighting the implications of this research for policy, theory, research and practice.

1.2 The current research

1.2.1 Research rationale.

Investigation of the present research agenda on ageing revealed a dialogue of concern regarding the rise of population ageing locally and globally. Subsequent to this discussion, with dominant theoretical understandings adding to the construction of ageing and later life as a time of loss and decline, a need was identified for research to investigate issues associated with the lived experience of ageing. Particularly, there has been a drive for research investigating the concept of healthy ageing theoretically, at a policy level, and in practice (Commonwealth of Australia, 2001; Commonwealth States and Territories, 2000; Office for Seniors Interests and Volunteering, n.d.; Peel et al., 2004; United Nations Educational Scientific and Cultural Organization, 2006; United Nations Programme on Ageing/International Association of Gerontology and Geriatrics, 2007). Furthermore, given that policy and program developments directed at older adults in WA, Australia and Wales, indicate 50 years and over as their target audience (Commonwealth of Australia, 1999, 2001; Council on the Ageing Australia, n.d.-a, n.d.-b; Council on the Ageing WA, 2012a, 2012b; Living Longer Living Stronger COTA, 2012a; Welsh Assembly Government, 2003, 2005), for the purposes of this research older adults over the age of 50 years were targeted for inclusion. For these reasons, the
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The purpose of this research was to explore how older adults over the age of 50 years socially construct meaning around their lived experience of ageing whilst drawing attention to dominant rhetoric about healthy ageing in wider society. In particular, this research aimed to understand the systemic influences on constructed meaning in ageing with a particular interest in the disjunction between policy constructions and lived experiences.

Therefore, to more appropriately accommodate the needs of an ageing population, it is important that current policy be reviewed with reference to the lived experience of ageing. By asking older adults not only about their experiences of ageing but also examining how they construe meaning about their experiences is required to allow for more meaningful analysis of policy relevance and effectiveness. This current research looked to achieve this by investigating the construction of meaning in ageing and experiences of ageing from the perspectives of those involved in a healthy ageing program. This information provided a platform from which to assess the role of policy in constructing meaning about the ageing experience. Information about the lived experience of ageing was further explored with interview data from a local community sample of older adults in WA as well as an international community sample from Wales, UK. The development and significance of the different groups sampled in this research will be discussed in the next section with particular attention placed on how involvement of the groups address the aims of this research.

1.2.2 Exploring healthy ageing.

In 2001, principles outlined in the National Strategy for an Ageing Australia (NSAA) (i.e., the building of a strong evidence base to inform policy for an ageing Australia - refer to Chapter three of this thesis for further information) (Commonwealth of Australia, 1999, 2001), corresponded to the United Nation’s (UN) principles for older persons relating to concepts such as participation, self-fulfilment and dignity (United Nations, 1991). As a result, the principles in the NSAA were guided by four overarching themes described in the terms of reference: independence and self provision; attitude, lifestyle and community support; world class care; and healthy ageing (Commonwealth of Australia, 2001). Australia’s response to ageing has particularly focussed on the healthy ageing theme to progress ageing policy forward. Of particular interest to this current study was the strategy’s proposition for research to develop the healthy ageing evidence base to better understand this area (Commonwealth of Australia, 2001). Consequently, in an attempt to further promote healthy ageing across Australia, it has been recognised that a first step involves asking older people about their experiences, whether it be through involvement in programs aimed at promoting healthy ageing or obtaining older adults’ views on aspects of healthy ageing important to them.
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The particular drive for research in the area of healthy ageing in relation to the ageing experience led to the researcher’s investigation into the types of institutions and organisations supportive of a healthy ageing perspective. This resulted in discussions with the Council on the Ageing (COTA) in WA and the Vario Wellness Clinic (formerly known as Vario Health and Wellness Institute). Recognised by the state and federal governments of Australia as the peak seniors organisation in WA, COTA’s vision is to protect and advance the rights of all older Western Australians with the wider purpose of working with all older adults to achieve a just, inclusive and equitable society (Council on the Ageing Australia, n.d.-b; Council on the Ageing WA, 2012a). As an independent non-government organisation for older people, COTA (WA) is respected for its policy and program work with submissions to government resulting in significant improvements in services for seniors (Council on the Ageing Australia, n.d.-a; Council on the Ageing WA, 2012b). A particularly successful program to develop through COTA (WA) has been the healthy ageing program, Living Longer Living Stronger (LLLS) (Living Longer Living Stronger COTA, 2012a). The LLLS program is introduced and discussed in further detail in the next section.

A healthy ageing program: Living Longer Living Stronger (LLLS).

LLLS is an evidenced based program that encourages and supports change in the health and fitness sectors to achieve improved health, quality of life and fitness of people aged over 50 years (Living Longer Living Stronger COTA, 2012b). The growth and popularity of this program has resulted in many providers (e.g., health and fitness centres, community centres, aquatic and recreation centres) across WA supporting the program. With its focus on health and fitness across the lifespan, the Vario Wellness Clinic began operation of the LLLS program through their centre in 2004. The Vario Wellness Clinic was first established in 2003 as an initiative to build collaboration among researchers, educators, industry and governments to optimise health and improve quality of life for people of all ages. Thus, the LLLS program provided the context for aspects of this current research related to healthy ageing. In particular, aspects to do with understanding the factors contributing to older adults’ involvement in, and withdrawal from a healthy ageing program were of primary concern with these factors reviewed in the context of older adults’ own experiences and constructions of ageing. The contexts of relevance to the remaining aims of this research are discussed in the next section.
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1.2.3 Exploring the lived experience of ageing: Four perspectives.

In addition to the interest in investigating constructions and experiences of healthy ageing, an underlying aim of this research was to explore the experiences and understandings of ageing from the perspective of older adults themselves. With a particular paucity of information on ageing from the perspective of older adults in WA, a primary aim of this research was to explore the lived experience of ageing from a community sample of older adults residing in WA as well as the aforementioned sample of older adults involved in a healthy ageing program. As the current research gained national and international recognition, it evolved to include an international sample to complement the WA data. Therefore, the current research project aimed to explore the experience and social construction of ageing for older adults in WA and Wales as well as for older adults involved in a healthy ageing program and those who have discontinued involvement in the same healthy ageing program. Subsequently, exploration of the motivations and challenges to remaining engaged in the healthy ageing program were also aims of this research. An additional aim was to investigate how older adults’ experiences and social constructions varied across the four contexts of this study. The delineation of these aims into research questions is detailed in the next section.

1.2.4 Research questions.

To accurately reflect the complexity of the phenomenon under investigation in the current study, two underlying theoretical frameworks informed this research; phenomenology and social constructionism. As these perspectives are primarily interested in exploring how reality comes to be understood and experienced from within a person’s own social context (Barkway, 2001; Caelli, 2000; Creswell, 2007; Gelo, Braakmann, & Benetka, 2008; Gergen, 1985, 2011; Grbich, 1999; Liamputtong, 2009b; Liamputtong & Ezzy, 2005; Moutsakas, 1994; Patton, 1990), a qualitative methodology was considered most suited to address the aims of this research. The exploratory nature of a qualitative approach meant it was especially useful for gaining a more holistic account of participants’ experiences with emphasis placed on the understanding of relationships within systems and the understanding of social settings and social process in participants’ meaning making (Chwalisz, Shah, & Hand, 2008; Corbin & Strauss, 2008; Creswell, 2007; Janesick, 2000). To this end, research questions for qualitative data collection strategies are often open-ended and exploratory in nature (Elliott & Timulak, 2005). The research questions to address the aforementioned aims of this research were:

1) What are the experiences and social constructions of ageing for older adults over the age of 50 years in the following four contexts?
   a. Participants involved in a healthy ageing program (‘LLLS group’).
b. Participants who have withdrawn from a healthy ageing program (‘Discontinuing group’).
c. Participants from a local community sample (‘WA group’).
d. Participants from an international community sample (‘Welsh group’).

2) How do the experiences and social constructions of ageing for older adults vary across the four group contexts outlined in research question one?

3) What are the experiences of being involved in a healthy ageing program?
   a. What are the challenges and motivations to remaining involved in a healthy ageing program?

1.2.5 Implications of this research.
This research contributes to a growing body of knowledge about the current ageing experience. Uniquely, findings from this research offer insight into the lived experience of ageing with this information assisting in understanding the holistic needs of older adults, particularly those ageing in WA. In practical terms, the identification of psychological and social factors important in maintaining good health and wellbeing in older adulthood, and insight into the decision making processes by those participating in a healthy ageing program, may be used to inform existing and future policy decision-making and models of best practice towards promoting healthy ageing. Subsequently, this research informs existing and future policy structures through the identification of previous omissions, misconceptions and outdated assumptions regarding ageing and the issues facing our ageing population. Moreover, this research contributes to understandings of ageing as a process of development involving positive choices and providing new opportunities rather than focused solely on the declines typically associated with ageing (Nussbaum & Coupland, 2004). Foremost, the findings contribute to the building of a more holistic understanding of the ageing experience and provide evidence that ageing is a socially constructed and therefore a modifiable experience.

1.3 Overview of thesis
This thesis consists of seven chapters. The first chapter introduces the research topic by identifying the need to understand the current experience and construction of ageing given the context of population ageing. With a dearth of information on the lived experience of ageing also identified, it is argued that to understand the contemporary ageing experience, it needs to be explored from the perspective of older adults themselves. Furthermore, recognising that theoretical frameworks and political agendas are significant factors influencing the construction of ageing, theory and policy in ageing will provide the basis of
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discussion in this thesis. Given the current focus on the implications surrounding population ageing in Australia and globally, this research is examined within the context of policy development locally, nationally and internationally with a particular focus on healthy ageing directives. This first chapter therefore introduces the context, development, focus and rationale of this research and outlines the specific research aims and questions relevant to the investigation. This discussion leads into the next chapter, which reviews the current literature and major theoretical developments in ageing.

The second chapter of this thesis explores the literature and context underpinning current conceptualisations of the ageing experience. As a focus of this research is on socially constructed experiences of ageing, psychosocial perspectives looking at older adults in interaction with their social world, are of primary concern in review of the literature. Specifically, this chapter aims to identify the current theoretical understandings of ageing with a particular focus on theories influencing the social and psychological experience of ageing. Dominant theories and models currently influencing contemporary debates and discussions on ageing are also reviewed. Presented in this chapter is a critical view on how the ageing experience has been considered in the context of broader social, political and economic conditions including the role of power and justice in legitimising knowledge in ageing. Importantly, how theory exerts influence on policies in ageing and how the two shape perspectives on ageing is assessed. This discussion leads into the next chapter, which follows the recent development of policy in ageing.

Chapter three of this thesis continues the discussion on current conceptualisations of ageing by reviewing the history of policy formation in the area. Population ageing is also assessed with regard to its impact at a local, national and international level of governance with specific reference given to contemporary Australia and more locally, WA. This is followed by a review of current demographic statistics and an introduction to the key historical strategies and action plans influencing decisions around the identification and prioritisation of issues in ageing. The response of Australia and specifically WA, to population ageing is discussed with a particular interest in the development of the identified critical policy area of healthy ageing. The current strategies and programs relevant to supporting the aims of healthy ageing policy in WA are reviewed. The LLLS program, an initiative resulting from current policy and strategy frameworks in WA is introduced into the discussion as it provides the context from which to explore older adults’ experiences of ageing with specific regard to healthy ageing principles and directives. Therefore, the overall aim of this chapter is to identify the current research agenda and policy on ageing and introduces the context from which to
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evaluate the impact of ageing policy in influencing how older adults attribute meaning to, and socially construct their own ageing experience. Discussions around socially constructed experiences leads onto the next chapter, which extends these ideas by outlining the theoretical, philosophical and methodological underpinnings and approaches employed in this research.

The fourth chapter of this thesis defines and outlines the methodological approach employed in this research. This chapter initially discusses phenomenological and social constructionist frameworks, which have informed and directed the current research. With this research adopting a qualitative methodology to explore older adults’ experiences and constructions of ageing, the philosophical underpinnings of qualitative methodology and research design are discussed. Participant details, research procedures, ethical considerations, role of the researcher, data collection and analysis processes are presented. Consideration is given in this section to the rigour and credibility of this research. Therefore, the aim of chapter four is to outline the research methodology and the means by which findings from the data were derived and qualified. The next chapter thus presents the findings and interpretations of the data.

The purpose of chapter five in this thesis is to introduce the research findings relevant to research questions one and two. Specifically, this chapter presents findings on the experiences and social constructions of ageing across all four groups of this study (i.e., the ‘LLLS group’, the ‘Discontinuing group’, the ‘WA group’ and the ‘Welsh group’). Similarities and differences between groups are reviewed with findings presented in the formation of five major themes and associated sub-themes. These major themes included: primed thought (consisting of sub-themes the “lucky” view, comparisons with others, healthy ageing, and decline and loss); connectedness (consisting of sub-themes the value of groups, supportive relationships, and religion and spirituality); social values (consisting of sub-themes generational interactions, ageism, and resource allocation); negotiating transitions in ageing (consisting of sub-themes life-stages and events, the dependence-independence continuum, the ageing body, and attitude and acceptance); and agency and influence (consisting of sub-themes meaningful roles, and personal value and worth). These findings are examined with reference to current theoretical and political understandings and constructions of ageing in order to address research questions one and two. The third research question is addressed in the next chapter.
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The purpose of chapter six in this thesis is to address the third research question of this research related to participants’ involvement in a healthy ageing program. Experiences of being involved in the healthy ageing program LLLS and the program’s influence on participants’ constructions and experiences of ageing provide the focus for discussion. Challenges and motivations for remaining involved in the program are reviewed and presented along with reasons for participants withdrawing from the program. Therefore, the aim of this chapter is to present findings concerning the experiences of being involved in a healthy ageing program and to review how these experiences relate to participants’ own constructions, understandings and experiences of ageing.

The concluding chapter in this thesis, chapter seven, draws together a summary of the salient findings and issues across the research. In the context of the research questions, the findings are discussed in relation to the implications they have for policy and theoretical development in ageing. The limitations of this research are then discussed with particular reference to the opportunities and recommendations for future research and practice.
Chapter 2: Constructing the ageing experience

This chapter introduces the topic of ageing by reviewing some of the major theoretical influences and definitions contributing to contemporary conceptualisations about ageing. In particular, Gerontology: the formal study of ageing is reviewed along with biological, psychosocial and lifespan perspectives on ageing. Assumptions underlying these theoretical perspectives are also identified and the current state of theory in ageing critiqued. Specifically, the dominant biomedical approach to ageing is challenged in view of a more positive approach including perspectives derived from successful ageing theory and a wellness approach to health. Therefore, to conclude the chapter, how knowledge is legitimised concerning contemporary understandings about the experience of ageing is critically reviewed.

2.1 Defining ageing

The phenomenon of ageing is complex and subsequently, the definition and study of ageing involves varying perspectives. Ageing is broadly referred to as a multidimensional process of biological, psychological and social change with some dimensions declining over time (i.e., mobility) and other aspects growing and expanding (i.e., the acquisition of knowledge or wisdom) (McPherson, 1990; Stuart-Hamilton, 1994, 2006). In its simplest form, ageing is defined by considering the causes of the characteristics commonly found in older people (Posner, 1995; Stuart-Hamilton, 2006). As such ageing can be considered in universal terms; factors that exist for all people (i.e., wrinkled skin), or in probabilistic terms; with the probability of certain changes happening to some but not all people as they age (i.e., certain illness or conditions may or may not present themselves such as arthritis) (Stuart-Hamilton, 2006). Therefore, a common method for measuring ageing is to examine the changes in features from young adulthood to later adulthood with a particular focus on how and when these features transform (Goldsmith, 2010; Posner, 1995; Stuart-Hamilton, 2006).

Chronological age, although considered a somewhat arbitrary measure provides an approximate indication of structural growth and decline, psychological and emotional development, and patterns of social interaction (McPherson, 1990). While not providing an explanation for the cause of behaviour, chronological age can be considered as inextricably linked to the measure of one’s social age or societal expectations of appropriate behaviour at a particular age (Cavanaugh & Blanchard-Fields, 2006; Stuart-Hamilton, 2006). Consequently, insight into the individual experience of ageing and how one accommodates changes in later life requires consideration of the broader socio-cultural context as well as consideration of the
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societies within which ageing occurs, particularly the interactions taking place within them (Estes et al., 2009; Jamieson, 2002b; Russell, 1981; Sheets, Bradley, & Hendricks, 2005).

Therefore, as this research centred on socially constructed ideas and experiences of ageing, consideration of people in relationships and their interaction with the social world, are of significance. To understand the contemporary ageing experience, this next section will review the influence of past theoretical perspectives in shaping current conceptualisations, particularly the influence of psychosocial perspectives in constructing meaning in ageing. Assumptions underlying these theoretical positions are also identified and where appropriate challenged to allow socially constructed ideas of ageing and personal realities of ageing to be distinguished.

2.2 Theoretical perspectives and assumptions in ageing

2.2.1 Gerontology and the study of ageing.

The large scope of ageing as a concept and the myriad of ways in which the ageing experience can be studied, has resulted in attention from a variety of discipline areas, and in theories, which categorise ageing in different ways (McPherson, 1990; Wadensten, 2006). Early conceptions and models of ageing typically represented broad world views encompassing theology, mythology and philosophy, for example; immortality was once conceived possible but lost due to humankind's own actions, and obeying God's commandments was considered as ensuring a long life (Birren & Schaie, 2001; Schaie, 2001). As scientific insights have accumulated during the twentieth century, a movement from broad worldviews to circumscribed theoretical models driven by disciplinary perspectives has occurred (Hendricks & Achenbaum, 1999; Schaie, 2001; Schroots, 1996). Theoretical interests in ageing can thus be viewed as being typically embedded within a socio-historical context and as such, reflect societal assumptions and agendas of a particular time (Estes et al., 2009; Kondratowitz, 2009).

The social climate of the western world following World War II gave rise to the welfare state and social security, with a distinctive vision for old age and a particular focus on social rights in the form of pensions, health and education (Birren & Schroots, 2001; Estes et al., 2009). Since the post war era, partly due to the growing awareness of increasing life expectancy and the growth of older populations, medical practitioners and governments have steadily advocated for the need to gain a better understanding of the ageing process and associated changes across the later stages of the lifespan (Bengtson & Schaie, 1999; Berkman & Glymour, 2006; Birren & Schaie, 2001; Ponzo, 1992). This increased interest in the social issues associated with ageing resulted in an escalation of organised research on ageing by
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social scientists. Consequently, to further study the “problem of old age” in modern society, in 1945 a new field of work developed known as gerontology (Estes et al., 2009; Jamieson, 2002b; Russell, 1981).

Since its inception, gerontology has evolved into a formal interdisciplinary science specifically interested in the study of ageing from maturity through old age (Cavanaugh & Blanchard-Fields, 2006; Jamieson, 2002b). Through incorporating biology, clinical medicine, and the behavioural and social sciences (Estes et al., 2009), the field of gerontology seeks knowledge about the normal process of ageing inclusive of biological, psychological and social perspectives (Jamieson, 2002b; Wadensten, 2006). In general, researchers interested in gerontology have attempted to define, conceptualise, and map the ageing process by reviewing typical states and changes during later life in order to understand the outcomes of ageing (M. M. Baltes & Carstensen, 1996; Bengston & Schaie, 1999; Rowe & Kahn, 1997). Consequently, a primary focus of gerontology has been on the objective difficulties in ageing (Russell, 1981) with investigations on a wide range of variables such as physical health, cognitive functioning, mobility, support systems, financial security, changing status within the family structure, satisfaction with life and attitudes towards the future (Berkman & Glymour, 2006; Robine, Mormiche, & Sermet, 1998).

In summary, new historical contexts and more modern views of the complexity of ageing have evolved assertions that ageing results from degenerative diseases to contentions that social context affects the expression of ageing (Birren & Schaie, 2001; Estes et al., 2009; Schaie, 2001). Perspectives (e.g., biological, psychosocial, lifespan and developmental) that continue to influence and dominate discourse on the experience of ageing today are reviewed in the next part of this chapter. The sections on each theoretical approach offer a detailed review of each perspective followed by a summary in table form of the key conceptual contributions offered by the perspective.

2.2.2 Biological approaches to ageing.

Determining why we age has resulted in gerontology becoming part of the mainstream of biology (Cristofalo, Tresini, Francis, & Volker, 1999). Biological age refers to the body’s state of physical development and degeneration (Stuart-Hamilton, 1994). A biological perspective on ageing further includes increased susceptibility to disease and adverse environmental conditions as well as loss of mobility and agility (Goldsmith, 2010; Holliday, 2010). The progressive physiological deterioration, increased vulnerability to stress, and the subsequent increased probability of death associated with the ageing process is more commonly referred to by scientists as senescence (Cristofalo et al., 1999; Goldsmith, 2010; Holliday, 2010;
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McPherson, 1990). Most theories of senescence (or physiological deterioration) include either stochastic theories; primarily concerned with the results of random damage, programmed theories; concerned with the role of developmental and genetically determined processes, or an incorporation of both (Cristofalo et al., 1999; Schaie, 2001). Popular theories in this area include; free radical theory, caloric restriction, somatic mutation, hormonal theories, and immunological theories (Goldsmith, 2010; Schaie, 2001). A common theme across these theories is the idea of ageing as a disease, and similar to other genetic conditions, considered as potentially treatable (i.e., the maintenance and repair of the body to extend the lifespan) (Derks, 2009). Consequently, a whole industry devoted to the promotion of anti-ageing and popular interest in treatments or lifestyles that prolong the lifespan, including medical interventions, has evolved (Estes et al., 2009; Goldsmith, 2010; Powell & Biggs, 2000).

Use of the biomedical model to assess the ageing experience reflects a focus on physical declines and losses, and therefore positions ageing issues under the control of biomedicine to counter and alter these changes (Estes & Binney, 1989). Despite the dominance of this perspective, at present the biological basis of ageing is still under debate (Goldsmith, 2010; Kirkwood, 2005; Stuart-Hamilton, 2006). As ageing is a relatively long-term process it is a difficult subject for experimentation and as such experimental approaches have had difficulty discerning the causes of ageing (Goldsmith, 2010). There is agreement that ageing across different species is to a large extent genetically based but not all hypotheses about biological ageing are accepted as theory (Masoro & Austad, 2001). This differentiation has resulted in scientific theories of ageing being limited to the logical analysis of the functional, externally observable, characteristics of various organisms but without experimentation in the scientific world these findings cannot be proven (Goldsmith, 2010). Consequently, many biological theories of ageing, some centuries old (i.e., Darwin’s theory of evolution, accumulation of damage theories), are still debated and with others remaining unchallenged for long periods of time, these theories have acquired the appearance of facts and assumed knowledge (Cristofalo, 1996; Goldsmith, 2010; Lynott & Birren, 1996).

In review, a major objective of a biological approach to ageing has been to identify and distinguish between aspects of human ageing and age-related disease with a major aim to improve treatment, prevent onset and/or understand the cause of disease (Cristofalo et al., 1999; Holliday, 1995, 2010; Kirkwood, 2005) (see Table 1 for a summary of biological perspectives in ageing). What is agreed is that while the likelihood of many diseases occurring in individuals as they age increases, this does not mean that all individuals will develop all pathologies that commonly present (Holliday, 1995). In addition, while there is much overlap between current biological theories, there remains no unified biological theory of ageing with
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none on their own entirely explaining ageing (Holliday, 1995; Lynott & Birren, 1996). Furthermore, while biological theories try to account for what physiologically happens to us when we age, they do not promote understanding of how people come to terms with the ageing process nor do they account for individual differences in coping strategies to accommodate changes (McPherson, 1990). This potentially minimises some of the more positive aspects of ageing. Therefore, with many of the changes and adaptations associated with biological ageing also influencing social and psychological processes and vice versa (Bengtson & Schaie, 1999), it is necessary to examine the psychological and social theoretical influences affecting how meaning in ageing is constructed and how this impacts on the individual experience of ageing.

Table 1
*Summary of Biological Perspectives in Ageing*

<table>
<thead>
<tr>
<th>Biological perspectives in ageing</th>
<th>Contribution of perspective to understandings about ageing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biomedical approach</td>
<td>• Ageing is largely genetically based</td>
</tr>
<tr>
<td></td>
<td>• Defined by physiological deterioration and increased susceptibility to disease</td>
</tr>
<tr>
<td></td>
<td>• Considered as a potentially treatable disease</td>
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</table>

2.2.3 Psychosocial approaches to ageing.

As an adjunct to biological factors, psychological and social factors are recognised as important determinants of human longevity with living longer and more healthily somewhat dependant on one’s own behaviour and the influence of societal experiences of ageing (Bengtson & Schaie, 1999; Coote, 2009; McPherson, 1990). As there are interactions between the biological and psychological systems there are also interactions between cognitive and behavioural changes within the individual and environmental factors that affect one’s psychological state (Coote, 2009; McPherson, 1990). Specifically, psychological ageing involves possible changes in personality, cognition, learning, motivation and emotional arousal while social ageing represents regular patterns of behaviour in individuals or groups as they interact with others within a social system (McPherson, 1990; Wadensten, 2006). Unlike processes of a biological and psychological nature, social ageing also involves reciprocal interaction between the social system and the ageing individual and these processes vary considerably within and
Exploring the Lived Experience of Ageing between cultures (Estes et al., 2009). It is therefore important that when investigating the individual experience of ageing that the influence of social processes be considered.

Psychological theories of ageing are relatively sparse compared to other life stages and commonly psychological and developmental theories of ageing are considered together under the banner of psychosocial theories (Schaie, 2001; Wadensten, 2006). Psychosocial theories of ageing attempt to explain human development and ageing in terms of individual changes in cognitive functions, behaviours, roles, relationships, coping ability, and social changes (Wadensten, 2006) while also considering the interaction of the ageing person in their social context (Coote, 2009; Estes et al., 2009; Phillipson, 1998). In recognition of the importance of the interaction between the psychological and social processes of ageing, rather than reviewing psychological and social theories as separate categories, the focus of this next section is on psychosocial theoretical developments in the study of ageing (see Table 2 for a summary of psychosocial perspectives in ageing).

Developed by Cummings and Henry, a widely accepted theory in the 1960s, and an initial influential theory in gerontology was disengagement theory (Cavanaugh & Blanchard-Fields, 2006; Cummings & Henry, 1961). As the name suggests, this theory proposes that with increased age, people begin to turn inward developing a preoccupation with the self and decreased involvement with others leading to a gradual withdrawal or disengagement from social activities and roles. Thought to be the result of a natural response to lessened capabilities and diminished interest (Bearon, 1996; Lemon, Bengtson, & Petersen, 1972; McPherson, 1990), society’s tendency is to reject ageing individuals resulting in further decreased interaction between the ageing person and others in the social system (Schroots, 1996; Wadensten, 2006). It is therefore assumed by the theory that the older individual should reduce activities and social roles and that withdrawal is not problematic in any way for the individual but rather considered natural and acceptable, even beneficial for the older person and society (McPherson, 1990; Stuart-Hamilton, 2006; Wadensten, 2006).

Disengagement theory while receiving widespread attention, has also been criticised for its lack of empirical evidence and the validity of the original data on which the theory is based (Cavanaugh & Blanchard-Fields, 2006; Estes et al., 2009; Phillipson, 1998). It is criticised for implying that disengagement in society is purely a response to ageing and that withdrawal behaviour is the norm rather than considering it as a potential sign of need for psychological intervention (Estes et al., 2009; Freedman, 1982). Consequently, the definition of disengagement has been interpreted to imply isolation, loneliness or passivity with no empirical support for the relationship of disengagement to life satisfaction or morale (McPherson, 1990). Further to this, the theory does not indicate whether it is the individual or
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society who starts the process of disengagement (McPherson, 1990; Wadensten, 2006). Despite criticism by researchers, it has been suggested that disengagement theory was the first formal theory making an attempt to explore the relationship between the individual and social aspects of ageing (Passuth & Bengtson, 1996). For this reason, the theory was instrumental in facilitating theoretical debates about the social dimensions of ageing (Estes et al., 2009; Phillipson, 1998).

Criticism surrounding disengagement theory contributed to the development of activity theory; an opposing theory based on the concept of developmental tasks (Schroots, 1996). This theory added to earlier ideas proposed by Robert J. Havighurst and Ruth E. Albrecht concerning the importance of social role participation in the positive adjustment to old age (Havighurst & Albrecht, 1953) and the successful achievement of developmental tasks across the lifespan (Havighurst, 1948). Activity theory later evolved keeping age-related developmental tasks as a central organising concept (Schroots, 1996; Wadensten, 2006). Opposing the foundations of disengagement theory, activity theory was the first theory in North America to attempt to provide a description of, and prescription for successful ageing in the later years of life (McPherson, 1990). The theory asserted that maintaining activity patterns and values typical of middle age are necessary for a rich and satisfying life (Lewis, 1984; McPherson, 1990; Wadensten, 2006). Importantly, from this perspective older people were considered active participants in the world around them with losses occurring with ageing being replaced with new and different roles, interests, and people (Lemon et al., 1972; Wadensten, 2006).

Activity theory thus assumes that being active is better than being inactive and that to age successfully is to remain involved in the social context (i.e., maintain social roles and relationships) (J. Reed et al., 2004; Wadensten, 2006). This further suggests that a person’s self-concept is related to the roles held by that person (Estes et al., 2009; Wadensten, 2006). For many years, activity theory was an accepted theory, however eventually the theory’s validity was questioned as further research sought to more thoroughly investigate its claims (Lemon et al., 1972; Longino & Kart, 1982; Longino, McClelland, & Peterson, 1980; McPherson, 1990). Studies found that aside from social activity with friends, activity in and of itself had little to do with life satisfaction (Lemon et al., 1972). The kind of activity relating to life satisfaction (e.g., informal, structured or solitary) was later found to be an important consideration in determining the use of the theory (Longino & Kart, 1982). Despite some empirical evidence for the theory, opponents argued it to be too simplistic, some even suggesting that it is not a theory but rather a set of assumptions, subsequently, only offering a one-sided view of the aged (Estes et al., 2009; Lemon et al., 1972; McPherson, 1990; Papalia,
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Sterns, Feldman, & Camp, 2007). Furthermore, the theory has been criticised for its lack of recognition for the role that both personality traits and circumstance can play in regards to wellbeing in older adulthood (Lemon et al., 1972; Longino & Kart, 1982; Schaie & Willis, 1996).

A later theory which attempted to account for both circumstance and personality in regard to the ageing process was continuity theory. Concepts of the continuity perspective were first proposed by Betty Havens (1968) and later structured into a theoretical framework by Robert Atchley (1980, 1989). This theory emphasised that people who age more successfully are those who take forward behaviours, attitudes, habits, preferences, lifestyles, and relationships developed in earlier years or from middle life into later life (Atchley, 1989; Estes et al., 2009; McPherson, 1990). Essentially, this view emphasises that habits, preferences and other dispositions developed during the process of becoming an adult become connected to personality and form the foundation of the ageing process in the future (Atchley, 1989; Wadensten, 2006). For example, it is thought unlikely that someone who has preferred to live alone will adjust well to retirement by joining voluntary associations (McPherson, 1990).

Assumptions underlying the theory therefore include the idea that future decisions and behaviour remain the same and the continuity of self happens internally (i.e., wanting to preserve some aspect of oneself from the past to sustain a new self) and externally (i.e., maintaining social roles, relationships and environments) (Wadensten, 2006). Consequently, as older adults adapt to normal ageing process changes, they attempt to rely on existing resources and familiar coping strategies with this sense of continuity between past and present thought to contribute to wellbeing in later life (Papalia et al., 2007; Wadensten, 2006).

Early critiques of continuity theory raised doubts about its validity by questioning the focus on the individual level of analysis and its suggestibility that continuity in lifestyle can only occur when there is compatible interaction with the social structure (Covey, 1981). Further assessment has suggested that there is little evidence that continuity is an adaptive form of behaviour and that continuity in lifestyle could be maladaptive if an individual relies on, or adheres to, outmoded values and behaviours (J. H. Fox, 1981-82). It has also been questioned whether continuity theory is even about ageing or whether it is more simply a reflection of a cohort, cultural, or period effect with reconstructions of the past only existing as remembered and in the interaction with present and future experiences. This suggests that over time we remember things differently which can influence how current experiences are considered. As such, while variables associated with mid-life have been demonstrated as good predictors of outcomes in later life, the tentative nature and lack of conclusive support for the theory suggests further development is required (Burbank, 1986; Covey, 1981; J. H. Fox, 1981-82).
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Other theories that consider the interconnectedness of past, present, and future experiences, include lifespan perspectives which are reviewed in the next section.

Table 2

*Summary of Psychosocial Perspectives in Ageing*

<table>
<thead>
<tr>
<th>Psychosocial perspectives in ageing</th>
<th>Contribution of perspective to understandings about ageing</th>
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| Disengagement theory               | • With increased age, people withdraw from social activities and roles as a natural response to lessened capabilities and diminished interest  
• Withdrawal and disengagement are not considered problematic, but rather beneficial for the older person |
| Activity theory                    | • Involvement in the social context is important and being active is considered better than being non-active  
• Maintaining activity patterns and values typical of middle age are necessary for a rich and satisfying life |
| Continuity theory                  | • Continuity between past and present is important with the perception of time central in influencing the salience of particular social goals  
• Taking forward behaviours, attitudes, habits and relationships in earlier years into later life contributes to successful ageing |

2.2.4 **Lifespan perspectives.**

Earlier premises that behaviours and personality are carried forward from mid to late life has been further explored from a lifespan perspective (P. B. Baltes, 1987; McPherson, 1990). A well known structure for ordering the life cycle has been the division of psychosocial development into stages (Erikson, 1959). During the late 1950s and early 1960s, a major influence of psychology to the area of ageing was Erik Erikson’s psychosocial stages of
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development theory (Cavanaugh & Blanchard-Fields, 2006; Erikson, 1959; Lewis, 1984; Papalia et al., 2007). Unique to this theory was its movement towards the exploration of the later stages of human development, a feature overlooked by earlier theorists investigating the psychology of personality (Lewis, 1984). With eight stages proposed, all are associated with different choices, identity crises and solutions with the outcome resulting in personal growth if one is successful in mastering each stage in sequence (Lewis, 1984; Wadensten, 2006). Unlike earlier stages of development, the later stages are defined in much less detail. However, consistent across all stages is the conflict that arises between two opposing tendencies that require resolution through the integration of personal needs (based on sequencing biological, psychological and social events) with the demands and expectations of the society and culture in which the person lives (Schroots, 1996; Wadensten, 2006).

The greater detail reflected on earlier stages of development is thought representative of an increased psychosocial variability with age. For example, developmental tasks of an infant are relatively universal but tasks in later life are more greatly affected by personal experiences as on general principles (Schroots, 1996), highlighting later life as a period of greater heterogeneity. The task of old age or the eighth and final stage of development outlined by Erikson details the issue of ego-integrity versus despair (Cavanaugh & Blanchard-Fields, 2006; Erikson, 1959; Papalia et al., 2007; Stuart-Hamilton, 1994). The crucial task in this stage is to develop ego-integrity by being able to balance the search for integrity and wholeness with a sense of despair. Despair is thought to occur when the person experiences feelings of worthlessness, dissatisfaction with life and a fear of death while ego-integrity is considered achieved if the individual can look back and evaluate their life and accomplishments with a sense of satisfaction regardless of whether they are positive or negative (Lewis, 1984; Wadensten, 2006). As the outcomes of the later stages are directly affected by the success or unresolved conflict of previous stages, the older person may be working through the final stage of development while also harbouring previously unresolved conflicts from earlier stages (Lewis, 1984).

Therefore, primarily the lifespan perspective has been used by psychologists interested in the micro-level system, particularly pertaining to socialisation in the earlier stages of life such as infancy and childhood (McPherson, 1990; Schaie, 2001). Erikson’s theory of psychosocial development continues to influence current conceptualisations about the ageing experience highlighting psychological process and social experiences across the lifespan with developmental conflicts acting as turning points in life. This suggests that the later period of life is not one of homogeneity as implied by biological consideration of ageing but rather it is a time of complexity with many varied experiences possible. However, while a primary goal of
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this perspective is to determine how and why earlier and later events in the life cycle are interrelated, until more recently, relatively little attention has been given to the later stages of life (McPherson, 1990).

One contemporary theory acknowledging the role of psychological process and social experiences across the lifespan and which attempts to mediate between the tenets previously discussed by disengagement theory and activity theory, is socioemotional selectivity theory (Carstensen, 1992). In review, disengagement theory suggested that impending death simulated a mutual psychological withdrawal from the person and society (McPherson, 1990), and the alternative, activity theory considered inactivity to be a societal induced problem stemming from social norms suggesting it may be of benefit to older people to become more active in some aspects of their lives and more disengaged in others (Schaie, 2001; Schroots, 1996). However, socioemotional selectivity theory differs in its consideration of cognitive and motivational factors in the changing of social networks and interactions (M. M. Baltes & Carstensen, 1999; Carstensen, 1992), with perception of time also considered of central importance in influencing the salience of particular social goals (Carstensen, Isaacowitz, & Charles, 1999). Socioemotional selectivity theory was initially formulated to account for age-related decreases in social interaction evidenced in old age, but with emotion regulation as a primary goal (Carstensen, 1992) the theory also holds relevance for understanding social preferences and social behaviour across the lifespan (M. M. Baltes & Carstensen, 1999; Carstensen, 1991; Schaie, 2001).

Therefore, the theory of socioemotional selectivity considers reductions in older people’s social networks and social participation to be the result of a motivated redistribution of resources by the person. This concept has stimulated varied interest in and support for the theory (P. B. Baltes, Kliegl, & Dittmann-Kohli, 1988; P. B. Baltes, Staudinger, & Lindenberger, 1999; Carstensen, 1992; F. R. Lang & Carstensen, 1994; F. R. Lang, Staudinger, & Carstensen, 1998). The principle that older people are proactive rather than reactive in managing their social contexts (M. M. Baltes & Carstensen, 1999; Schaie, 2001) recognises older adults’ agency in their own ageing process and has prompted further thinking about the nature of psychosocial development in the later stages of life.

Since the early 1980s, Paul B. Baltes and associates have conducted a series of studies on the psychological processes of development and ageing from a lifespan perspective. Findings from these studies eventuated in the development of a psychological model of successful ageing known as selection optimisation with compensation (SOC) (M. M. Baltes & Carstensen, 1999; P. B. Baltes, 1997; P. B. Baltes et al., 1999; Birren & Schaie, 2001; Birren & Schroots, 2001; Schroots, 1996). In their conceptualisation, the process of SOC forms a system
of behavioural action or outcome-orientated functioning that regulates successful
development through management of the dynamics between gains and losses in ageing (i.e.,
engaging in life tasks that are important to the individual despite the reduction in energy they
may be experiencing) (M. M. Baltes & Carstensen, 1996, 1999; P. B. Baltes, 1997; Birren &
Schaie, 2001; Birren & Schroots, 2001; Schroots, 1996).

To demonstrate the principles of SOC, an example often used is the case of concert
pianist Arthur Rubinstein. Rubinstein was found to preserve high-level concert performances
by playing fewer pieces (selection), practicing each piece more often (optimisation), and using
variations in speed to generate the impression of faster play (compensation) (M. M. Baltes &
Carstensen, 1999; P. B. Baltes et al., 1999; Papalia et al., 2007). This example illustrates the
element of selection as the choice of goals and life tasks and involves choosing to do what is
possible given current restraints (e.g., increasing age). Both compensation and optimisation
are then concerned with the means to maintain or enhance chosen goals with optimisation
referring to engaging in behaviours designed to carry out the selected activity as well as
possible (Papalia et al., 2007). Compensation involves either an overt behavioural or inner
psychological response to a loss or reduction in the ability to achieve valued goals (M. M.

Therefore, the SOC model suggests that there are psychological gains and losses at
every life stage but in old age the losses are generally considered as exceeding the gains
(Schaie, 2001). The primary use of the model of SOC has been from within a person-centred
framework generally illustrating older people’s use of pragmatic strengths to compensate for
other weakened abilities (M. M. Baltes & Carstensen, 1999; Papalia et al., 2007). Baltes and
Smith (1999) further suggested that evolutionary development remains incomplete for the last
stage of life when societal supports are no longer adequate to compensate for the decline in
physiological infrastructure and losses in behavioural functionally. Using various techniques of
assessment, this theoretical approach has gained much support (M. M. Baltes & Lang, 1997;
Freund & Baltes, 1998, 2002b). However, it has been suggested that the model be expanded to
include collective processes of SOC to reflect how individuals age in social contexts and
furthermore, at a macro level, looking at how collective SOC might entail the improvement of
social systems and structures (M. M. Baltes & Carstensen, 1999). In review, the model has
been important for providing an alternative strengths-based perspective on how the declines
and losses experienced in ageing are managed as well as drawing attention to some of the
societal influences affecting the experience of ageing.

More recently within the field of psycho-gerontology, featured in an extended version
of The Lifecycle Completed, a ninth stage of human psychosocial development incorporating
the concept of gerotranscendence was proposed (Erikson & Erikson, 1997). The concept of gerotranscendence was developed by Lars Tornstam (1989) who describes the developmental process of ageing based on his own studies as well as theories and observations of others (i.e., Jung, Erikson, Gutman) (Wadensten, 2006). In 1989, Tornstam suggested that the very process of living into old age encompasses a general potential towards gerotranscendence; that is a shift in meta-perspective from a materialistic and traditional vision to a more transcendent one with an anticipated increase in life satisfaction (Schroots, 1996). During the process of gerotranscendence the individual is thought to experience a redefinition of self and of relationships with others by way of a decrease in self centeredness; decreased interest in material things and superficial social interactions and; an increase in self reflection and need for solitude (Gatz & Zarit, 1999; Schroots, 1996; Wadensten, 2006). From this perspective, human development is considered a life-long process and the very process of living into old age is characterised by a general potential towards gerotranscendence (Wadensten, 2006).

Therefore, gerotranscendence is regarded as the final stage of maturation and achieving gerotranscendence implies attaining wisdom, with changes in the perception of time, space, and objects bearing a new understanding of fundamental existential issues (i.e., a disappearing fear of death and increased affinity with past and coming generations) (Schroots, 1996; Wadensten, 2006). It is also assumed that the degree to which gerotranscendence increases over time is either accelerated or obstructed by various aspects of culture (Wadensten, 2006), for example, the practice of religion in an organisational or non-organisational way and the impact of individualistic features of modern societies (Lewin, 2001).

While based on limited empirical evidence, gerotranscendence attempts to integrate and develop some of the classical and more modern psychosocial theories of ageing (Schroots, 1996). Outwardly, there appears to be some resemblance of concepts in gerotranscendence to classical concepts of disengagement, activity and integrity development but on closer inspection important distinctions can be made (Achenbaum, 2006; Schroots, 1996). For example, gerotranscendence implies a redefinition of reality which is connected with social activity while also recognising the need for solitary “philosophising”, whereas disengagement is restricted to simply “turning inwards” and withdrawal socially seen as the only possibility in ageing (Schroots, 1996). Furthermore, the process of redefining reality according to gerotranscendence, represents a more forward direction of integrity development rather than just meaning the integration of elements in a life that has passed as suggested by Erikson (Achenbaum, 2006; Schroots, 1996). This process of redefining reality also begins to address earlier proposed conflicts regarding body transcendence verses body preoccupation (i.e., the ability to overcome bodily preoccupation by finding enjoyable activities where bodily status is
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relatively unimportant), and ego transcendence verses ego preoccupation (i.e., coming to
terms with inevitable death by becoming more concerned with the needs of those that will be
left behind) (Peck, 1968; Schroots, 1996).

Theoretically, gerotranscendence is unique in that it takes a phenomenological
approach to understanding developments in ageing with subjective meanings given preference
before that of experimentally based ascriptions to ageing (Achenbaum, 2006; Jonson &
Magnusson, 2001). Reviewed against earlier influential psychosocial theories such as
disengagement and activity theory, gerotranscendence differs by highlighting the active role
that older adults play in redefining their own lives and interactions with others and society
(Gamliel, 2001; Gatz & Zarit, 1999; Schroots, 1996; L Tornstam, 1996) as well as recognising the
role that various aspects of culture can play in achieving gerotranscendence (Ahmadi, 1998;
Lewin, 2001; Wadensten, 2006) (see Table 3 for a summary of lifespan perspectives in ageing).
Furthermore, with gerotranscendence referring to multi-coping strategies in the process of
ageing rather than primarily focussing on social breakdown, older people’s personal growth
and potential is supported and encouraged (Lewin, 2001; L Tornstam, 1996; Wadensten, 2005,
2006). Considering ageing in this way has important implications for how issues in ageing are
conceptualised and addressed in terms of policy development and service delivery and can
ultimately influence the individual experience of ageing.
Table 3

**Summary of Lifespan Perspectives in Ageing**

<table>
<thead>
<tr>
<th>Lifespan perspectives in ageing</th>
<th>Contribution of perspective to understandings about ageing</th>
</tr>
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| Erikson’s theory of psychosocial development | - Developmental conflicts across the lifespan act as turning points in life  
  - The eighth and final stage details the issue of ego-integrity verses despair |
| Model of selection optimisation with compensation (SOC) | - Successful development achieved through the management of the dynamics between gains and losses  
  - Selection of goals and life tasks based on choices to do what is possible given current constraints |
| Socioemotional theory | - Mediates between disengagement and activity theory by considering cognitive and motivational factors in the changing of social networks and interactions across the lifespan |
| Gerotranscendence | - Adopts a phenomenological approach to understanding development in ageing  
  - Involves a redefinition of reality connected with social activity resulting in a shift in meta-perspective from a materialistic vision to a more transcendent one (i.e., the need for self reflection and solitude) |

2.3 The current state of theory in ageing

The theories and models of ageing reviewed so far have derived either from a biological, psychological, or social perspective, or as a combination of these conceptual frameworks. In consideration of the term “psychological”, with no major theory linking all the various areas of psychology (e.g., social psychology, developmental psychology, cognitive psychology), often theories are labelled according to their emphasis of subject matter which can leave the ageing individual exposed to the trap of biological or social reductionism
Exploring the Lived Experience of Ageing (Schroots, 1996). For example, the psychosocial approach is primarily concerned with the social, and the bio-behavioural or neuro-psychological concerned with the biological (Schroots, 1996). This process of reduction continues to transpire despite acknowledgement that the processes of social, biological and psychological ageing do not occur independently of each other (Bengtson & Schaie, 1999; Estes et al., 2009; Jamieson, 2002b; Stuart-Hamilton, 2006).

Furthermore, psychology of ageing studies are typically grounded in a two-stage of life perspective, with development and ageing typically described as two successive processes of change with the transition point being maturity (Schroots, 1996). This perspective is based in the biological conceptualisations of growth and decline, however psychological processes of change do not necessarily parallel biological changes along the lifespan (Schroots, 1996). For example, fluid abilities (i.e., speed of information processing) reflect genetic-biological determinants that typically decline with age while crystallised abilities represent more socio-cultural influences (i.e., general world knowledge) and may display growth with age (Horn, 1989; Schroots, 1996). This poses the question as to what extent psychological processes of development and ageing are different from each other as both processes refer to age-related changes which further highlights an issue regarding what changes are considered “typical” or “normal” and which are considered “abnormal” or “pathological” in ageing (Schroots, 1996).

To provide a more contextual analysis of ageing, often theories have blended psychological and sociological approaches. As evidenced by the review of theories thus far, psychosocial theories of ageing are interested in the behaviour of individuals as a function of micro-social variables that offers diverse perspectives on the ageing process and meaning of ageing (Schaie, 2001; Wadensten, 2006). For example, topical concepts such as dependency in ageing from a psychosocial perspective are considered the consequence of social conditions and images that reinforce dependency, such as neglect or punishment in response to the pursuit of independence (Featherstone & Wernick, 1995; Schaie, 2001; Townsend, 1981). Later developments have attempted to mediate between the extremes of earlier theories proposing either active engagement or total withdrawal as accounting for behaviour change in older adults by suggesting that there is a selective process involved, and active decision making required by older adults as to their level of inclusion in society as they age (M. M. Baltes & Carstensen, 1999; L Tornstam, 1989). Despite later theories of ageing recognising the ageing person within a context and as an active participant in their own ageing process, none have singularly provided a definitive explanation of the ageing process. While offering useful insights, these theories are generally considered too constricted in their outlook of ageing, only representing a particular way of viewing life (Austin, 1991).
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Therefore, despite movement towards a more inclusive view of ageing and one that recognises older adults own agency in the process of ageing, conceptualisations of ageing still continue to be associated with the word “problem” (Hanson, 2004; Phillipson, 1998). Commonly ageing has been framed as a social problem (McPherson, 1990; Russell, 1981) without providing concrete guidance on how to support older adults through the ageing process (Wadensten, 2006). This is despite care and consideration of older people explicitly and implicitly steered by theoretical assumptions about what old age entails (Berkman & Glymour, 2006; Holstein & Minkler, 2007; Kondratowitz, 2009; Wadensten, 2006). Even with later psychosocial theoretical developments beginning to acknowledge the importance of focussing on the strengths of ageing rather than the losses (P. B. Baltes & Baltes, 1990a; LTornstam, 1989), medicine is considered the dominant force in the definition and treatment of ageing (Estes & Binney, 1989). This has resulted in the biomedicalisation of ageing and connotation of it as a medical problem encouraging society (and older adults themselves) to view ageing as abnormal and pathological (Estes, 1993; Estes et al., 2009; Estes & Binney, 1989; Phillipson, 1998). This view focuses on physical and mental losses and deterioration and presents ageing as a series of individual decrements or losses to which older adults and society need to adapt (Means, 2007; Phillipson, 1998). This view therefore also elicits an image of inevitable decline and dependency in ageing and ignores older adults’ wider life and potential contributions to society (Featherstone & Wernick, 1995; Hanson, 2004; Means, 2007). Such an approach leaves little opportunity for promoting ageing as a positive passage of life. Consequently, there is a need to challenge the medical model in order to move away from negating a negative experience of ageing involving decline and loss as the only experience possible.

2.3.1 Challenging decline and loss: Alternatives to the medical model.

Despite the influence of psychosocial theoretical perspectives in understanding the contemporary ageing experience, the study of ageing continues to remain primarily within a discourse subordinate to biomedical related concerns (Estes et al., 2009). This conflict has seen the rise of critical gerontology; an approach aimed at challenging unreflective acceptance of established positions, substantive value assumptions, theories, and perspectives in ageing (Estes et al., 2009; Holstein & Minkler, 2007). Critical gerontology offers a response to some of the major concerns of research in ageing including: critique of the biomedical model and its preoccupation with deterioration and disease; the need for a clearer understanding of the “social construction of dependency” in old age; and a shift from an individualistic focus to consideration of social structure and economic relationships in ageing (Bernard & Scharf, 2007;
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Estes et al., 2009; Holstein & Minkler, 2007; Townsend, 2007). This more critical approach to the study of ageing aimed at countering some of the negative stereotypes associated with decline and loss issues, has seen a shift in focus to concepts associated with positive ageing.

A more positive approach to ageing has usually incorporated the use of terms such as “active”, “productive” and “successful” (Estes et al., 2009). These terms are primarily based on assumptions underlying earlier theoretical understandings of ageing, in particular disengagement theory (Cummings & Henry, 1961); activity and continuity theory (Atchley, 1980, 1989, 1991; Havens, 1968; Havighurst, 1948; Havighurst & Albrecht, 1953); and Paul B. Baltes’ model of SOC (M. M. Baltes & Carstensen, 1996, 1999; P. B. Baltes, 1997; P. B. Baltes et al., 1999). As such, use of these terms has for the most part asserted a particular way of viewing ageing laden with expectation about what constitutes a “normal” ageing experience (Estes et al., 2009; Holstein & Minkler, 2007). Each term implies a moral as well as an objective basis on which to grow old as they problematise the question of later life and suggest remedies that can be deployed with a particular valuing of work and work-like activities (Biggs, 2001), as well as those based on leisure (S. Katz, 2000). Despite debate surrounding these positions they have formed the core of the current disciplinary development of social gerontology as they suggest a means for countering negative stereotyping of older people essentially looking to increase their social inclusion (Estes et al., 2009). While the terms active and productive have principally been used in the context of social and economic policy development (Estes et al., 2009; World Health Organization, 2002), the term “successful ageing” has become more widely known as a theoretical model useful for moving from looking at the “what” in ageing to the “how” (M. M. Baltes & Carstensen, 1996). Due to its focus on describing how the ageing experience can be improved, the development and influence of successful ageing as a theoretical perspective is reviewed in the next section.

2.3.2 Successful ageing.

Until the 1980s, life expectancy was considered a primary measure of success in ageing (Berkman & Glymour, 2006). In an effort to move beyond the “decline and loss” paradigm, the study of successful ageing has grown in popularity and become an important psychological based theoretical contribution to the development of social theory in gerontology (Estes et al., 2009; Holstein & Minkler, 2003). The concept of successful ageing is probably most noted as reflecting a newfound optimism in the study of ageing (P. B. Baltes & Baltes, 1990a) and for its vigorous emphasis on the potential for a healthy and engaged old age (Holstein & Minkler, 2003). Despite its long history dating back to the early 1960s (P. B. Baltes & Baltes, 1990b), the concept only became popular in 1998 when Rowe and Kahn argued that the effects of ageing
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were the effects of disease (Rowe & Kahn, 1998). They presented a widely debated three-tiered approach towards defining the hallmarks of successful ageing including: the avoidance of disease and disability; the maintenance of high physical and cognitive functional capacity; and active and continued engagement in life (Rowe & Kahn, 1998). By this definition, it is assumed that successful ageing is largely dependent upon individual choices and behaviours and that many of the losses associated with “usual ageing” are not “normal” aspects of ageing but instead caused by extrinsic factors (i.e., poor diet, lack of exercise) (Holstein & Minkler, 2003). This view indicated an important shift in how ageing was considered reflecting more of a focus on the individual’s role and responsibility in their own ageing process (Holstein & Minkler, 2007).

In an attempt to evaluate the utility of Rowe and Kahn’s (1998) definition of successful ageing in predicting wellbeing, Strawbridge, Wallhagen and Cohen (2002) conducted a comparative study whereby older adults were asked to rate their own success at ageing. When older adults self-reported responses were compared to the criteria set by Rowe and Kahn’s definition, that is, the absence of disease, disability and risk factors; the maintaining of physical and mental functioning; and active engagement with life, it was found that a high number of individuals who rated as having high wellbeing (as defined by ratings on different dichotomous and continuous measures based upon established scales such as the Perceived Control Scale and the Life Orientation Test), were also classified as not ageing successfully (Strawbridge et al., 2002). Despite this contradiction, physical health and functioning were still seen as important components of successful ageing as self-rating scores of perceived success declined as the number of prevalent chronic conditions increased (Strawbridge et al., 2002). Furthermore, the study illustrated that other factors contribute to one’s perception of how well they are ageing which offered important insight into how to promote quality, not just quantity of life (Bevan & Jeeawody, 1998; Hanson, 2004).

Further attempts to expand the definition of successful ageing have focussed on investigating older adults’ own perspectives on the concept (Phelan et al., 2004). Phelan et al., (2004) found that older adults’ views of successful ageing were multi-dimensional rather than focused on single dimensions of health (i.e., physical health) as had been suggested by earlier research (Rowe & Kahn, 1998). Instead successful ageing was found to encompass physical, functional, psychological and social factors with social health perceived as the most important condition for wellbeing and successful ageing (Phelan et al., 2004). This aligns with earlier considerations, such as the model of SOC which minimises the restriction caused by placing boundaries such as physical and mental functioning as being imperative for successful ageing by instead viewing achievement as doing the best one can, with what one has (M. M. Baltes &
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Carstensen, 1996; Freund & Baltes, 2002a). Broadening the definition in this way allows successful ageing to be achievable to more people (Phelan et al., 2004) rather than positioning those who might fall outside of certain physical or mental parameters (i.e., people with disability or other visible “oldness”) as signifying some sort of failure to ageing successfully (Holstein & Minkler, 2003).

In a more recent longitudinal study investigating aspects of “ageing in adversity” among 224 participants aged 55-98 years living in the community with Alzheimer’s disease (AD), it was found that future wellbeing was directly predicted by mental health (i.e., depression and anxiety) and social relationships rather than by general health and global dementia severity (Livingston, Cooper, Woods, Milne, & Katona, 2008). With the analysis of factors informed by literature relating to self-rated quality of life (QoL) in dementia, the study employed various measures and assessments such as the Health Status Questionnaire-12 (HSQ-12) and the Quality of Life-Alzheimer’s Disease Scale (QoL-AD). Analysis offered support for the concept of a “disability paradox” whereby people with chronic conditions consistently rate their own QoL highly, suggesting that the multi-dimensional nature of QoL often encompasses emotional, social, and psychological, as well as health-related domains (Albrecht & Devlieger, 1999; Livingston et al., 2008; Vogel, Mortensen, Hasselbalch, Andersen, & Waldemar, 2006). The study highlighted that successful ageing was common in a cohort of people with dementia with mental health and social relationships mediating the relationship between health perception and wellbeing 18 months later. Primarily, the necessity to broaden the conceptualisation of successful ageing beyond its emphasis on avoiding health related impairments and instead encompass a subjective sense of overall wellbeing, regardless of living with impairments such as dementia, was identified (Livingston et al., 2008).

In review, Rowe and Kahn’s (1998) approach lends itself to investigations that operationalise aspects of successful ageing for specific measurement and has stimulated much research into the relationship between health and wellbeing during the ageing process (M. Andrews, 2009; Freund & Baltes, 1998, 2002a; Hanson, 2004; Holstein & Minkler, 2003; Livingston et al., 2008; Strawbridge et al., 2002). However, while making a considerable contribution towards understanding the ageing process, the perspective of ageing being measured by specific hallmarks and achieved through individual choice and effort is considered limited by some researchers (M. Andrews, 2009; Holstein & Minkler, 2003; Phelan et al., 2004; Strawbridge et al., 2002), particularly with conceptualisations argued to be squarely based on the medical model (Holstein & Minkler, 2007) and prescribed for whole populations while ignoring those whom it marginalises (Ranzijn, 2010). Furthermore, with Rowe and Kahn’s definition primarily focussing on aspects of disease and disability, it fails to
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account for the inequality present between the different challenges individuals face during life such as psychological, emotional and contextual issues that accompany the ageing process (e.g., adequate income, education, access to affordable and nutritional food, healthcare and safe living environments) (M. M. Baltes & Carstensen, 1996; Holstein & Minkler, 2007; Ranzijn, 2010; Strawbridge et al., 2002).

Therefore, normative terms such as successful ageing are not neutral but instead imply, like success in other areas, that it is a measurable, visible attribute proportionate to an individual’s efforts and built on an assumption of equal opportunity to achieve the desired ends (Holstein & Minkler, 2003, 2007). Criticism of the successful ageing concept reveals that even in an effort to promote approaches that counter negative stereotyping, during this process it is common that conformity to the wider values are assumed which may not take alternative possibilities for late-life development into account (Estes et al., 2009; Holstein & Minkler, 2007). Consequently, posing the question of ageing in terms of success draws attention to the ways in which structural and personal components of identity interact (Bevan & Jeeawody, 1998; Estes et al., 2009). This encourages reflection on the role that public policy has in creating an atmosphere that fosters one view of ageing over another which can result in exclusion and perceived failure in achieving success in ageing if one doesn’t conform to these views (Bernard & Scharf, 2007; Estes et al., 2009; Holstein & Minkler, 2007). A more critical perspective, reflective of older adults’ own views, insists that to understand the problems associated with old age, the effects of gender, class, race, and other socioeconomic factors also need to be considered (M. M. Baltes & Carstensen, 1996; Holstein & Minkler, 2003; Phelan et al., 2004). Furthermore, with arguments that an individual’s experience of ageing is integrally bound to questions of culture, particularly the systems of meaning within culture, means that a more ecological view of ageing in context consisting of multiple narratives is required (M. Andrews, 2009).

2.3.3 A wellness approach to health and ageing.

More recently, a “wellness” approach has been preferred for the delivery of health services (Harkin, 2004; Larson, 1999). Principles guiding this approach to health provide a promising alternative to the dominant biomedical approach to health and can also be useful for considering ageing. A wellness approach relies on the principles and guiding concepts such as successful ageing by placing emphasis on holistic health and wellbeing while uniquely also recognising that a person’s ecology, meaning experiences and influences from all facets of a person’s life including: work; government policies; cultural values and ideologies; physical; intellectual; social; psychological; and spiritual factors, all impact on a person’s health (Gordon,
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2006; Larson, 1999; Lavretsky, 2010). Therefore, working from this framework allows health to be promoted, maintained and restored in micro (e.g., close personal relations), meso (e.g., work) and macro (e.g., community) spheres (Prilleltensky & Prilleltensky, 2003b) with power and control regarded as coming from both internal and external sources that are not exclusively psychological or political but rather they are both (Prilleltensky, Nelson, & Peirson, 2001) (see Figure 1).

Figure 1. An illustration of a wellness approach to health mediated by a person’s ecology. Adapted from (Gordon, 2006; McMahon, Williams, & Tapsell, 2010; Myers & Sweeney, 2008; National Wellness Institute, n.d.; Pettit & Peabody, 2008; Prilleltensky et al., 2001; Prilleltensky & Prilleltensky, 2003b; World Health Organization, 2002).

Although a wellness approach to health and wellbeing involves focussing on all facets of a person including the mind, the body, the spirit and the social, there are different viewpoints as to how wellness is achieved and realised. A critical psychology perspective considers wellness as a satisfactory state of affairs brought about by the combined presence of values, resources, programs and policies, or in other words, through the satisfaction and synergised interaction of three primary factors; personal, relational, and collective needs.
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(Prilleltensky & Fox, 2007; Prilleltensky et al., 2001; Prilleltensky & Prilleltensky, 2003a).

Abundance of one main factor is not considered as a replacement for a deficit in another and thus a balance is required across the three domains. For example, a person considered to have abundant personal wellness (i.e., self-esteem) does not make up for the fact that they may be lacking in collective wellness (i.e., access to health care is poor) in relation to their overall wellness (Prilleltensky & Fox, 2007). Therefore, to be “well” one would need to experience certain personal needs psychologically and subjectively (Felice, 2003; Prilleltensky & Fox, 2007; Seligman, 2002), as well as experience interpersonal exchanges based on respect and mutual support and under cultural, political and economic conditions that are not exploitive or abusive of human rights (Felice, 2003; Prilleltensky & Fox, 2007; Sen, 1999a, 1999b).

While Individual and relational factors are considered important factors to achieving wellness, focussing solely on these aspects implies that wellness is dependent on our inherent capacities and personal relationships (D. R. Fox & Prilleltensky, 1997). Considering wellness from within only personal and relational domains is considered neglectful of the broader contextual influences (D. R. Fox & Prilleltensky, 1997; Stumpers, Breen, Pooley, Cohen, & Pike, 2005). Collective variables acknowledged as playing a role in achieving wellness include concepts such as justice and equality. However, these variables are often portrayed as more difficult to discern or beyond our reach to actively influence or attain (Macedo, 1994; Miller, 1999; Prilleltensky & Fox, 2007). In order to promote wellness and justice, it is first necessary to understand the reciprocal relationship between the two concepts. While wellness is enhanced by the balanced satisfaction of needs, justice is enhanced and contributes to wellness through experiences affected by power, capacity and opportunity (Goodman, 2001; Prilleltensky & Fox, 2007). For example, one person’s personal need for physical and psychological health is influenced by the opportunity and capacity to obtain adequate health care just as a person’s collective need for equality is influenced and affected by fair and equitable distribution of resources (Prilleltensky & Fox, 2007).

Therefore, consideration of wellness and justice highlights that power and control are not only political in nature but also psychological. This further implies that personal, relational and collective needs can only realistically be fulfilled when the psycho-political factors are considered and understood (Prilleltensky & Fox, 2007). “Psycho-political literacy”, or the ability to understand the relationship between political and psychological factors that enhance or diminish wellness and justice (Prilleltensky & Fox, 2007), allows for examination of the impact that social constructions informed through mediums such as the media (e.g., television, newspapers) and government policy have on an individual’s own experience of ageing. While it is implied from this perspective that socialisation should encourage critical thinking about
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society (Ayers, Hunt, & Quinn, 1998; Prilleltensky & Fox, 2007), those that proclaim to support a more just distribution of resources and power across society often work through the institutions they dominate (i.e., schools, the media) (Prilleltensky & Fox, 2007). Professionals, governments, educators, and the media routinely emphasise apolitical factors such as biological determinants and personality traits as defining health status, which can create an impression that power is either unimportant or secondary to intrapersonal variables such as motivation, intelligence or locus of control in health and ageing (Goodman, 2001; Mitchell & Schoeffel, 2002; Prilleltensky & Fox, 2007).

2.3.4 Legitimate knowledge and the ageing experience.

Professional interests create certain methods and intellectual discourses that define what counts as legitimate knowledge, that is, knowledge used to justify control over an area of interest (Estes et al., 2009; Powell & Biggs, 2000; J. Reed et al., 2004). This knowledge then defines what is visible to policy makers and all associated allied fields in the area (i.e., nurses, social workers) and thereby in the case of ageing, defines what comprises old age (Biggs, 2001; Estes et al., 2009; S. Katz, 1996). This can serve to maintain their privileged position whereby effectively a profession’s or discipline’s own values and power interests become the basis for deceptively neutral institutional norms (S. Katz, 1996; Kondratowitz, 2009; Prilleltensky & Fox, 2007). Thus, legitimate knowledge is created when an area or problem is given shape through the process of professional or disciplinary formation (Estes et al., 2009; Kondratowitz, 2009). The construction of a social problem requires entering into the discourses that constitute these areas of legitimate knowledge such as a particular discourse on old age will “problematise” the experience of ageing in specific ways (Biggs, 2001; Cardona, 2008; Estes et al., 2009; S. Katz, 1996; Kondratowitz, 2009; Powell & Biggs, 2000; Prilleltensky & Fox, 2007). The ultimate result is that acquired and political distortions can lead large numbers of relatively powerless people to also believe an imbalance in wellness and justice is inevitable and acceptable (Prilleltensky & Fox, 2007).

When a dominant group has achieved widespread support for its priorities, its worldview is said to have gained hegemony (Sassoon, 2001). This worldview is useful for understanding the changing social construction of ageing as it is usually influenced by different historical circumstances whereby the balance between consent and coercion changes as the means by which dominant groups in society maintain control over subordinate groups (Estes et al., 2009). This can be illustrated by drawing on Foucault’s (1975, 1977) work which examined how creation of a certain category of human behaviour evolves in harness with professional
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groups control over the particular category (Estes et al., 2009; Powell & Biggs, 2000). Psychiatry as an example, did not simply discover mental illness but rather psychiatric issues and deviant behaviour were created through human diversity and the growth and development of professional power (Estes et al., 2009). Similarly, in relation to issues associated with ageing, Estes (1979) in her book The Ageing Enterprise illustrates how the vested interests of those who stand to gain from identifying age as a particular sort of problem creates powerful voices that drown out the experiences of older people themselves. This draws attention away from underlying structural inequalities and instead restricts the “problem of ageing” to whom those with power and influence can profit from (Estes, 1979, 1993; Estes et al., 2009). The biomedicalisation of ageing for example, sees decline and decay in ageing as an individual and corporeal problem without consideration of the larger structural inequalities that may be present and as such rely on medically based treatment and interventions usually through the provision of individual acute care services administered by “experts” (Brickman et al., 1982; Estes, 1993; Estes et al., 2009; Estes & Binney, 1989).

In review, unlike definitions and models of successful ageing, a wellness perspective comprises positive physical, emotional and political features that enable individuals and groups to pursue their goals in a context of equality and justice and therefore offers a framework from which to view and promote health and wellbeing in older adulthood (Prilleltensky & Fox, 2007; Tones, 1996). In the context of a wellness framework, power and control are of central importance and are defined as having opportunities to access material and psychological resources that satisfy basic human needs, to experience participation and self-determination (i.e., opportunities to experience meaningful decision-making power in matters affecting wellbeing), and to develop competence and self-efficacy which allows for a sense of stability and predictability in life (Prilleltensky et al., 2001). Psycho-political literacy encourages recognition of the interaction between individual and societal variables involved in wellness (Prilleltensky & Fox, 2007) and by recognising this interaction, acquired distortions and social constructions which can result from only examining particular aspects rather than the whole of a person’s experience, can be challenged. Employing such an approach, is thought to lead to more effective intervention development, systemic change and redirection of social policy which encourages older people to recognise their role as agents of change by means of challenging the status quo where it conceals and affects wellness in ageing (Estes et al., 2009; Prilleltensky & Fox, 2007).
2.4 Conclusions

In this chapter, influential theoretical developments in the study of ageing including recent popular definitions, concepts and frameworks such as successful ageing and wellness, have been reviewed. Until the 1980s, measurement of success in ageing was primarily based on length of life or life expectancy (Berkman & Glymour, 2006) with psychosocial theories predominantly based on developmental principles and changes in social roles (Cummings & Henry, 1961; Erikson, 1959; Havighurst, 1948; Havighurst & Albrecht, 1953). While it is still acknowledged that through the process of ageing many deficits are noticed (e.g., decreased efficiency for immune, cardiovascular and nervous systems) (Berkman & Glymour, 2006), the extent of loss and how people adapt is thought to be variable, critical and modifiable (Ponzo, 1992), and success in ageing acknowledged as a subjective experience (Albrecht & Devlieger, 1999; Bearon, 1996; Livingston et al., 2008; Vogel et al., 2006). Therefore, more contemporary perspectives on ageing focus on the strengths and growth potential of ageing individuals by recognising the impact that the interaction of individual and social variables has on experience (Holstein & Minkler, 2003).

With earlier gerontological research focussing on objective difficulties, and with later acknowledgement that meaning is situationally specific, the power of structurally derived assumptions about the meaning of behaviour in old age in influencing experience becomes significant. For this reason, what is objectively measured about the ageing experience may not reflect what is subjectively experienced (Russell, 1981). It thus becomes important to also investigate the subjective experience of ageing and the factors influencing the meaning that people assign to their experience (Estes et al., 2009; Ray, 2007; J. Reed et al., 2004). Furthermore, as a response to the lack of attention given to social structures and economic relationships in traditional gerontology, the field of critical gerontology evolved, challenging many traditional theories and perspectives on ageing (Bernard & Scharf, 2007; Estes et al., 2009; Holstein & Minkler, 2007). A wellness approach to health and ageing supports this critical position by offering an alternative to the dominant biomedical view of health by acknowledging that there are systemic influences at the macro and micro levels that account for a person’s health status and that can influence people’s own constructions of meaning in ageing (Gordon, 2006; McMahon et al., 2010; Myers & Sweeney, 2008; National Wellness Institute, n.d.; Pettit & Peabody, 2008; Prilleltensky et al., 2001; Prilleltensky & Prilleltensky, 2003b; World Health Organization, 2002). A critical psychology approach to wellness further acknowledges the role of power and justice as part of the larger systemic influences on wellbeing (Prilleltensky & Fox, 2007). Support for such an approach does not suggest that medical interventions are no longer effective or required, but rather that these services and
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thinking about health and ageing can be integrated within an overarching wellness framework (Swain & French, 1998).

Therefore, adopting a critical approach to theory in ageing means questioning the unreflective acceptance of established positions and assumptions that influence understandings of the position of older people in society (Estes et al., 2009; Holstein & Minkler, 2003, 2007). This requires study of the structural inequalities in society as well as a commitment to the voice and interests of older adults and the personal experience of ageing (Estes et al., 2009; Russell, 1981). This does not infer an uncritical acceptance of whatever older people might say but rather questions whose voice is being heard and in whose interests, which subsequently draws attention to systemic influences and in particular, the social construction of policy (Cardona, 2008; Estes et al., 2009; Walker, 2009a). Consequently, in the context of ageing, social policy - although socially constructed, defines the parameters of legitimate ageing (that is, what it means to age well) (Biggs, 2001; Estes et al., 2009; Powell & Biggs, 2000) thus making it important to examine how the development and implementation of policy relates to the personal experience of ageing. To further assist in understanding the construction and experience of ageing, the next chapter identifies current policy in ageing at a local, national and an international level. This allows for the relationship between policy, theory and the individual experience of ageing to be further explored and examined, particularly in relation to the specified contexts of this current research.
Chapter 3: Responses to population ageing - Policy’s role in constructing meaning

This chapter continues the discussion concerning how meaning is constructed about the ageing experience by focussing on policy formation in the area. The chapter begins by reviewing the topic of population ageing and the associated political discourse concerning this topic. In the first instance, the review outlines the major international policies of the past four decades namely, the Vienna International Plan of Action on Ageing (VIPAA); the United Nations Principles for Older Persons and International Year of Older Persons (IYOP); the Madrid International Plan of Action on Ageing (MIPAA); and the major developments in policy and research since the MIPAA. Population ageing in the context of Australia and Wales is then discussed. Australia’s policy responses to population ageing including, the Healthy Ageing Taskforce; the Commonwealth, State and Territory Strategy on Healthy Ageing (CSTSHA); the National Strategy for an Ageing Australia (NSAA): An Older Australia, Challenges and Opportunities for all; and the Framework for an Australian Ageing Research Agenda are outlined and discussed. Wales’s policy responses including, When I’m 64...and More: The Report from the Advisor Group on a Strategy for Older People in Wales; the Strategy for Older People in Wales 2003-2008; Healthy Ageing Action Plan for Wales; Commissioner for Older People (Wales) Act 2006; and The Strategy for Older People in Wales 2008-2013 – Living longer, Living Better are also outlined and discussed. With the identification of healthy ageing as a critical area of development on political and research agendas nationally and internationally, this construct is critically assessed. To conclude this chapter, the promotion of healthy ageing is reviewed locally in Western Australia (WA), with a particular focus on the healthy ageing program, Living Longer Living Stronger (LLLS).

3.1 Population ageing

Population ageing is a pervasive global phenomenon affecting all current generations (United Nations/Department of Economic and Social Affairs/Population Division, 2002, 2010). Population ageing means that there is a shift in age distribution sustained by low fertility rates and declining mortality rates (Australian Bureau of Statistics, 2010b; Gavrilov & Heuveline, 2003). Worldwide, the proportion of people aged 60 years and over is increasing faster than any other age group with an expected growth of 223% between 1970 and 2025 (World Health Organization, 2002). Average life expectancy at birth has increased by 21 years since 1950 to 67.6 years, with a further increase of eight years expected by 2050 (United Nations/Department of Economic and Social Affairs/Population Division, 2010). This changing distribution of population is most apparent in wealthy industrialised countries and results in smaller proportions of people at younger ages and larger proportions at older ages (Australian
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Bureau of Statistics, 2010b; United Nations/Department of Economic and Social Affairs/Population Division, 2010). By 2050, 80% of the two billion people over the age of 60 years are expected to be living in developing countries (World Health Organization, 2002). Therefore, population ageing may be viewed as a major social achievement, represented by the manifestation of progress in the human condition or in another sense, it can be viewed as a time fraught with economic and social change and potential difficulties (United Nations Educational Scientific and Cultural Organization, 2006).

The expected demographic transition related to population ageing will result in the old and young representing an equal share of the world population by mid-century (United Nations, 2002, 2012; United Nations/Department of Economic and Social Affairs/Population Division, 2010). This trend is already evident in some countries including in Australia and in the United Kingdom (UK) where the current age structure is similar in distribution with the proportion of the population aged 65 years and over accounting for 14% and 17% respectively, with estimates of a further 2% increase in the next four years (see Table 4) (Australian Bureau of Statistics, 2010b). As population ageing continues, community at the local, national and international level encounter the challenge of providing policy, programs and services to meet the changing values, needs, behaviours and attitudes of an older population (Australian Bureau of Statistics, 2006; United Nations/Department of Economic and Social Affairs/Population Division, 2010). To understand the current local policy context of ageing, historical plans, strategies and policies nationally and internationally that have formed the current ageing agenda first need consideration. Significant plans, strategies and policies influencing the local context are reviewed in the next section.
Table 4

*Population Age Structure, International Comparison* (a) – at 30 June 2010

<table>
<thead>
<tr>
<th>Selected countries</th>
<th>Aged 0-14 years (%)</th>
<th>Aged 65+ years (%)</th>
<th>Median age (years)</th>
<th>Aged 0-14 years (%)</th>
<th>Aged 65+ years (%)</th>
<th>Median age (years)</th>
<th>Total fertility rate (c)</th>
<th>Life expect. (d) years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>18.9</td>
<td>13.6</td>
<td>36.9</td>
<td>17.6</td>
<td>16.4</td>
<td>39.9</td>
<td>1.9</td>
<td>82.0</td>
</tr>
<tr>
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<td>16.3</td>
<td>14.1</td>
<td>39.9</td>
<td>15.8</td>
<td>16.0</td>
<td>40.9</td>
<td>1.6</td>
<td>81.4</td>
</tr>
<tr>
<td>China (excl. SARs and Taiwan)</td>
<td>19.9</td>
<td>8.2</td>
<td>34.2</td>
<td>19.0</td>
<td>9.4</td>
<td>35.6</td>
<td>1.8</td>
<td>74.0</td>
</tr>
<tr>
<td>Hong Kong (SAR of China)</td>
<td>11.5</td>
<td>12.9</td>
<td>41.9</td>
<td>10.6</td>
<td>14.9</td>
<td>43.8</td>
<td>1.0</td>
<td>82.8</td>
</tr>
<tr>
<td>France</td>
<td>18.4</td>
<td>17.0</td>
<td>40.1</td>
<td>18.1</td>
<td>19.1</td>
<td>41.3</td>
<td>1.9</td>
<td>81.9</td>
</tr>
<tr>
<td>Greece</td>
<td>14.2</td>
<td>18.3</td>
<td>41.6</td>
<td>14.1</td>
<td>19.5</td>
<td>43.3</td>
<td>1.4</td>
<td>80.1</td>
</tr>
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<td>28.7</td>
<td>5.4</td>
<td>26.5</td>
<td>2.5</td>
<td>65.2</td>
</tr>
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<td>24.5</td>
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<td>43.4</td>
<td>1.3</td>
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<td>41.6</td>
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<td><strong>17.4</strong></td>
<td><strong>16.6</strong></td>
<td><strong>39.9</strong></td>
<td><strong>17.2</strong></td>
<td><strong>17.9</strong></td>
<td><strong>40.3</strong></td>
<td><strong>1.9</strong></td>
<td><strong>80.1</strong></td>
</tr>
<tr>
<td>United States of America</td>
<td>20.2</td>
<td>13.0</td>
<td>36.6</td>
<td>19.8</td>
<td>14.3</td>
<td>37.2</td>
<td>2.0</td>
<td>79.9</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>25.1</td>
<td>6.3</td>
<td>28.5</td>
<td>23.1</td>
<td>6.6</td>
<td>30.2</td>
<td>2.0</td>
<td>75.4</td>
</tr>
<tr>
<td>World</td>
<td><strong>26.9</strong></td>
<td><strong>7.6</strong></td>
<td><strong>29.1</strong></td>
<td><strong>26.0</strong></td>
<td><strong>8.2</strong></td>
<td><strong>30.2</strong></td>
<td><strong>2.5</strong></td>
<td><strong>68.9</strong></td>
</tr>
</tbody>
</table>

Notes. (a) Selected countries included major OECD countries, the world's most populous countries, Australia’s closest neighbours and trading partners. (b) International data are United Nations medium variant projections. Australian data are ABS medium series (Series B) projections. Series B projections largely reflect current trends in fertility, life expectancy at birth, net overseas migration and net interstate migration, as opposed to Series A and Series C projections which are based on high and low assumptions for each of these variables respectively. (c) Births per woman. United Nations are medium
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variant projections for the period 2010-2015. (d) Life expectancy at birth. United nations are medium
variant projections for the period 2010-2015, for males and females combined. Adapted from

3.2 A focus on ageing: Plans, strategies and policies

Population ageing is not only a projected occurrence but also a current phenomenon. As such, shifts in policy development and implementation have been required to accommodate existing changes and those that will inevitably continue in the future. The challenge in designing policy for an ageing population, has been deciding the issues of importance and how to prioritise these issues. The formulation of policy first requires identification of problems, albeit perceived societal problems that need addressing (G. R. Andrews & Clark, 1999). The following section examines policy in ageing from within its historical context (G. R. Andrews & Clark, 1999; Berman, 1978). Although ageing and related issues have been studied for centuries, it is only more recently that ageing has been considered in terms of human rights and politics (G. R. Andrews, 1999; G. R. Andrews & Clark, 1999; Minkler, 1996). This next section reviews this relatively recent interest in ageing from a political perspective with a particular focus on the associated developed plans, strategies and policies aimed at addressing ageing issues on the international stage as well as nationally in Australia and locally in WA.

3.2.1 Vienna International Plan of Action on Ageing (VIPAA).

Dating as far back as the 1940s and 1950s, the United Nations (UN) has been involved in issues relating to older people through population projection work, however the concern of the UN has since shifted largely from problem identification work related to demographic growth patterns to attempting to influence policy formulation at national and international levels (G. R. Andrews & Clark, 1999). The first international agenda on ageing was the historic Vienna International Plan of Action on Ageing (VIPAA). Drafted in 1982, this plan was designed to guide policies and programs on ageing and was adopted by the World Assembly on Ageing; comprising representatives from UN member states (e.g., Australia) (G. R. Andrews & Clark, 1999; United Nations, 1983). Later that same year, the plan was endorsed by the UN General Assembly. The main aim of the VIPAA was to strengthen the capacities of Governments and civil society to deal effectively with the ageing of populations (United Nations, 1983). Considered in relation to the principles, agreed standards and objectives of other international strategies and plans in areas such as human rights, welfare and health, the VIPAA included 62 recommendations for action (G. R. Andrews & Clark, 1999; United Nations, 1983). These recommendations aimed to address issues in research, data collection and analysis, training, as well as the following sectoral areas: health and nutrition; protection of elderly consumers;
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housing and environment; family; social welfare; income security and employment; and education (United Nations, 1983). These recommendations also brought attention to the human rights of older adults and later informed the development of a set of principles for the treatment of older persons. The development of these guiding principles is discussed in the next section.

3.2.2 United Nations Principles for Older Persons.

In the two decades that followed the VIPAA, guidelines, principles and frameworks aimed at addressing issues in ageing continued to evolve. Significantly, in 1991, the UN devised 18 principles for older persons, later adopted by the General Assembly which became known as the United Nations Principles for Older Persons (United Nations, 1991). Contributing greatly to the formulation of the principles was the then current gerontological thinking about factors believed to contribute to the wellbeing of older persons such as, access to adequate resources; opportunities for meaningful participation in society; and the right to live in dignity with security and freedom (G. R. Andrews & Clark, 1999). After attempting to have these principles passed as a declaration of rights, due to a lack of consensus by all member nations, a compromise was reached whereby language used to assert the principles as “rights” was diluted to “shoulds” (Nusberg, 1991, p. 3). For example; “older persons have the right to live in dignity” (Nusberg, 1991, p. 6), instead became “older persons should be able to live in dignity” (United Nations, 1991, p. 162).

The use of particular language in policy and other governing documents has important implications for the allocation of responsibility and subsequent justification of service provision to different groups in society. Nusberg (1991) draws attention to this by suggesting that through the omission of language alluding to rights and responsibilities from such documents as the United Nations Principles for Older Persons, the language could be used against the group the document seeks to serve. For example, a responsibility to take care of one’s health might be used to justify a government’s lack of adequate health care provision (Nusberg, 1991; Pond, Stephens, & Alpass, 2010). Furthermore, reasoning for not issuing a declaration for the elderly includes assertion that older adults’ rights are already protected under declarations such as the Universal Declaration of Human Rights, and that the creation of more declarations would mean too many (Nusberg, 1991). It then may be argued that other groups (i.e., children, women) are supported by their own separate declarations proposing standards for decent treatment and the elderly are not. This is particularly concerning considering older people’s vulnerability to abuse and discrimination and with the size of this
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Although omissions alluding to rights can have powerful implications and be reflective of deeper societal values (i.e., a devaluing and/or unequal treatment of particular groups), the final agreed Principles for Older Persons relating to concepts of independence, participation, care, self-fulfilment and dignity, represent a significant achievement for older people (Nusberg, 1991; United Nations, 1991). Furthermore, the principles have provided important guidelines for governments to ensure priority attention is given to the situation of older persons by encouraging them to incorporate the principles into their national programs where possible (Annan, 1999; Nusberg, 1991; United Nations, 1991). Importantly, these principles have stimulated acknowledgment of the contribution that older people make to society. An example of this includes the dedication of a day recognising older people’s contribution to society with the declaration of the International Day of Older Persons in 1990 (United Nations, 1990), and the subsequent announcement nearly a decade later proclaiming 1999, International Year of Older Persons (IYOP) (United Nations, 1999).

3.2.3 The International Year of Older Persons (IYOP).

In the same year that the Principles for Older Persons were adopted by the UN, the International Day of Older Persons originated following the UN General Assembly’s designation of October 1st as marking the occasion (United Nations, 1990). This day, primarily aimed at acknowledging the contribution of older people to society, is now celebrated annually by many countries (G. R. Andrews & Clark, 1999) and promotes the UN’s Program on Ageing to facilitate and contribute to the creation of a society for all ages (Department of Ageing Disability and Home Care, 2004; United Nations, 2012). This philosophy was behind the announcement by the UN General Assembly nearly a decade later proclaiming 1999, International Year of Older Persons (IYOP) with the theme for that year being “towards a society for all ages” (Ageing and Health Programme/World Health Organization, 1999; Annan, 1999; United Nations, 1999). In recognition of rapid global population ageing, the IYOP was committed to creating an enabling environment for healthy lifestyles as people age while also being inclusive of all ages recognising that it is in early life where economic, human and social capital are established (G. R. Andrews, 1999; Annan, 1999). The primary aim of the IYOP was therefore to make important inroads on a broad range of issues affecting older people by providing an opportunity for governments, policy makers, researchers, professional and community associations, and the general public to focus specifically on the situation of older persons (G. R. Andrews, 1999; G. R. Andrews & Clark, 1999). Assessment of how these goals were being met
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was later reviewed by the Madrid International Plan of Action on Ageing (MIPAA), successor to the VIPAA, which is discussed in the next section.

### 3.2.4 Madrid International Plan of Action on Ageing (MIPAA)

In 2002, to assess the progress made by Member States in the two decades since the implementation of the VIPAA, the Second World Assembly on Ageing, was hosted by the Spanish government in Madrid (United Nations, 2001). The main purpose of the Second World Assembly on Ageing was to review, revise and update the International Plan of Action while also reinforcing the need to better detail the human rights of older people (Butler, 2002). The Madrid International Plan of Action on Ageing (MIPAA) resulted from the Second World Assembly on Ageing with an overarching focus of the MIPAA to ensure all persons have the opportunity to age with security and dignity and to participate in their societies as citizens with full rights (Butler, 2002; United Nations, 2002). The MIPAA constitutes a key global policy document concerned with the implications of population ageing covering a variety of topics and incorporating 239 recommendations (United Nations, 2002).

As part of the implementation of the MIPAA, the World Health Organisation (WHO); the directing and coordinating authority for health within the UN’s system (World Health Organization, 2012), developed and disseminated an Active Ageing Policy Framework (World Health Organization, 2002). Consistent with the UN’s Principles for Older Persons, the policy framework was divided into three key areas: health; security; and participation, with key intentions to inform discussions and the formulation of action plans that promote healthy and active ageing (World Health Organization, 2002). The volume of information in the MIPAA also prompted the release of a guide for its national implementation which specifically aimed to provide a critical framework for the design of policies and procedures to be used by those in the policy arena (e.g., stakeholders, program developers, policy makers) and to offer guidance as to how to put the recommendations into action (United Nations/Department of Economic and Social Affairs, 2008).

As an auxiliary to the guide for implementing the MIPAA, a joint initiative developed by the UN Program on Ageing together with the International Association of Gerontology and Geriatrics (IAGG), resulted in a Research Agenda for the Twenty-First Century (United Nations Programme on Ageing/International Association of Gerontology and Geriatrics, 2007). Primarily the research agenda was designed to influence the direction and priorities for research in ageing by specifically identifying priorities for policy related research and data collection based on information from the MIPAA. Recognising the already substantial body of knowledge established on ageing issues, mainly in gerontology, the research agenda
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particularly directed encouragement towards researchers pursuing studies in policy related areas of ageing where the findings may have practical and realistic applications. Twelve critical research areas (including healthy ageing) were outlined in the research agenda and all areas were based on the three priority directions set out by the MIPAA: older persons and development; advancing health and wellbeing into old age; and ensuring enabling and supportive environments. A timeline of international policy and research development leading up to this point and beyond, is summarised in Table 5.

Table 5

**Timeline of International Ageing Policy Development**

<table>
<thead>
<tr>
<th>Significant Plans of Action</th>
<th>Year</th>
<th>Associated outcomes of Plans</th>
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<tbody>
<tr>
<td>Vienna International Plan of Action on Ageing (VIPAA)</td>
<td>1982</td>
<td></td>
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<tr>
<td>1990 - 1991</td>
<td></td>
<td>United Nations Principles for Older Persons</td>
</tr>
<tr>
<td></td>
<td></td>
<td>International Day of Older Persons</td>
</tr>
<tr>
<td>1999</td>
<td></td>
<td>International Year for Older Persons (IYOP)- ‘towards a society for all ages’</td>
</tr>
<tr>
<td>Second World Assembly on Ageing Madrid International Plan of Action on Ageing (MIPAA)</td>
<td>2002</td>
<td>Active Ageing Policy framework</td>
</tr>
<tr>
<td>2006</td>
<td></td>
<td>Report on the major developments since the Second World Assembly</td>
</tr>
<tr>
<td>2007</td>
<td></td>
<td>Research Agenda for the Twenty-First Century</td>
</tr>
</tbody>
</table>

3.2.5 Major developments in policy and research since the MIPAA.

Since the Second World Assembly on Ageing in 2002, as defined by the broad framework outlined in the MIPAA, governments have introduced a range of measures aimed at addressing the various challenges stemming from population ageing. A report on the major developments since the Second World Assembly identified that many developed countries have introduced reforms and adjusted their pension and health care programs to try to account for the needs of older adults as well as considering future generations (United Nations Educational Scientific and Cultural Organization, 2006). The report recognised an increasing trend towards reversing early retirement with several countries (including Australia) through the elimination of mandatory retirement ages enabling workers to continue for as long as they...
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are willing and able. Recognising the growing demand for care in ageing societies, the goal of healthy and active ageing to ensure a healthy old age have also shown to be more widespread among policy makers (Commonwealth States and Territories, 2000; J. E. Lang et al., 2005; V. W. Marshall & Altpeter, 2005; Mittelmark, 2001; Office for Seniors Interests and Volunteering, 2006, n.d.; Prime Minister’s Science Engineering and Innovation Council [PMSEIC], n.d.; U.S. Department of Health and Human Services, 2000; United Nations Educational Scientific and Cultural Organization, 2006; World Health Organization, 2002). Despite positive moves to creating and encouraging a healthy old age including the introduction of anti-age discrimination legislation, such as that in Australia, it is recognised that further attention is needed to combat age discrimination and to prevent elder abuse (Australian Institute of Health and Welfare, 2007, 2009; United Nations Educational Scientific and Cultural Organization, 2006). The Secretary-General of the UN suggested this be achieved through furthering the geriatric training of health professionals and the general public about the ageing process as well as educating older persons about their human rights and helping them to play a more active role in securing these rights (United Nations Educational Scientific and Cultural Organization, 2006).

The report further highlighted the importance of removing structural barriers in an attempt to achieve a more balanced perspective on ageing, not one that is portrayed as a one-dimensional experience but rather one that highlights its complex and heterogeneous nature (Lloyd-Sherlock, 2004; United Nations Educational Scientific and Cultural Organization, 2006). Some governments have created coordinating bodies on ageing issues, which encourage older persons to express their views about the impact of national policy actions affecting them. For this process of empowerment to become sustainable, it is recognised that older adults first need to feel appreciated and valued members of society (United Nations, 2002). However, older adults are still considered as being devalued as evidenced by the continuing dominance of alarmist natured reports, usually built on a fear of economic difficulties, particularly via the media about the potentially negative impact of population ageing (United Nations Educational Scientific and Cultural Organization, 2006). This detracts from the more positive ageing stories and undermines the recent promotion of an “active ageing” approach (World Health Organization, 2002).

A key priority of policy-related research in population ageing highlighted in the Report on the major developments since the Second World Assembly on Ageing, included a move away from disease-specific approaches to ageing towards one more focussed on the prevention of disease and aimed at promoting healthy and active ageing (United Nations Educational Scientific and Cultural Organization, 2006). WHO’s contribution to the assembly included the
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submission of a policy framework to assist in the implementation of the MIPAA (World Health Organization, 2002). The framework implicated the promotion of active ageing - a process of optimising opportunities for health, participation, and security in order to enhance quality of life as people age. This has resulted in the rise of research in this area focussing on other positive effects of life-long physical, mental and social engagement of older persons. The policy framework takes into account the determinates of health throughout the life course and has helped to shape ageing policies, nationally and regionally as well as directed academic research on ageing (World Health Organization, 2004a). In practice, however the link between research and policy agendas remains sporadic highlighting that better coordination is still needed in this area (United Nations Educational Scientific and Cultural Organization, 2006).

Therefore, since the adoption of the historic VIPAA at the World Assembly on Ageing in 1982, ageing issues have emerged as being of significance internationally. As the first international instrument to guide policy on issues associated with ageing (Department of Ageing Disability and Home Care, 2004), the VIAPPA prompted the development of guidelines, principles, frameworks and research agendas aimed at promoting awareness of the multifaceted nature of ageing and the varied needs and rights of older adults (Ageing and Health Programme/World Health Organization, 1999; G. R. Andrews, 1999; G. R. Andrews & Clark, 1999; Annan, 1999; Department of Health and Ageing Australian Government, 2007; Nusberg, 1991; United Nations, 1983, 1991, 2001, 2002; United Nations Programme on Ageing/International Association of Gerontology and Geriatrics, 2007; United Nations/Department of Economic and Social Affairs, 2008). While it would be difficult not to find some local relevance in the markers of concern set out by the UN in regards to global ageing issues, it is recognised that culture and country-specific initiatives are necessary to ensure optimal local effectiveness (G. R. Andrews & Clark, 1999). Of particular interest to this research is the evolution of ageing policy in WA, Australia and in Wales. Consequently, this next section outlines the political responses to population ageing in these three contexts with a particular focus on each contexts position in regard to the critical research area of “healthy ageing” as identified in the Research Agenda for the Twenty-First Century under the MIPAA priority direction II; advancing health and wellbeing into old age (United Nations Programme on Ageing/International Association of Gerontology and Geriatrics, 2007).
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3.3 Ageing in Australia

3.3.1 Population ageing in Australia.

In 2010, the proportion of Australia’s population aged 65 years and over was 13.6% (an increase of 2.5% since 30 June 1990) (Australian Bureau of Statistics, 2010b), with this proportion projected to increase to between 23% and 25% by 2056, and between 25% and 28% by 2101 (see Table 6) (Australian Bureau of Statistics, 2008). This means that one in four Australians are expected to be over the age of 65 years by this time. Furthermore, the proportion of population aged 85 years and over has more than doubled since 30 June 1990 from 0.9% to 1.8% as at 30 June 2010 (Australian Bureau of Statistics, 2010b), and it is projected that this cohort will account for 5% to 7% of the total population by 2056 (Australian Bureau of Statistics, 2008). Consequently, over the past two decades, the median age of the population in Australia has increased by 4.8 years from 32.1 years at 30 June 1990 to 36.9 years at 30 June 2010 (Australian Bureau of Statistics, 2010b), with a further increase of just under 10 years projected by 2056 (Australian Bureau of Statistics, 2008).

Table 6

<table>
<thead>
<tr>
<th>Current and Projected Population Proportions for Australia</th>
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<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Australia</td>
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<tr>
<td></td>
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<td></td>
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<tr>
<td><strong>2010(a)</strong></td>
</tr>
<tr>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>Median age (years)</td>
</tr>
<tr>
<td>Proportion under 15 years (%)</td>
</tr>
<tr>
<td>Proportion 65 years and over (%)</td>
</tr>
<tr>
<td>Proportion 85 years and over (%)</td>
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</tbody>
</table>

Note. (a) Year ended 30 June. Adapted from (Australian Bureau of Statistics, 2010b) and (Australian Bureau of Statistics, 2008).

The group known as the “baby boomers” are Australia’s biggest demographic cohort (5.5 million) (Quine & Carter, 2006), making them of particular interest when considering issues and plans for change to accommodate the future needs of an ageing population. Baby

---

1 Projections are not predictions or forecasts, but rather illustrations of the growth and change in population, which would occur if certain assumptions about future levels of fertility, mortality, internal migration and overseas migration were to prevail over the projection period. The assumptions incorporate recent trends, which indicate increasing levels of fertility and net overseas migration for Australia.

2 Only one Australian Bureau of Statistics (ABS) national population survey collects data from people living in residential aged care reflecting the methodological difficulties associated with data collection in this population which particularly limits reporting capabilities on the health of older people since almost one-quarter of the very oldest age group are excluded from data collection (Australian Institute of
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boomers are those Australians born in the 20-year period between 1946 and 1965 (Australian Bureau of Statistics, 2008), which can be further subdivided as the immediate post-World War II decade composed of people in 2007 aged 52-61 years and a later decade now aged 42-51 years (Quine & Carter, 2006). It is important to note that older adults who currently surpass the baby boomer cohort (those adults over the age of 61 years) are also an integral cohort of inquiry as they are able to comment on their experience of older adulthood currently as well as comment on their continued longevity (as suggested by current population projections) (Australian Bureau of Statistics, 2008). Therefore, given the interest in the above cohorts as well as key policy and program developments across Australia (and internationally in Wales) directed at older adults indicating 50 years and over as their target audience (Commonwealth of Australia, 1999, 2001; Council on the Ageing Australia, n.d.-a, n.d.-b; Council on the Ageing WA, 2012a, 2012b; Living Longer Living Stronger COTA, 2012a; Welsh Assembly Government, 2003, 2005, 2008, 2009a), for the purposes of this research older adults over the age of 50 years were targeted for inclusion.

3.3.2 Policy responses to ageing in Australia.

Australia’s political practices follow the Western democratic tradition, reflecting British and North American practices (Australian Institute of Health and Welfare, 1999). The Australian federation has three levels of government: federal, state/territory and local (Australian Institute of Health and Welfare, 2007; Department of Health and Ageing Australian Government, 2007). Headed by the Prime Minister, the Federal Parliament and the Federal Government deal with matters of national interest with the Cabinet the major policy-making body of government (Australian Institute of Health and Welfare, 1999). The health care system in Australia comprises a blend of public and private sector involvement with the national health funding scheme, Medicare providing Australian residents with access to affordable medical services by subsiding the fees charged by doctors (Australian Institute of Health and Welfare, 2007). While the federal government has become more involved in developing and coordinating national health care policies, legislation and standards, it is the state and local governments that have responsibility for providing public health services (Australian Institute of Health and Welfare, 2007; Australian Local Government Association, 2004a). This highlights the important role local governments play in addressing issues important to health and consequently has implications for healthcare and service delivery associated with ageing. Progress in ageing policy development nationally is reviewed in the next section with a summary of these key developments illustrated in Table 7.
Timeline of Ageing Policy Development in Australia

<table>
<thead>
<tr>
<th>Significant policy developments</th>
<th>Year</th>
<th>Associated outcomes of developments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Ageing Taskforce</td>
<td>1996</td>
<td></td>
</tr>
<tr>
<td>Establishment of Minister for Ageing position</td>
<td>1998</td>
<td></td>
</tr>
<tr>
<td>Commonwealth, State and Territory Strategy on Healthy Ageing (CSTSHA)</td>
<td>1999 – 2000</td>
<td></td>
</tr>
<tr>
<td>National Strategy for an Ageing Australia (NSAA): An Older Australia, Challenges and Opportunities for all</td>
<td>2001</td>
<td></td>
</tr>
<tr>
<td>Framework for an Australian Ageing Research Agenda</td>
<td>2003</td>
<td>Research collaborations:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• National Health and Medical Research (NHMRC) and the Australian Research Council (ARC)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• ARC/NHMRC Research Network in Ageing</td>
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<tr>
<td></td>
<td></td>
<td>• Emerging researchers in Ageing (ERA) initiative</td>
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<td></td>
<td></td>
<td>• Australian Institute of Health and Welfare (AIHW) and Office for an Ageing Australia</td>
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<td></td>
<td></td>
<td>• Building Ageing Research Capacity (BARC) Project</td>
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</table>

Similar to international trends, issues associated with population ageing in Australia are wide reaching and diverse with the prioritisation of these issues continually being debated at a national and state level (Bartlett, 2003). In October 1996, in recognition of the challenges of an ageing population in Australia, the Commonwealth, State and Territory Health and Community Services Ministers established the Healthy Ageing Task Force which constituted a member from the Commonwealth agency and each state and territory agency responsible for ageing issues (Commonwealth States and Territories, 2000). It was intended that the taskforce would assist in improving the planning and coordination involved in addressing ageing issues across jurisdictions. The particular focus of the taskforce reflected a view of healthy ageing as an Australian outlook on life that recognises that growing older is a natural and positive part of living, and one that recognizes the interdependence of generations while also acknowledging the diversity and individuality of older people (Commonwealth of Australia, 1999; Commonwealth States and Territories, 2000).
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The importance of ageing in Australia was further recognised in 1998, with the establishment of a position for a Minister for Ageing, making Australia one of the first countries to create such a position (Department of Health and Ageing Australian Government, 2007). Furthermore, in 1999, signalling commitment to honouring the goals set out by the UN for the IYOP theme “toward a society for all ages” and as a national response to Australia’s own ageing population, The Healthy Ageing Taskforce developed the Commonwealth, State and Territory Strategy on Healthy Ageing (CSTSHA) (Commonwealth States and Territories, 2000). Officially adopted in early 2000, the strategy articulated an agenda by identifying areas for action and provided a planning framework so that a national coordination point for work already undertaken in individual jurisdictions, which focus on maximising healthy ageing outcomes, could be achieved. The vision of the strategy was to encourage and develop: “A fair society where all older people can lead satisfying and productive lives which maximise their independence and wellbeing” (Commonwealth States and Territories, 2000, p. 3). The principles guiding the implementation of the strategy included: supporting independence; encouraging a good quality of life for Australians as they age; promotion of fairness and equity; recognition of interdependence; recognition and response to Australia’s growing diversity; and encouraging personal responsibility while providing support for those most in need (Commonwealth States and Territories, 2000; Prime Minister's Science Engineering and Innovation Council [PMSEIC], n.d.). These principles were also instrumental in the establishment of a national ageing strategy for Australia, as discussed in the next section.

National Strategy for an Ageing Australia (NSAA): An Older Australia, Challenges and Opportunities for all.

In 2001, a further response to the IYOP from the Australian government was the announcement of the National Strategy for an Ageing Australia (NSAA): An Older Australia, Challenges and Opportunities for all. The NSAA was developed through an extended process of consultation including community views and the preparation of six discussion papers (Commonwealth of Australia, 1999, 2001). This strategy argued that policies that support continued economic and social contributions by older people would be essential in the future, with a major goal again in line with the IYOP theme, to deliver the best outcomes for all Australians regardless of age (Commonwealth of Australia, 2001; United Nations, 1999). Responsibility for better outcomes were considered the responsibility of the commonwealth government and businesses, communities, and individuals, with principles outlined in the strategy reflecting support for increasing opportunities for participation in society of all people with access to services across the lifespan (Commonwealth of Australia, 2001). Specific
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principles included: all Australians (regardless of age) having access to appropriate employment as well as opportunities to make “life-long” contributions to society and economy; the need for public and private contributions to be made to meet the needs and aspirations of an older Australia; a focus on public programs supplementing rather than supplanting the role of individuals, their families and communities; and the building of a strong evidence base to inform policy for an ageing Australia (Commonwealth of Australia, 2001; Department of Health and Ageing Australian Government, 2007). With the later principle being of particular significance to this research, a more detailed account of this principle follows in the next section.

A Framework for an Australian Ageing Research Agenda.

With a key principle of the NSAA recognising the need to build and develop a strong evidence base to inform policy decision making processes for ageing societies (Australian Institute of Health and Welfare, 2003; Commonwealth of Australia, 2001), in 2003, a Framework for an Australian Ageing Research Agenda was developed to provide a structure for building this evidence (Australian Institute of Health and Welfare, 2003). As a background paper to the National Symposium on Ageing Research, the Framework specifically provided an overview on the 2003 research environment with the intention of being a dynamic document responsive to changes in the development of the evidence base and with a focus to further develop an ageing agenda for Australia. Guided by the four key identified national research priorities announced by the Prime Minister, the Hon John Howard MP in 2002, of relevance to the development of an Australian ageing research agenda was the research priority of “promoting and maintaining good health” (Australian Institute of Health and Welfare, 2003). The three goals identified under this priority area were: a healthy start to life; ageing well, ageing productively; and preventative healthcare. These goals were derived from three key reports generated by the Australian Government, the NSAA (Commonwealth of Australia, 2001), the Intergenerational Report (Australia’s first report of this kind) (Commonwealth of Australia/Federal Treasurer, 2002) and the CSTSHA report (Commonwealth States and Territories, 2000). A further six policy issues including achieving healthy ageing to maintain health and independence; developing positive images of ageing; and supporting continued social participation were identified.

Progression of the above priorities is evidenced by various activities including, a report on Promoting Healthy Ageing in Australia presented by an independent working group of the Prime Ministers Science, Engineering and Innovation Council (PMSEIC) (Prime Minister’s Science Engineering and Innovation Council [PMSEIC], n.d.); Flagship Programs such as
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Preventative Health (P-Health) identified by the Commonwealth Scientific and Industrial Research Organisation (CSIRO); and collaborations between major research bodies have also been stimulated with both seeking to strengthen cross-disciplinary work, research networks and capacity building (Australian Institute of Health and Welfare, 2003). Research collaborations include that between the National Health and Medical Research Council (NHMRC) and the Australian Research Council (ARC), and between the Australian Institute of Health and Welfare (AIHW) and the Office for an Ageing Australia in their development of the Building Ageing Research Capacity (BARC) Project. (Australian Institute of Health and Welfare, 2003).

As part of the wider goal to promote research in ageing, initiatives have not just included mapping out the research priorities, but have also involved assisting and supporting researchers through the process by encouraging better dialogue and collaboration (Australian Institute of Health and Welfare, 2003). For example, the development of the ARC/NHMRC Research Network in Ageing, which resides in the national research priority of “ageing well, ageing productively”. Another example includes, the Emerging Researchers in Ageing (ERA), an initiative of the Australasian Centre on Ageing at the University of Queensland. The ERA initiative has since resulted in varied events aimed at facilitating networking among emerging researchers in the field including, conferences, Masterclass workshops and international exchange opportunities. These types of activities are considered important in working towards maximising the translation of research into policy and practice (Australian Institute of Health and Welfare, 2003).

In summary, principles outlined in the NSAA correspond to the UN’s Principles for Older Persons (United Nations, 1991) and are guided by four overarching themes described in the terms of reference for the strategy: independence and self provision; attitude, lifestyle and community support; world class care; and healthy ageing (Commonwealth of Australia, 2001). While the broad concept of positive ageing is intrinsic to all four themes of the NSAA, with specific goals to be met under each area, Australia’s response to ageing has focussed on the healthy ageing theme to progress forward. Therefore, of particular interest to this current research was the strategy’s proposition for sound research to develop the healthy ageing evidence base to better understand the area (Commonwealth of Australia, 2001). Consequently, this next section will explore the specific theme of healthy ageing by reviewing the Healthy Ageing Discussion Paper, which informed the NSAA, current conceptualisations of the concept, as well as the specific policy responses aimed at addressing needs in this area, particularly at the state and local government level in WA.
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3.4 Healthy ageing

The concept of healthy ageing was first defined by the WHO (Commonwealth of Australia, 1999). The basis of the healthy ageing concept lies in the WHO’s definition of health as a “state of complete physical, mental and social wellbeing; not solely the absence of disease” (World Health Organization, 1946, p. 2). Furthermore, grounded in the conceptualisation of ageing as a lifelong process with a particular focus on improving the wellbeing of people as they age, the VIPAA (drafted by the UN’s assembly on ageing in 1982) recognised that health promotion for older people should focus on promoting activities, initiatives and structures that enhance wellbeing, health, choice, independence, and quality of life for all ages (Commonwealth of Australia, 1999). Drawing from the above basis of understanding, the overarching aim of the healthy ageing theme in the NSAA, was to examine measures that over a person’s lifetime enhance quality of life and improve life expectancy. Consequently, the Healthy Ageing Discussion Paper informing the NSAA, primarily focused on health promotion and illness prevention issues and strategies from a population health perspective (Commonwealth of Australia, 1999), that is, one that regards health as a positive concept rather than simply the absence of disease with emphasis placed on the social determinants involved in health (Frankish, Green, Ratner, Chomik, & Larsen, 1996; Public Health Agency of Canada, 2012).

In policy terms, healthy ageing is considered an individual, community, public, and private sector approach to ageing that aims to maintain and improve the physical, emotional and mental wellbeing of older people and which may be affected by many factors including socioeconomic status, social interactions, perceptions, and attitudes (Commonwealth of Australia, 1999; Commonwealth States and Territories, 2000; Prime Minister’s Science Engineering and Innovation Council [PMSEIC], n.d.). Broad in its approach, the concept has been interpreted and defined in various ways. With policy decisions concerning ways to extend quality and length of life, achieving these goals is difficult when there remains confusion as to the nature of the concept itself (Peel et al., 2004). While it is the health related dimension of quality of life implied in a healthy ageing approach that has attracted most attention in regard to health policy development in ageing, due to the discord between definitions and empirical research, confusion about the concept has resulted (Cardona, 2008; Peel et al., 2004). For example, policy documents conceive healthy ageing in positive terms but research has largely been based on more negative aspects such as mortality and disability (Peel et al., 2004). Furthermore, with the terms “successful”, “active”, “productive”, and “positive”, also used to describe various aspects important for enhancing quality of life in older people (Cardona, 2008;
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Peel et al., 2004; Peel et al., 2005), the terms have at times been used synonymously with healthy ageing which has added to the confusion.

Variations in the use of the term healthy ageing in research prompted a review of existing studies that defined and measured healthy ageing as an outcome. The review examined 18 studies between 1985 to 2002 (e.g., (Burke et al., 2001; D. M. Reed et al., 1998)), that covered the prevalence of healthy ageing in population-based samples with the outcome measure including an indicator of health functioning beyond subjective measures of wellbeing such as life satisfaction (Peel et al., 2004). Definitions of healthy ageing ranged from primarily biological (i.e., absence of morbidity) to more comprehensive understandings incorporating the use of the biopsychosocial model in sustaining wellbeing. Results suggested that the arbitrary nature of the definition, the populations sampled, and other aspects of measures employed resulted in considerable variation between studies in terms of those considered “healthy agers” and further prompted the need to establish a standard for defining and quantifying the concept (Peel et al., 2004). It was also proposed that researchers interested in healthy ageing need to shift from outcome measurement and instead focus on aspects of those who are ageing well.

Adjunct to conceptual disparities, some of the assumptions underlying a healthy ageing approach highlight how policy can influence people’s own construction of meaning in ageing and thinking about how they ought to behave (Estes et al., 2009; J. Reed et al., 2004). For example, while a goal of healthy ageing is to provide conditions to allow people to move in a positive direction to improve their health and wellbeing (Commonwealth of Australia, 1999), strategies such as this emphasise notions of responsibility informed by values that position the achievement and maintenance of health as a personal goal achievable by particular lifestyle choices, and typically shadowed by consumption power (Cardona, 2008). This is highlighted by Cardona (2008), who reflects on how the anti-ageing industry, which seeks to benefit from notions of self-management and responsibility for health, echoes goals linked to social policy frameworks and strategies such as healthy ageing policies in their marketing campaigns. Moreover, while healthy ageing is considered to be free from competition with everyone considered a winner if gains are made to individual health (Commonwealth of Australia, 1999), it could be interpreted that such policies assert underlying blame for the health and associated qualities and outcomes in later life directly on the individuals themselves which can minimise the responsibilities of social and political institutions for ensuring health and wellbeing (Cardona, 2008; Holstein & Minkler, 2003). This has been particularly emphasised as an issue within the discipline of public health which has been criticised for not giving enough thought to the structural, social, and economic issues that are central to the theories underpinning social
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determinants of health, which often results in policies built on a philosophy that blames the victim (Estes et al., 2009; Mooney, 2008).

Therefore, promoting healthy ageing currently involves developing evidence in relation to the outcomes of healthy ageing including, the motivational factors needed to ensure engagement in activities that result in healthy ageing, determining the effectiveness of preventative health strategies, critiquing the negative myths on ageing and encouraging older adults not currently engaged in healthy lifestyle activities to realise the potential benefits to be gained from participating in such activities (Commonwealth of Australia, 1999). As such, in Australia, healthy ageing primarily continues to refer to specific policies and strategies introduced by the government which prioritise the maintenance of physical and mental health through programs targeting ageing individuals (Cardona, 2008) with most states and territories having local plans and programs in place that have significant health promotional elements (Commonwealth of Australia, 1999). A more critical reflection of promoting health in ageing realises the challenge of also considering outcomes of healthy ageing from the view of health as a resource for everyday life which encourages a more ecological focus considering influential interpersonal, structural and social policy factors (V. W. Marshall & Altpeter, 2005; Sabelli et al., 2003). It is further thought that healthy ageing is best achieved when physical environments and communities are considered safe and support the adoption and maintenance of health promoting behaviours and attitudes (J. E. Lang et al., 2005), and as such these factors need to also be considered when promoting healthy ageing. This next section identifies how healthy ageing has been promoted in the Welsh context as well as in the Western Australian context with a particular focus on the specific political strategies employed by each. Furthermore, to illustrate how healthy ageing policy is being implemented in the community, the program Living Longer Living Stronger (LLLS) in WA (Living Longer Living Stronger COTA, 2012a) provides the primary focus of discussion.

3.4.1 Promoting healthy ageing in Wales, United Kingdom (UK).

Wales has a higher concentration of older people than the rest of the UK with 17% of the population aged over 64 years compared to less than 16% of the total UK population (Welsh Assembly Government, 2005). With changes in age structure over time, there is often a subsequent effect on the proportion of dependant people. In the UK, children (0-15 years) and older adults (aged 65 years and over) are considered dependents (Statistical Directorate: Welsh Assembly Government, 2010). When there is an increase in dependents compared to those considered of working age (15-64 years), there are consequences to the distribution of resources (i.e., pensions and other benefits). In mid-2009, Wales recorded to highest
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proportion of people aged 65 years and over compared to other UK countries resulting in the most dependents in its population (578 per 1,000 persons of working age) (see Table 8).

Table 8
Dependency Ratios by UK Constituent Country, 2009(a)

<table>
<thead>
<tr>
<th>Number per 1,000 persons of working age(b)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>England</td>
</tr>
<tr>
<td>Wales</td>
</tr>
<tr>
<td>Scotland</td>
</tr>
<tr>
<td>Northern Ireland</td>
</tr>
<tr>
<td><strong>United Kingdom</strong></td>
</tr>
</tbody>
</table>

Notes. (a) 2008 mid-year population estimates. (b) Children (0-15 years), Older people (65 years and over). Adapted from (Statistical Directorate: Welsh Assembly Government, 2010).

Further to this, the number of people aged 65 years and over is projected to increase by 55% by 2035 with this increase driven partly by the post-war baby boomers entering the age group (Knowledge and Analytical Services: Welsh Government, 2011) (see Table 9). This demographic shift highlights the importance of investigating ageing issues within a Welsh context and has subsequently prompted ageing policy and program development in recent decades.

Table 9
Projected Population by Age and Median Age, Wales, 2010-2035

<table>
<thead>
<tr>
<th>Age</th>
<th>2010</th>
<th>2025</th>
<th>2035</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 16 (%)</td>
<td>18.2</td>
<td>18.6</td>
<td>17.4</td>
</tr>
<tr>
<td>16-64 (%)</td>
<td>63.2</td>
<td>58.6</td>
<td>57.0</td>
</tr>
<tr>
<td>65+ (%)</td>
<td>18.6</td>
<td>22.7</td>
<td>25.6</td>
</tr>
<tr>
<td>Median age (Years)</td>
<td>41.5</td>
<td>41.9</td>
<td>43.7</td>
</tr>
</tbody>
</table>

Adapted from (Knowledge and Analytical Services: Welsh Government, 2011).

In 2003, as a response to population ageing in Wales, the first strategy for older people was released. The Strategy for Older People in Wales 2003-2008 was a landmark for Wales and the first of its kind in the UK demonstrating Wales’s commitment to supporting its ageing population (Welsh Assembly Government, 2009b). The strategy was the product of extensive consultation, research and expert views about the lives of older people in Wales relevant to that time and projected for the future (Welsh Assembly Government, 2003). The strategy
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provided an overarching framework within which health promoting policies and programs for older adults were to be developed (Welsh Assembly Government, 2005). The strategy recognised that future policies and programs in Wales must reflect the needs of an ageing society and that there was a need to improve the quality, quantity and responsiveness of services for older people. The aims and objectives of the strategy specifically reflected the findings of the report of the Advisory Group ‘When I’m 64… and more’ (i.e., social inclusion, health promotion) (Welsh Assembly Government, 2002), as well as embracing the UN Principles for Older Persons (i.e., participation, self-fulfilment, dignity) (United Nations, 1991; Welsh Assembly Government, 2003). In particular, the strategy recognised the social and economic determinants of health and wellbeing and supported the promotion of active and healthy ageing. This strategy and other significant developments relevant to ageing in Wales are outlined in Table 10, with subsequent developments of particular relevance to healthy ageing reviewed in further detail below.

Table 10
Timeline of Ageing Policy Development in Wales

<table>
<thead>
<tr>
<th>Significant developments</th>
<th>Year</th>
<th>Associated outcomes of developments</th>
</tr>
</thead>
<tbody>
<tr>
<td>When I’m 64......and More: The Report from the Advisory Group on a Strategy for Older People in Wales</td>
<td>2002</td>
<td></td>
</tr>
<tr>
<td>Strategy for Older People in Wales 2003-2008</td>
<td>2003</td>
<td></td>
</tr>
<tr>
<td>Commissioner for Older People (Wales) Act 2006</td>
<td>2006</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2007</td>
<td>Healthy Ageing Action Plan for Wales</td>
</tr>
<tr>
<td>Strategy for Older People in Wales 2008-2013 – Living Longer, Living Better</td>
<td>2008</td>
<td>Appointment of the first Older Peoples Commissioner for Wales (Ruth Marks)</td>
</tr>
</tbody>
</table>

In 2005, as a response to the Strategy for Older People in Wales 2003-2008 emphasis on promoting a healthy ageing approach in future policy developments, a Healthy Ageing Action Plan for Wales was introduced to help clarify the scope of this element of the strategy (Welsh Assembly Government, 2005). Specifically, the need for the Welsh Assembly Government to develop a coherent and effective approach to health promotion and to policy...
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development for older people, taking into account issues from diverse areas such as health
and local government, was identified. One component of the action plan was to maintain
existing programs and develop new initiatives that increase opportunities and support for
older people to lead healthy lives with particular reference to physical activity; healthy eating;
emotional health and wellbeing; alcohol; sexual health; smoking; and health protection and
safety promotion (Welsh Assembly Government, 2005). Furthermore, in the same year that
the Strategy for Older People in Wales 2003-2008 was launched, an advisory group of people
with a particular understanding of how an Older People’s Commissioner might work in practice
resulted in the Commissioner for Older People (Wales) Act 2006 (The National Archives, 2006).
Based on recommendations put forward by the Act (Welsh Assembly Government, 2004), in
2008 the first Older People’s Commissioner for Wales was appointed (Welsh Government,

Also in 2008, the Welsh Assembly Government outlined the key strategic objectives for
the second five years (2008-2013) of the original ten year strategy (Welsh Assembly
Government, 2008). This second phase of the strategy - Living Longer, Living Better followed
an independent review in 2007 outlining the progress and achievements to date from the first
phase of the strategy and set the priorities for the future (Welsh Assembly Government, 2007).
Of relevance to the original theme - health, wellbeing and independence in the first phase of
the Strategy, the broad category healthy ageing was reviewed. The review concluded that the
Healthy Ageing Action Plan was successful in raising the profile of health promotion initiatives
for older people but that there needed to be further review to resolve what worked in order to

Following the review of the Strategy for Older People in Wales 2003-2008, the second
phase of the Strategy - the Strategy for Older People in Wales 2008-2013 - Living Longer, Living
Better, was released in 2008 (Welsh Assembly Government, 2008). Four themes made up the
focus of the Strategy, each associated with the broader strategic aims. The four themes
included valuing older people - maintaining and developing engagement; changing society -
the economic status and contribution of older people; wellbeing and independence; and
making it happen - the implementation of the strategy (Welsh Assembly Government, 2008).
Promotion of healthy ageing under the theme wellbeing and independence, continued to
present as a priority, particularly through the implementation of relevant policies and
programs. With prevention considered at the heart of the Healthy Ageing Action Plan (2005)
(Welsh Assembly Government, 2005), healthy ageing activities that are of specific benefit to
older people addressing issues such as physical activity, healthy eating and emotional health
Exploring the Lived Experience of Ageing and wellbeing, were again highlighted as priority areas (Welsh Assembly Government, 2008). Monitoring reports since the implementation of this strategy indicate that health promotion initiatives may be having a positive influence on older adults’ health behaviours as evidenced by self-reported feedback from older adults about their own wellbeing. For example, respondents placing importance on a healthy diet in maintaining good health and claiming to eat healthily as a result of increased awareness about these aspects of health (Welsh Assembly Government, 2009a).

3.4.2 Promoting healthy ageing in Western Australia (WA).

With all states in Australia experiencing growth in their populations aged 65 years and over, WA was amongst those that experienced the highest growth with a 3.6% increase in the number of persons over 65 years (and a 5.9% increase in the number of people aged 85 years and over) in the 12 months to 30 June 2010 (see Table 11) (Australian Bureau of Statistics, 2010a, 2010b). In June 2010, 12.1% of WA’s population was aged over 65 years of age (Australian Bureau of Statistics, 2011) and by 2031, one quarter of WA’s population is expected to be aged 60 years or over (Western Australia Office for Seniors’ Interests and Volunteering, 2004). This demographic shift highlights the importance of investigating ageing issues within a Western Australian context and has promoted policy and service planning in all areas of government.
Table 11

*Experienced Growth(a) in Population for People Aged 65 Years and Over by State, Australia, 2010(b)*

<table>
<thead>
<tr>
<th>State</th>
<th>Experienced growth for those aged 65 years and over</th>
<th>Median age (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Territory (NT)</td>
<td>7.2%</td>
<td>31.3</td>
</tr>
<tr>
<td>Australian Capital Territory (ACT)</td>
<td>4.2%</td>
<td>34.7</td>
</tr>
<tr>
<td>Queensland (Qld)</td>
<td>4.0%</td>
<td>36.2</td>
</tr>
<tr>
<td><strong>Western Australia (WA)</strong></td>
<td><strong>3.6%</strong></td>
<td><strong>36.2</strong></td>
</tr>
<tr>
<td>South Australia (SA)</td>
<td>-</td>
<td>39.2</td>
</tr>
<tr>
<td>Tasmania (Tas)</td>
<td>-</td>
<td>39.9</td>
</tr>
<tr>
<td>Victoria (VIC)</td>
<td>-</td>
<td>36.9</td>
</tr>
<tr>
<td>New South Wales (NSW)</td>
<td>-</td>
<td>37.2</td>
</tr>
<tr>
<td><strong>Australia</strong></td>
<td><strong>3.3%</strong></td>
<td><strong>36.8</strong></td>
</tr>
</tbody>
</table>

Notes. (a) Only those states that experienced the highest growth were recorded. (b) 12 months to 30 June 2010. Adapted from (Australian Bureau of Statistics, 2010b).

In line with the WHO policy framework and definition of active ageing emphasising the concepts of prevention and promotion, to address population ageing in WA, the State Government established an *Active Ageing Taskforce* in 2002 to develop a relevant framework that would specifically guide and promote active and visible participation of older Western Australians (Office for Seniors Interests and Volunteering, 2006, n.d.). The framework also aimed to change the community’s negative attitudes towards ageing and encourage government departments and the broader community to work together to maximise the benefits of ageing and individual and community wellbeing (Office for Seniors Interests and Volunteering, 2006). The *Active Ageing Framework* and other significant policy developments relevant to ageing in WA are outlined in Table 12, with subsequent developments reviewed in further detail next.
Table 12

<table>
<thead>
<tr>
<th>Significant developments</th>
<th>Year</th>
<th>Associated outcomes of developments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Ageing Taskforce</td>
<td>2002</td>
<td>Generations Together: The Western Australian Active Ageing Strategy</td>
</tr>
<tr>
<td></td>
<td>2004</td>
<td>State Aged Care Plan of Western Australia 2003-2008</td>
</tr>
<tr>
<td></td>
<td>n.d.</td>
<td></td>
</tr>
</tbody>
</table>

In 2004, to provide some strategic direction in response to the taskforce, the State Government released *Generations Together: The Western Australian Active Ageing Strategy* (Office for Seniors Interests and Volunteering, 2006; Western Australia Office for Seniors' Interests and Volunteering, 2004). To measure WA’s progress toward achieving active ageing, the Office for Seniors Interests and Volunteering was funded to develop an *Active Ageing Scorecard* to report on community indicators of active ageing (Office for Seniors Interests and Volunteering, n.d.). These indicators were developed to assess priority areas of action highlighted in *Generations Together* including, health and wellbeing; community attitudes; community and social participation; employment and learning; accessibility; and protection and security (Office for Seniors Interests and Volunteering, 2006). Census data and community surveys\(^2\) provided the main data sources for analysis and findings indicated that policies and strategies were particularly required to address some areas further including: the health and wellbeing of Indigenous people; increasing involvement in physical activities, particularly for females; improving social participation of seniors, especially males; improving financial security; and improving community attitudes towards ageing among the general community and seniors themselves (Office for Seniors Interests and Volunteering, 2006, n.d.).

Another key local government strategy during this time was the *State Aged Care Plan of Western Australia 2003-2008* (WA Aged Care Advisory Council, 2003). Providing a strategic framework for age related action plans, the plan focused on the wellbeing and quality of life for older people through responsive health and aged care supports and services. A particular objective of the plan was to ensure older people are valued. A strategy for achieving this was to encourage social and political recognition of older people’s experiences and expectations.

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\(^2\) Only one Australian Bureau of Statistics (ABS) national population survey collects data from people living in residential aged care reflecting the methodological difficulties associated with data collection in this population which particularly limits reporting capabilities on the health of older people since almost one-quarter of the very oldest age group are excluded from data collection (Australian Institute of Health and Welfare, 2007).
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(WA Aged Care Advisory Council, 2003). This highlights the importance and relevance of talking to older adults about their own experiences of ageing. Furthermore, under the key priority of health and wellbeing outlined in the Active Ageing Strategy, a holistic view of health was incorporated with an emphasis on resources for the retention of good health and prevention of illness - particularly the promotion of personal, social and environmental facilitators of wellbeing (Office for Seniors Interests and Volunteering, n.d.). In an attempt to further promote healthy ageing, it was again recognised that a first step involves asking older people about their experiences whether it be involvement in programs aimed at promoting healthy ageing or getting older adults’ views on aspects of healthy ageing important to them.

In response to the national policies and strategies addressing population ageing in Australia, local government action plans have also resulted which complement national plans, but also focus on local needs of the State in regard to ageing issues (Office for Seniors Interests and Volunteering, 2006, n.d.; WA Aged Care Advisory Council, 2003; Western Australia Office for Seniors' Interests and Volunteering, 2004). Like the Australian Government, the State Government also recognises that age related policy frameworks must be supported by a research and evidence base (Australian Institute of Health and Welfare, 2007). Strategies and plans developed by the WA State Government have particularly focussed on the need to adopt a holistic focus on health in ageing and the need to first recognise older adults’ own experiences and expectations of ageing and health, and in particular healthy ageing (Bartlett, 2003). Consequently, this current research aims to address these needs by exploring the experience of ageing for older adults in WA as well as exploring the experiences of those involved in a healthy ageing program. One key initiative to result from the priority area of health and wellbeing in the Active Ageing Strategy funded under existing resources with key agency involvement from the Department of Health and the Office for Seniors Interests and Volunteering, was the Living Longer, Living Stronger (LLLS) program (Office for Seniors Interests and Volunteering, n.d.). As this program evolved through the strategy, and is a key example of a healthy ageing program in WA, the background to the implementation of this program provides the focus of discussion in the next section.

3.4.3 The Living Longer Living Stronger (LLLS) program.

The LLLS program is a recent example of a program designed to promote healthy ageing by primarily focussing on the physical health of older adults in WA (Living Longer Living Stronger COTA, 2012a). In 2004, the Council on the Ageing (WA) Inc (COTA(WA)) launched the LLLS program with the aim of increasing the range and quality of strength training opportunities for people over 50 years of age (Living Longer Living Stronger COTA, 2012b;
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Newton, n.d.). The program is a research based progressive strength training program that encourages and supports changes in the health and fitness sectors and is supportive of a preventative approach to healthy ageing. Broader aims of the program include the achievement of outcomes of improved health, quality of life and fitness (Living Longer Living Stronger COTA, 2012a). An investigation into the efficacy of the LLLS program as implemented in WA after six months participation in the program showed that participants recorded improvements in quality of life, perception of health, fear of falling, muscle strength, balance, and performance of tasks of daily living (using measures such as the one repetition maximum test [1-RM] to test Neuromuscular Strength) (Newton, n.d.). Bound within the context of a health perspective, participants’ perceptions of their psychological health and wellbeing were also quantifiably recorded with particularly significant improvements recorded in general health, mental health and vitality for both men and women (using measure such as the Medical Outcome Short Form [36] Health Survey [SF36])(Newton, n.d.).

In summary, the primary focus of the LLLS program is the improvement and maintenance of physical health for older adults. While physical health is certainly an important aspect in the ageing process, a wellness framework considers health more holistically by recognising the importance and impact of a person’s ecology on their health (McMahon et al., 2010; National Wellness Institute, n.d.; Pettit & Peabody, 2008; Prilleltensky et al., 2001). This approach acknowledges that health also incorporates psychological and social factors that are mediated by power differentials and opportunities to develop basic human needs (Gordon, 2006; Larson, 1999; Prilleltensky et al., 2001). It is significant that the older adults involved in the LLLS program have taken an interest in their own ageing process by voluntarily becoming involved in a healthy ageing program that primarily focuses on improving their health and preventing future health problems. This provides a unique opportunity to explore the experience of ageing for those who have taken an interest in their own ageing process by deciding to be involved in a healthy ageing program. It also offers the opportunity to explore the motivations and challenges to staying engaged in programs like LLLS, with this information critical to informing future policy development and service delivery.

3.5 Conclusions

In response to current concerns relating to adequately servicing the needs of an ageing population, recent local, national and international plans, strategies and research agendas have highlighted the need to investigate aspects of healthy ageing and preventative approaches to health (Cardona, 2008; Commonwealth of Australia, 1999; Commonwealth
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States and Territories, 2000; Gordon, 2006; J. E. Lang et al., 2005; V. W. Marshall & Altpeter, 2005; Peel et al., 2004; Prime Minister’s Science Engineering and Innovation Council [PMSEIC], n.d.; D. M. Reed et al., 1998; Schmidt, 1994; U.S. Department of Health and Human Services, 2000; Welsh Assembly Government, 2003, 2005, 2008, 2009b). Furthermore, it is important to acknowledge the current trends in policy and program development particularly knowing the role of policy in influencing social constructions of ageing, and acknowledgment that systemic factors such as government policy can affect the individual ageing experience (Bernard & Scharf, 2007; Estes et al., 2009; Gordon, 2006; Holstein & Minkler, 2007; Larson, 1999; Prilleltensky et al., 2001). Given the increase and projected future increase in the number of older adults in the Western Australian community and the Welsh community, exploring the contemporary lived experience of ageing in these contexts is of particular relevance. Moreover, talking to older adults involved in a healthy ageing program offers a unique opportunity to develop insight into how older adults who have been, or are currently participating in a healthy ageing program in WA perceive their own ageing process. This also offers an opportunity to investigate whether those involved in a healthy ageing program socially construct and experience ageing differently from older adults with no involvement in a healthy ageing program. As well as being responsive to current political and research agendas, this information adds to current understandings about healthy ageing and has implications for future interventions and service delivery models by challenging current assumptions surrounding a healthy ageing approach to policy and practice. The next chapter articulates the aims and questions of this current research as well as outlines the philosophical and methodological decisions underlying the research process.
Chapter 4: Methodology

This chapter outlines the philosophical and methodological decisions underlying the process and implementation of this research. Specifically, phenomenological and social constructionist frameworks are reviewed and discussed in reference to how they have informed the current research. This leads to an introduction about the research design and the qualitative methodology undertaken in this research followed by an outline of the research aims and questions. A description of how data were collected including the procedures for recruitment of all participant groups and information about the instrument used to collect data are then discussed. Background information about the local context – the City of Joondalup, WA and information about the international context – Wales, UK is also presented. The interview and debriefing procedures for all groups are reviewed followed by a discussion on additional ethical considerations including consequences of this research and the role of the researcher. This chapter concludes by identifying the various data validation strategies employed to ensure the rigour, dependability, credibility, confirmability and transferability of this research. How the data were analysed including information on the following phases of thematic development: getting familiar with the data; generating initial codes; searching for themes; reviewing themes, defining and naming themes; and producing a report are also reviewed.

4.1 Conceptualising methodology

Methodology refers to the way in which problems are approached, and specific to the social sciences, how research is conducted with assumptions and interests shaping the methodology chosen to answer questions relevant to the identified problem (Gelo et al., 2008; Taylor & Bogdan, 1998). Consequently, there is much debate regarding the criteria of knowledge and the subsequent decisions regarding appropriate methodological decisions (Chamberlain, 2000; Chwalisz et al., 2008; Corbin & Strauss, 2008; Gelo et al., 2008; Majima & Moore, 2009; Taylor & Bogdan, 1998). Of particular interest is the quantitative-qualitative relationship (Chamberlain, 2000; Corbin & Strauss, 2008; Denzin & Lincoln, 1994; Jovanović, 2011; Karpatschof, 2007; Kinn & Curzio, 2005; Majima & Moore, 2009; Patton, 1990, 2002;Valsiner, 2006). The overwhelming valuing of methodology whereby researchers place much weight on finding the “right” or “proper” method to conduct their research has been termed, “methodolatry”, which often leads to an oversimplification of what constitutes certain methodologies (Chamberlain, 2000; Janesick, 1994; Jovanović, 2011). For example, considering qualitative research as an additional method to quantitative methods by suggesting it adds a
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depth or context to the main findings, leads to the assumption that anything not statistical must be qualitative (Bartunek & Seo, 2002; Chamberlain, 2000) and also implies that qualitative methods are not a legitimate in their own right (Chamberlain, 2000; Creswell, 2007; Karpatschof, 2007; Kinn & Curzio, 2005). Regardless of the debate surrounding the choice and use of quantitative or qualitative methodology, what is widely agreed is that the decision be based on employing a method appropriate to investigate the research question (Chamberlain, 2000; Corbin & Strauss, 2008; Gelo et al., 2008; Grbich, 2007; Liamputtong, 2009b; Valsiner, 2006). With acknowledgement that there are many different and functional ways to explore a research question, the focus then turns to the philosophical assumptions that guide and direct a researcher to an appropriate method.

Behind the conceptualisation of method lies one’s philosophical position which is predominantly shaped by personal experiences and historical influences including exposure to the dominant discourse operating in a researcher’s own field of work. In psychology there is a strong positivist and empiricist history still carried forward today (Chamberlain, 2000; Gelo et al., 2008; Polkinghorne, 2005). A traditional empirical approach to research is characterised by specific philosophical foundations that claim experiences to be objective truths that are confirmed or challenged through the analysis of causal relationships between variables (Chamberlain, 2000; Creswell, 1994, 2003; Denzin & Lincoln, 1994; Gelo et al., 2008; Gergen, 1985; Gilbert & Irons, 2005). This is represented by most quantitative research, which emphasises objective measurement (Chamberlain, 2000; Gelo et al., 2008; Hempel, 2005). A more rationalist approach to research is embedded in postmodern thought whereby there is movement from describing what currently exists to participating actively in the interpretive process of meaning (Gergen, 2001). The aim is not to solely increase the objective validity of constructions of meaning, but rather, by considering reality as socially and psychologically constructed, the aim becomes exploring and increasing sensitivity to finer detail (Corbin & Strauss, 2008; Gelo et al., 2008; Gergen, 1985). This allows constructions of experiences to be considered within the context of wider political, social, and practical considerations (Corbin & Strauss, 2008; Gergen, 1985) with research of this nature generally presenting itself in the form of qualitative methodologies (Gelo et al., 2008).

The growth of qualitative research in the social sciences has challenged the way in which knowledge constitution is considered and subsequently now represents a legitimate mode of social and human science exploration without apology or comparisons to quantitative research (Corbin & Strauss, 2008; Creswell, 2007). Rather than focussing on the dualism inherent in the debate between empiricist and rationalist schools of thought, qualitative
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research aims to place knowledge within the process of social interchange (Chwalisz et al., 2008; Corbin & Strauss, 2008; Gelo et al., 2008; Gergen, 1985). As Psychology considers the complex subject matter of human life, the interconnections between different forms of knowledge depends on interpretive systems which express these interconnections (Stenner, 2009). For this reason, qualitative methodology involves exploring the complex interactions of factors rather than testing them for cause and effect (Chwalisz et al., 2008; Corbin & Strauss, 2008) and the interest of the qualitative researcher is to provide opportunity to address questions that are difficult to address with more traditional quantitative methods (Corbin & Strauss, 2008).

Thus, notwithstanding one’s approach to research, good research requires making one’s philosophical, paradigmatic and interpretative assumptions explicit and acknowledging the ways these assumptions can influence the conduct of inquiry (Creswell, 2007). By first working through one’s ontological (i.e., beliefs about the nature of reality or when something is considered “real”), epistemological (i.e., what a science knows about reality and how researchers know it) and axiological (i.e., the role of values in research) assumptions (Chwalisz et al., 2008; Corbin & Strauss, 2008; Creswell, 2007; Grbich, 2007), the researcher’s theoretical perspective and subsequent methodological decisions naturally follow (Chamberlain, 2000; Corbin & Strauss, 2008; Denzin & Lincoln, 2005). Therefore, in considering research questions designed to investigate people’s experiences of a phenomenon such as ageing, an exploratory qualitative approach was considered best suited to adequately investigate such experiences.

4.1.1 Methodological and theoretical paradigms: Perspectives and considerations.

Methodological implications of considering the world in terms of interactions between people and people, and people and meaning, include acknowledging that the world is complex (Corbin & Strauss, 2008). Therefore, any methodology attempting to understand experience and explain certain phenomena will also be complex. Multiple perspectives are required on issues and an acknowledgement that to understand experience is to take into account the larger events located in a social, political and cultural framework (Corbin & Strauss, 2008; Gergen, 1985). To accurately reflect the complexity of the phenomenon under investigation in the current study, two underlying theoretical frameworks informed this research; phenomenology and social constructionist inquiry. The philosophical underpinnings of these two frameworks are discussed in the next section with specific regard to how these positions have informed and directed the current study.
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**Phenomenology.**

Phenomenological theory has influenced qualitative research, particularly within the social sciences (Flood, 2010; Liamputtong & Ezzy, 2005; Zippel, 2010). In the literature, phenomenology is viewed as both a paradigm and a philosophy (Patton, 1990). As the philosophical underpinnings of phenomenology guide the nature and practice of a phenomenological study, it is important to have an understanding of how one relates to the other. Phenomenologists focus on how people put together the phenomena they experience in such a way as to make sense of the world (Creswell, 2007; Flood, 2010; Patton, 1990; Zippel, 2010). It is assumed then that there is no objective reality for people, there is only what they know their experience to be, which ultimately results in that person’s worldview (Patton, 1990; Zippel, 2010). These concepts, central to current understandings of phenomenology and to qualitative research practice have developed over time via the contribution of influential phenomenological philosophers (Flood, 2010; Liamputtong & Ezzy, 2005; Patton, 1990).

Phenomenology as a philosophical tradition first appeared in the works of German philosopher, Edmund H. Husserl (1859-1938) in his book *Ideas 1* (1913) (Grbich, 2007). Husserl asserted phenomenology to mean the study of how people describe things with the assumption that we can only know what we experience by attending to meanings that awaken our conscious awareness (Flood, 2010; Patton, 1990). The idea that meaning is created by the mind and reality needs to be consciously and intentionally interpreted, is referred to as intentionality (Alvesson & Sköldeberg, 2009; Grbich, 2007; Liamputtong, 2009b). Consciousness is considered as being intentional to how an individual thinks about their experience in that it is always intentionally directed at some phenomenon or towards objects (P. Berger & Luckmann, 1967; Grbich, 2007; Liamputtong, 2009b). Phenomenology was originally considered a philosophical questioning about the way to see the world as it is rather than as it is constructed and influenced by social and cultural factors (Caelli, 2000). Based on Husserl’s original thoughts, the idea of seeking to objectively examine the subjective reality of phenomena in our experiences so as to describe unchanging aspects of phenomena and to access descriptions of phenomena in their original form, free from their cultural context as possible, is currently recognised as “European phenomenology” (Barkway, 2001; Caelli, 2000).

The establishment of phenomenology as a philosophical perspective, was extended by Alfred Schutz (1899-1959) (Patton, 1990). Schutz’s interest centred on how people process experience in their everyday lives (Liamputtong & Ezzy, 2005). He believed that by examining “typifications” or classificatory systems in everyday life that develop as a consequence of people in interaction (P. Berger & Luckmann, 1967) allows for the examination of the taken-
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for-grantedness of people’s life world (Liamputtong & Ezzy, 2005). The focus then becomes how members of the social world act upon the objects of their experience that, unlike Husserl’s conceptualisations, are viewed as categorically distinct from actions of perceptions or interpretation (Gubrium & Holstein, 2000). From this perspective, interpretation then also becomes essential to an understanding of experience (Patton, 1990). The fundamental principles underlying this way of understanding phenomenology has been labelled a “North American hybrid” (Barkway, 2001). also termed the “new phenomenology” (Crotty, 1996).

Arising from these philosophical influences, a well-developed phenomenological research tradition aimed at describing the life worlds of individuals has evolved (Creswell, 2007; Flood, 2010). Phenomenological inquiry at its most basic level focuses on examining and describing the meaning for several individuals of their lived experiences of a phenomenon as they are considered the ones best able to describe their experiences (Creswell, 2007; Grbich, 2007; Liamputtong & Ezzy, 2005; Moutsakas, 1994; Patton, 1990). A phenomenological study focuses on descriptions of people’s experience with the underlying assumption being that there is an essence to shared experience, which when bracketed, analysed and compared, core meanings mutually understood through a phenomenon can be identified (Moutsakas, 1994; Patton, 1990). This description includes “what” is experienced and “how” it is experienced (Creswell, 2007; Moutsakas, 1994). It is through this understanding of the lived experiences of individuals that marks phenomenology as a philosophy as well as a research method (Creswell, 2007; Liamputtong, 2009b; Moutsakas, 1994). Therefore, conducting a study with a phenomenological focus (i.e., getting at the essence of the experience of some phenomenon) is considered different from using phenomenology to philosophically justify the methods of qualitative inquiry as legitimate in social science research (Patton, 1990).

The evolution of phenomenology from its philosophical questioning of the nature of reality to its more practical application as a method can be further understood by examining how data is interpreted in phenomenological research. According to European traditions, phenomenology is essentially viewed as a first person experience whereas now, it is more common within the social sciences to see phenomenology considered as the study of other people’s experiences primarily reported in the third person (particularly in the North American context) (Barkway, 2001). Therefore, in the American context, phenomenological questions include thoughts and interpretations of the experiences in the data collection and analysis, which allows for the exploration of experience while in the European tradition pre-reflective experience is sought. Analytically, the American mode tends to focus on describing participants’ everyday lived experiences within the context of culture whether the experience
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has already been reflected upon and interpreted by the person or not rather than searching for the universal or unchanging meaning of experience before reflection as favoured by the European approach (Caelli, 2000). Consequently, the core task becomes understanding the reality of experiences to the person as they engage with the phenomena and so it becomes important to seek understanding within the situated meanings of phenomena rather than the more objective reality of the nature of the phenomenon itself (Caelli, 2000; Flood, 2010; Gubrium & Holstein, 2000). To that end, although each approach claims traditional phenomenological thought as their foundation, the assumptions about the role and place of culture in understanding experiences differ (Crotty, 1996; Paley, 1997; H. Silverman, 1987).

Despite difference in opinion of the use of phenomenology today, there is common ground for some of the philosophical presuppositions. Commonalities include; the study of the lived experience of persons, the consideration of these experiences as being conscious ones (Flood, 2010; van Manen, 1990; Zippel, 2010), the development of describing the essences of these experiences (Flood, 2010; Moutsakas, 1994), and at a broader level, the refusal of the subject – object dichotomy; thus the assumption that the reality of an object is only perceived within the meaning of the experience of an individual (Creswell, 2007; Flood, 2010; Zippel, 2010). Considering all the above, phenomenology can be viewed as being most concerned with the social construction of everyday life emphasising that people’s actions are only understood when they are situated in the routines of everyday interactions in the world (Flood, 2010; Liamputtong & Ezzy, 2005). Importantly, a person’s actions are considered in reference to their conscious intentions, the taken for granted assumptions about their life and the typification or categories of understandings that people develop (Liamputtong & Ezzy, 2005).

Therefore, phenomenology in philosophical terms posits the nature of how reality comes to be understood and experienced (Caelli, 2000; Flood, 2010; Grbich, 2007; Liamputtong, 2009b; Liamputtong & Ezzy, 2005; Patton, 1990). As an approach to research or as a methodology, its primary focus is on how to investigate the experience of a phenomena and the lived experiences of a phenomenon for those who have experience with it (Barkway, 2001; Creswell, 2007; Liamputtong & Ezzy, 2005; Moutsakas, 1994; Patton, 1990). This understanding of phenomenology aligns with the purpose of the current research which aims to explore the experience of ageing focusing on the context people live in to aid understandings about how meaning about ageing and healthy ageing is determined (Creswell, 2007; Flood, 2010). For this reason, the interest of phenomenology to this research is in gaining an understanding of how older adults experience the phenomena of ageing. Of particular interest is how participants’ interactions in the world influence their experiences. As
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such, how participants socially construct their experiences becomes an important focus. Consequently, the philosophical underpinnings of a social constructionist approach to research is discussed in the next section with particular reference to how this approach has informed the current research.

**Social constructionism.**

Any discussion involving social constructionism should also consider social constructivism (Gergen, 1985). While the two epistemologies are often used interchangeably in the literature due to their common interest in addressing ways in which social phenomena develops, the two perspectives are distinct in their interpretation of how meaning is construed by individuals (Gergen, 2011; Gubrium & Holstein, 2000). The epistemological concern of both approaches asserts that we do not find or discover knowledge so much as construct or make it and that we invent concepts and models so as to make sense of experience and continue to modify these constructions in light of new experiences (Corbin & Strauss, 2008; Creswell, 2007; Gergen, 2011; Gubrium & Holstein, 2000). From the constructivist worldview, individuals make meaning of knowledge within a social context by their construction and interpretation as conscious (and self-conscious) human beings (Barkway, 2001; Chwalisz et al., 2008). The focus of this perspective is therefore on the individual as a proactive co-creator of their reality and is suggestive of the idea that no meaningful reality exists independent of consciousness (Barkway, 2001). With constructionist thought, meaning is not primarily constructed by individual persons as they encounter phenomenon but rather it is socially constructed or comes into being out of human interaction (Alvesson & Sköldberg, 2009; Barkway, 2001; Gergen, 1985, 2011). From this position, it is thought that we are born into a world of meaning with an emphasis placed on the role of culture in shaping how we view and feel things (Barkway, 2001; Gubrium & Holstein, 2000). With the later approach recognising the role of culture and human interaction in shaping meaning, it allows for more critical thought and reflection of the way in which certain phenomena develop relative to social contexts (Barkway, 2001; Gergen, 2011).

Social constructionist inquiry therefore presents a move away from traditional positivist psychological concepts that claim an objectively knowable world, (through observation, prediction and control) (Gergen, 1985, 2001) and focuses on explicating the processes by which people come to describe and account for the world in which they live (Alvesson & Sköldberg, 2009; Gergen, 1985, 2011). As such, the nature of this inquiry assumes that knowledge is constructed not discovered by the mind and reality is reflected in a contextualised way (Alvesson & Sköldberg, 2009; Schwandt, 2003). This position then
Exploring the Lived Experience of Ageing considers a person’s own processes as well as the constraints over understanding engendered by linguistic conventions that categorise the world and bring phenomena into sight (Gergen, 1985; Talja, Tuominen, & Savolainen, 2004).

Critics of the constructionist position have questioned its strong emphasis on subjectivity and relativism (Giarmo, 1997; P. Marshall, Kelder, & Perry, 2005; Michael, 1996). The goal of social constructionist inquiry is not to suggest that a “real” world or knowledge cannot exist but rather it is subject to change based on where it is historically and culturally situated (P. Berger & Luckmann, 1967, 1991; Gergen, 1985). Having its roots in dialogic theories and language philosophy (Semin, 1990; Stenner, 2009; Talja et al., 2004), critics have also challenged the constructionist position for its strong focus on the linguistic processes and elements of human life (P. Marshall et al., 2005; Michael, 1996; Talja et al., 2004). However, from an ontological viewpoint, social constructions are seen as constituted through other interactions with the world not solely linguistic but rather the process for understanding is the result of persons in relationship (Alvesson & Sköldberg, 2009; P. Berger & Luckmann, 1991; Edwards, 1997). This also takes into consideration interactions with organisations, and economic and ecological structures as well as incorporating historically situated interchanges among people (Alvesson & Sköldberg, 2009; Gergen, 1985; P. Marshall et al., 2005; Talja et al., 2004). Consequently, as reality is considered constructed socially, primarily through the person in relationships and the structure of human interaction, it is proposed that multiple realities can exist with no one view being privileged (Gergen, 1985; P. Marshall et al., 2005; Taylor & Bogdan, 1998).

Therefore, employing a social constructionist perspective directs attention to the social, moral, political, and economic institutions that sustain and support current assumptions and allows for the diversity of conceptions of psychological process from one culture to another to be recognised and explored (Gergen, 1985, 2011; P. Marshall et al., 2005). Subsequently, the goal of research underpinned by such assumptions is to understand how the participants’ worlds and experiences are constructed (Barkway, 2001; Chwalisz et al., 2008; Gergen, 2011; Stenner, 2009), relying as much as possible on participants’ views of a given phenomenon and acknowledging that these subjective meanings are often negotiated socially and historically (P. Berger & Luckmann, 1991; Creswell, 2007; Taylor & Bogdan, 1998). Also of significance is the relationship between the researcher and participant and the interaction between the two through which meaning of the phenomenon in question emerges (Ponterotto, 2005) (for further information, see sections within this chapter: 4.3.2 Role of the researcher and 4.4 Qualitative research and appropriate data validation strategies). If we are
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to give older adults “a voice” (Rappaport, 1995) to discuss their own experiences of ageing, it
seems appropriate that a social constructionist approach be employed to inform this
exploratory process, especially considering that it encourages the challenging of assumptions
about how meaning is formed (Alvesson & Sköldberg, 2009; Gergen, 1985, 2011).

Considering the theoretical underpinnings of a social constructionist and
phenomenological approach as applied to the current research allows for description of
everyday experience from within the life-world of the person experiencing it and examines
understandings as evolving through social processes rather than through empirical validity
Liamputtong & Ezzy, 2005; Taylor & Bogdan, 1998). Consistent with such an approach, the
current research was designed to allow participants’ experiences to be explored and
interpreted. The next section discusses the process undertaken to construct an appropriate
research design and methodology including the collection of data; recruitment of participants;
procedures for conducting the study; instruments used; ethical considerations; and the role of
the researcher in the research process.

4.2 Research Design

4.2.1 Qualitative Methodology.
Historically, the definition of qualitative methodology has evolved over time (Creswell,
2007; Denzin & Lincoln, 1994, 2000, 2005) to include an emphasis on the “process” of research
(i.e., as flowing from philosophical and theoretical assumptions) (Creswell, 2007; Denzin &
Lincoln, 2008). Typically, qualitative research has a deep involvement in issues of culture and
marginalised groups, which can often make topics emotion laden, close to people, and of a
practical nature (Creswell, 2007) and exploratory questions suitable as the base for qualitative
inquiry are often used when existing research in the area is contradictory, confusing or not
moving forward and when the topic under investigation is highly complex (Elliott & Timulak,
2005). As such, to study these types of issues, open-ended research questions are required
which means that participants guide and direct the research as data is derived from their own
lived experiences (Corbin & Strauss, 2008). In particular, the explorative nature of a qualitative
approach means it is especially useful for gaining a more holistic account of experience with
emphasis placed on the understanding of relationships within systems and the understanding
of social settings and social process in meaning making (Chwalisz et al., 2008; Corbin & Strauss,
2008; Creswell, 2007; Janesick, 2000) and also allows the researcher to understand the “inner
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experience” of participants to determine how meanings are formed through, and in, context and culture (Chwalisz et al., 2008; Denzin & Lincoln, 2008). A qualitative methodology is thus supportive of the philosophical position of a social constructionist and phenomenological approach to research.

Qualitative inquiry involves the collection and use of a variety of empirical materials (i.e., interviews) that describe moments and meanings in individuals’ lives with a range of interconnected interpretive practices utilised to acquire a better understanding of the subject at hand (Denzin & Lincoln, 2008). Common elements of a qualitative methodology include: the use of a “natural setting” to interview participants (i.e., participants’ own home), use of the researcher as a key instrument (i.e., the researcher collects the data themselves and makes use of self-developed interview schedules), the use of multiple sources of data (i.e., interviews and anecdotal data), the use of inductive data analysis techniques (i.e., going back and forth to build themes) and the use of an emergent design meaning one that is not tightly prescriptive with phases of the process potentially changing and shifting (Creswell, 2007; D. Silverman, 2004). As it is fundamentally an interpretive inquiry, different interpretations across the process are utilised to see how multiple views of an issue can emerge with participants’ meanings kept as the focus for learning the meaning that they hold (Corbin & Strauss, 2008; Creswell, 2007).

Furthermore, the “theoretical lens” of the researcher is important for how information is organised (i.e., around identifying the social, political and/or historical context of the problem under investigation), and gaining a “holistic account” is primarily achieved through the reporting of multiple perspectives and the identification of many factors involved in a situation becomes important (Creswell, 2007; Gelo et al., 2008). This process provides opportunity for the researcher to connect with participants at the human level and facilitates thinking in terms of complex relationships (Creswell, 2007). Multiple sources of information can then be examined moving from the particular to more general perspectives (i.e., themes) and this information can be considered through different forms of analysis (e.g., metaphors, matrix, tables) to convey and reconfigure information (Creswell, 2007; Gelo et al., 2008; Miles & Huberman, 1994). Analysis of data are then presented based on participants’ perspectives as well as on the researcher’s own interpretations (Creswell, 2007).

In review, a qualitative methodology adopts an interpretive, naturalistic approach to the subject matter under investigation and involves making sense of a phenomenon through interpreting the meanings that participants bring to them (Denzin & Lincoln, 1998, 2008; Gelo
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et al., 2008; Patton, 2002). As such, the design of this current study utilised a qualitative methodology to conduct in-depth interviews with purposive samples of participants. As research questions leading to employment of qualitative data collection strategies are often open-ended and exploratory in nature (Elliott & Timulak, 2005), this methodology was preferred and chosen in order to address the following research questions:

1) What are the experiences and social constructions of ageing for older adults over the age of 50 years in the following four contexts?
   a. Participants involved in a healthy ageing program (‘LLLS group’).
   b. Participants who have withdrawn from a healthy ageing program (‘Discontinuing group’).
   c. Participants from a local community sample (‘WA group’).
   d. Participants from an international community sample (‘Welsh group’).

2) How do the experiences and social constructions of ageing for older adults vary across the four group contexts outlined in research question one?

3) What are the experiences of being involved in a healthy ageing program?
   a. What are the challenges and motivations to remaining involved in a healthy ageing program?

To understand how people construct meaning about their own ageing experience, it was necessary that these experiences be investigated from the perspective of older adults themselves. Employing a qualitative approach allowed sensitivity toward individual differences and meant that the interrelations and connections between people’s stories could be explored, which could potentially be overlooked if an alternative method had been chosen (Creswell, 2007). A complex detailed understanding of ageing from older adults’ lived experiences consequently allowed information to be viewed against current theory and policy in the area of ageing. Considering perspectives and experiences of individuals involved in a healthy ageing program has also facilitated examination of policy and service delivery in the healthy ageing sector. Information on how the data were collected for this research including details regarding the research participants and procedures for recruitment is discussed in the next section.

4.2.2 Data collection.

Multiple information sources and methods exist that can be utilised to collect qualitative data (Chwalisz et al., 2008; Patton, 2002). As qualitative inquiry looks for verbal accounts or descriptions in words (Elliott & Timulak, 2005), a key strategy for obtaining data
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includes conversing with other people to learn about their lived world (Creswell, 2007; Kvale & Brinkmann, 2009) using techniques such as conversational interviewing, semi-structured interviewing, and narrative interviewing (Kvale & Brinkmann, 2009; Wengraf, 2001). Qualitative interviews on a general level attempt to understand the world from the participant’s point of view and aim to uncover the meaning of their experiences prior to scientific explanations (Kvale & Brinkmann, 2009; Liamputtong & Ezzy, 2005; Taylor & Bogdan, 1998). More specifically, phenomenological interviewing involves selecting individuals who have experienced a particular phenomenon and asking them to provide data (i.e., through interviews) (Creswell, 2007). The assumption of the interview method is that the specific knowledge, feelings, perceptions and experiences about the social world can be articulated best by the verbal messages provided by participants in their own words (Liamputtong, 2009b). An in-depth interviewing approach was considered the best method to investigate the “essence” of the lived experiences of participants in the current study (Creswell, 2007; Elliott & Timulak, 2005).

Therefore, the decision of an appropriate method becomes primarily dependent on the research questions (Chwalisz et al., 2008; Kvale & Brinkmann, 2009; Patton, 1990, 2002). There were two key experiences of interest in this study: older adults’ experiences and social constructions of ageing and older adults’ experiences of being involved in a healthy ageing program (see Figure 2 for an illustration of outline of data collection). To adequately explore these experiences, a semi-structured interviewing technique, that is, one that provided a set of questions to ask about the topics but also allowed the conversation freedom to vary substantially between participants was adopted (Fylan, 2005; Wengraf, 2001). The choice of a semi-structured interview style was considered most appropriate to investigate these interests and questions as it provided the researcher with the scope needed to explore the phenomenon but also allowed the use of probing questions to elicit more layered responses and descriptions which may have particular interest or relevance to the emergent findings (Chwalisz et al., 2008; Elliott & Timulak, 2005; Fylan, 2005). For this reason, a semi-structured interview style was also well suited to a social constructionist approach. Consequently, the main rationale of the researcher conducting interviews in this way was to explore how people construct and express meaning about their particular experiences and to obtain descriptions of the life world of the participant (Bruner, 1993; Liamputtong, 2009b). In addition, of further interest to the researcher was to elicit information about how participants socially construct meaning about their experiences, which subsequently was reflected in the types of questions
used in the interview schedule (e.g., “What in your life has had the most influence on your thinking about ageing?”) (see Appendix A).

As the process of qualitative research cannot be rigidly codified it requires an intuitive sense of what is going on in the data, and therefore flexibility throughout the process has been fundamental to the current research (Corbin & Strauss, 2008). The use of a semi-structured format allowed flexibility for participants’ stories and experiences to guide the interview to become active participants in the process rather than respondents to a fixed criterion of questioning (Chwalisz et al., 2008; Elliott & Timulak, 2005; Polkinghorne, 2005). Obtaining knowledge and understanding of a phenomena in this way allows for greater detail and allows consideration of the wider context of experience which is important when dealing with complex values and emotions about a topic (Miles & Huberman, 1994; Patton, 1990). Therefore, undertaking qualitative research has required the researcher to accept oneself as a research instrument and to recognise that research procedures for this research are not linear but rather iterative, which requires viewing work as provisional and open to modification and

Figure 2. Illustration of outline of data collection.
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negotiation as new knowledge is gathered (Corbin & Strauss, 2008; Easterby-Smith, Golden-Biddle, & Locke, 2008).

In review, the aim of employing a qualitative methodology with a semi-structured interviewing technique for this study was to understand the interpretive process through which older adults experience and come to understand ageing as well as to investigate the motivations and challenges to becoming, and remaining involved in a healthy ageing program. Employing a qualitative methodology allowed for movement away from the reduction of older adults’ experiences of ageing to quantifiable capacities and the pure measurement of outcomes. With the ability of the qualitative interview to probe in-depth considering everything as relative to a person’s construction of the world, and by being principally concerned with deriving meaning from the processes people undergo in order to explain and describe the world and their place in it, allowed for detail that is not amendable to quantification (Corbin & Strauss, 2008; Gergen, 1985; Moutsakas, 1990). Drawing on an inclusive account of participants’ experiences was therefore important to interpreting the meaning of the described phenomena (Kvale & Brinkmann, 2009; Liamputtong, 2009b; Polkinghorne, 2005) and employing a semi-structured interview style for all components of the study allowed the detail and description discussed by participants to emerge (Denzin & Lincoln, 1994; Miles & Huberman, 1994) facilitating a fuller understanding and appreciation of the issues arising from their responses (Breakwell, Hammond, & Fife-Schaw, 1995).

Information relating to participant groups, specific detail about the development and use of the interview schedules, and other relevant procedural information is discussed in the next section.

4.2.3 Participants.

It is essential when looking to understand the experiences of individuals about a given phenomenon, that those who have the relevant experience be selected to provide this information (Polkinghorne, 2005). Consequently, to investigate the lived experiences of ageing, 59 older adults 50 years of age and over participated in this study. Given the age requirement for entry into the LLLS program was from 50 years with no age limit the other side of 50 years, the recruitment age of participants for the other sample groups of the research were kept consistent with this. Furthermore, given that a majority of policy documentation addressing ageing issues across the different contexts of this study relate to older adults aged 50 years and over (Commonwealth of Australia, 1999, 2001; Council on the Ageing Australia, n.d.-a, n.d.-b; Council on the Ageing WA, 2012a, 2012b; Living Longer Living Stronger COTA, 2012a; Welsh Assembly Government, 2003, 2005, 2008, 2009a), this same age criteria was considered
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appropriate for use in this research. Subsequently, across all four participant groups, the age of participants ranged from 50 years to 89 years with 23 males and 36 females. The 59 participants were divided across four groups as determined by research question one:

1) What are the experiences and social constructions of ageing for older adults over the age of 50 years in the following four contexts?
   a. Participants involved in a healthy ageing program (‘LLLS group’).
   b. Participants who have withdrawn from a healthy ageing program (‘Discontinuing group’).
   c. Participants from a local community sample (‘WA group’).
   d. Participants from an international community sample (‘Welsh group’).

All groups of participants comprised mixed gender samples with numbers in each group dependant on the response order during recruitment (see procedure section for further information). There were 17 participants in the ‘LLLS group’ and 12 participants in the ‘Discontinuing group’, while the community sample from WA, the ‘WA group,’ and the community sample from Wales, the ‘Welsh group’ both comprised 15 participants (see Table 13). Involvement from all participants was voluntary with consent sought prior to participation in the study (see the sections within this chapter: 4.2.5 Procedure and 4.2.6 Interview procedures, for further information).
Table 13

**Group Descriptions and Recruitment Details**

<table>
<thead>
<tr>
<th>Participant group</th>
<th><strong>LLLS group</strong></th>
<th><strong>Discontinuing group</strong></th>
<th><strong>WA group</strong></th>
<th><strong>Welsh group</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>Healthy ageing sample recruited through the Living Longer Living Stronger program</td>
<td>Healthy ageing sample recruited through the Living Longer Living Stronger program</td>
<td>General community sample recruited in Perth, WA</td>
<td>General community sample recruited in Barry, Wales</td>
</tr>
<tr>
<td><strong>Selection method</strong></td>
<td>Purposefully selected based on their engagement in a healthy ageing program</td>
<td>Purposefully selected based on their withdrawal from a healthy ageing program</td>
<td>Purposefully selected to complement data (within a local context)</td>
<td>Purposefully selected to complement data (within an international context)</td>
</tr>
<tr>
<td><strong>Number of participants</strong></td>
<td>17</td>
<td>12</td>
<td>15</td>
<td>15</td>
</tr>
</tbody>
</table>

Qualitative research typically tries to sample broadly enough that all aspects and variations of the studied phenomenon are captured in the sample based on a criterion of saturation; meaning that adding new cases to the point of diminishing returns, when no new information emerges (Elliott & Timulak, 2005). To satisfy the saturation criterion, a common sampling strategy used is purposeful sampling (Elliott & Timulak, 2005; Liamputtong & Ezzy, 2005; Patton, 1990). Purposive sampling requires selection of information rich cases for study in-depth in order to examine meanings, interpretations and processes undergone by a sample of participants from whom the researcher can learn the most about the issue(s) of central importance to the purpose of the research (Liamputtong & Ezzy, 2005; Patton, 1990; Wengraf, 2001). Therefore, all participants were recruited through purposeful sampling strategies as the study aimed to depict central, important aspects of the investigated phenomenon. This type of sampling allowed flexibility ranging from sampling from a maximum variation to focussing in-depth on single exceptional cases (Easterby-Smith et al., 2008; Elliott & Timulak, 2005; Miles & Huberman, 1994).

As the aim of qualitative research is to describe the processes involved in a phenomenon rather than its distribution, the size of the samples used for all groups, depended on the number of cases needed to provide a full, refined and deeper understanding of the
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phenomenon (Liamputtong & Ezzy, 2005). Therefore, the emphasis of data collection was on proximity to the life worlds of participants rather than on quantity of data (Easterby-Smith et al., 2008). It is important to note that in the interest of the ethical treatment of participants, all respondents of each group were interviewed (i.e., no one who responded during the recruitment period was declined the opportunity of an interview). This also meant that follow-up recruitment within each group was deemed unnecessary due to the depth of responses resulting from the first recruitment period. Detail regarding the recruitment of each group in this study is provided in the procedure section, which follows this next section relating to information on the instrument used to collect interview data for this research.

4.2.4 Instrument.

A different semi-structured interview schedule containing open-ended questions was designed and utilised to address the particular research questions of the study. The first interview schedule (see Appendix A) was designed to address the following research question:

1) What is the experience and social construction of ageing for older adults over the age of 50 years in the following contexts?
   a. Participants involved in a healthy ageing program (‘LLLS group’).
   b. Participants who have withdrawn from a healthy ageing program (‘Discontinuing group’).
   c. Participants from a local community sample (‘WA group’).
   d. Participants from an international community sample (‘Welsh group’).

Example questions from the schedule include “Tell me about your experience of ageing” and “Describe a moment you have experienced that typifies ageing to you?” An additional section was added to the interview schedule for the ‘LLLS group’ and the ‘Discontinuing group’, which included questions aimed at identifying aspects around older adults’ participation in the LLLS program and motivations and challenges surrounding this experience (see Appendix B).

Example questions from this section of the schedule include: “What is your experience of being involved in the LLLS program?” and “What was happening in your life at the time that led you to become involved in the LLLS?”. Consistent with a “funnelling” technique the schedules began generally and became more specific (J. A. Smith, 1995). In addition, probes and questions were used to explore the issues raised by participants, for example, “Can you tell me more about that?”

Prior to the main study, interview questions were pilot tested with a group of six older adults who did not participate in the current study but who matched the profile of
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requirement for those participants recruited for this study (i.e., same age, voluntary participation). The pilot study was conducted so as to determine the effectiveness and appropriateness of the initial list of interview questions in gathering information (Kvale & Brinkmann, 2009; J. A. Smith, 1995). Participants in the pilot study were recruited through the Council on the Ageing (COTA) in WA and participation was voluntary based on interest to participate. The researcher was contacted by the administrator of COTA once a group of people had come forward to participate and a time and place to conduct a focus group was arranged. An information letter (see Appendix C) with details about the research along with a consent form (see Appendix D) was provided to participants prior to any interviewing. A short demographics information form (e.g., questions related to age, health status, relationship status) was also provided which participants were asked to complete before the focus group (see Appendix E). A digital voice recorder was used to record the focus group. As a result of the focus group, a few questions deemed redundant, were removed from the schedule. For example, the question “What is your experience of the ageing process?” was removed as it was felt that responses reflected that this was already addressed in the question “What is your experience of ageing?”

4.2.5 Procedure.

Recruitment of the ‘LLLS group’ and the ‘Discontinuing group’.

As well as being pivotal to addressing the aims of research questions one and two, participants involved in a healthy ageing program and participants who had withdrawn from the same healthy ageing program were required in order to address the third research question of this research:

(3) What are the experiences of being involved in a healthy ageing program?

(a) What are the challenges and motivations to remaining involved in a healthy ageing program?

As the healthy ageing program LLLS is located at the Vario Wellness Clinic, both groups were sourced through the Clinic, which is situated on campus at Edith Cowan University (ECU) in the North Western Suburb of Joondalup, in the City of Joondalup, Perth, WA (see Figure 3). LLLS classes at the time of interviewing ran four times a week, twice daily and went for an hour in duration. The first group recruited through the clinic included participants who were currently involved in the LLLS program. The second group recruited from this population comprised participants who had withdrawn from the program. All participants who had withdrawn from the program had not been involved for at least a period of six months.
As part of the recruitment process for participants in the ‘LLLS group’ and the ‘Discontinuing group’, the researcher liaised with the director of the Vario Wellness Clinic, the clinic supervisor and COTA (WA) about the nature and purpose of the research. The relevant key people within these organisations were approached due to their different roles and involvement with the implementation and organisation of the LLLS program. The Vario Wellness Clinic is responsible for providing the location for the program while the clinic
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The supervisor is responsible for the support needed to effectively implement the LLLS program and is pivotal in ensuring that the needs, rights and ethical treatment of participants in the program were appropriately considered. COTA were responsible for the inception of the LLLS program and as such, their consent was also sought to undertake the current research. A copy of the information letter (see Appendix F) and consent form (see Appendix G) distributed to participants were also made available to all stakeholders so that everyone involved in the operation of the LLLS program were aware of the details of the study.

Following liaison with the above stakeholders of the LLLS program, to begin recruitment for the ‘LLLS group’, the researcher arranged with the clinic supervisor to meet with each LLLS class at the beginning of the session to provide information and details to attendees regarding the research. At this time, information letters (see Appendix F) and consent forms (see Appendix G) were left at the entrance of the room where the class was being facilitated for those interested in being involved in the study. As consent forms were returned, the researcher contacted respondents to arrange a mutually convenient time and place to meet for an interview. Sixteen of the 17 interviews were conducted onsite at the Vario Wellness Clinic in an allocated private room. One interview was conducted in a public place mutually agreed to by the participant and the researcher.

Recruitment of participants in the ‘Discontinuing group’; those who had withdrawn from the LLLS program, were contacted by mail using contact information provided by the administrator of the LLLS program at the Vario Wellness Clinic. Former attendees were sent a letter outlining the nature of the research and reasons as to why they had been contacted (see Appendix H) along with the necessary information letter (see Appendix F) and consent form (see Appendix G). Those interested in participating in the study, returned the consent form by mail signed and with contact information included for the researcher to use to follow up with respondents so a mutually convenient time and place to meet for an interview could be arranged. All 12 interviews were conducted at Vario Wellness Clinic in an allocated private room. Prior to conducting each interview, participants were asked if they had any questions concerning the information letter (see Appendix F) and/or the consent form (see Appendix G). Issues of confidentiality and data collection, storage and dissemination of the findings were reiterated to ensure participants were clear of the process (see section 4.2.6 Interview procedures, for further information).
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Recruitment of the community samples: The ‘WA group’ and the ‘Welsh group’.

To address research questions one and two of this study, two community samples of participants were recruited. Participants from a local community sample in WA, and those from an international community sample in Wales. The community sample from WA comprised participants situated in the City of Joondalup in the North West Metropolitan area of Perth, WA (see Figure 3). The second community sample comprised participants from Barry a town in the Vale of Glamorgan (outside of Cardiff - the capital of Wales) (see Figure 5). Access to participants in this community sample were facilitated through networks formed during the researcher’s fieldwork whilst on a research exchange program at Swansea University in Wales. Both of these groups provided supportive data to elaborate further understanding, assess variations and seek exceptions from insights gained during collection of data from the ‘LLLS group’ and the ‘Discontinuing group’ (Miles & Huberman, 1994; Patton, 1990).

Recruitment of the ‘WA group’.

Participants in the ‘WA group’ comprising the community sample from WA, were sought using a purposeful sampling strategy (Liamputtong & Ezzy, 2005; Patton, 1990) by placing a newspaper advertisement in the local North Western Suburbs community paper in Perth, WA (see Appendix I). Readers of the newspaper interested in participating in the research were asked to contact the researcher at which point interviews were arranged. All 15 interviews took place in participants’ own homes. Prior to conducting an interview, an information letter (see Appendix C) was provided and discussed with participants and a consent form (see Appendix D) signed. Issues of confidentiality and data collection, storage and dissemination were also outlined to participants (see section 4.2.6 Interview procedures, for further information). A digital voice recorder was used to record the interviews to allow for verbatim transcription by the researcher. Background information relating to the local context where participants were recruited from, is discussed in the next section.

Background information of the local context – Perth and the City of Joondalup.

The City of Joondalup is located in the northern suburbs of Perth, between 15 and 30 kilometres from the Perth General Post Office (GPO) (City of Joondalup, 2011a). The City is predominantly residential, with some commercial and industrial areas encompassing a total land area of about 97 square kilometres, including substantial areas of coastline, parkland, foreshore reserves and bushland. Bounded by the City of Wanneroo in the north and east, the City of Stirling in the south and the Indian Ocean in the west, the City of Joondalup includes the suburbs of Beldon, Burns Beach, Connolly, Craigie, Currambine, Duncraig, Edgewater,
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In 2006, estimated resident population (ERP) figures reported that 157,871 people resided in the City of Joondalup with preliminary updated estimates (based on 2006 census data) for 2010 reporting an increase in population to 164,445 residents in the area (City of Joondalup, 2011b). A major difference between the age structure of Joondalup City and the Perth Statistical Division included a larger percentage of 50 to 59 year olds (15.1% compared to 12.9%). However, the largest changes in age structure in this area between 2001 and 2006 were reported in the older age groups: 50 to 59 (+3,196 persons); 60 to 69 (+2,352 persons), compared with persons under 50 years of age: 35 to 49 (-2,730 persons), and; 5 to 11 (-1,804 persons) (see Figure 4) (City of Joondalup, 2011c). The growth of older age groups in this area made the City of Joondalup an area of particular interest for collecting data for this research.

![Change in age structure of Joondalup City, 2001 to 2006 (Enumerated data)](source: Australian Bureau of Statistics, 2006 and 2001 Census of Population and Housing (Enumerated)

*Figure 4. Change in age structure of Joondalup City, 2001 to 2006. The enumerated data represents where people were counted on Census Night (8 August 2006), which may not be where they usually live. This population figure generally includes overseas visitors and visitors to the area from within Australia, but excludes Australians overseas. Where enumerated population data is used in the profile, overseas visitors have been specifically excluded from the tables, but visitors from within Australia are included. Adapted from (City of Joondalup, 2011c).*

Recruitment of the ‘Welsh group’.

Participants comprising the community sample in the ‘Welsh group’ were recruited through links made with colleagues whilst on exchange at Swansea University. Through
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networks at Swansea University, the researcher was able to approach the registered Charity organisation - Age Concern, to recruit a community sample of older adults to complement the findings from WA. Age Concern is a Charity that seeks to improve the quality of life for older people in the regions of Cardiff and the Vale of Glamorgan by offering various services to support older people including, advocacy; charity shops; counselling; and welfare rights (Age Concern Cardiff and The Vale of Glamorgan, 2001). The researcher was able to attend the Age Concern centre located in Barry, the Vale of Glamorgan’s administrative centre and largest town with a population of nearly 48,000 (Vale Learning Network, n.d.) (see Figure 5). Older adults over the age of 50 years meet regularly at the Age Concern centre to socialise with other older adults when the centre is operating as a “cafe”. The centre is also used as a resource centre and on occasion older adults were invited to attend seminars and information sessions on topics relevant to issues in ageing (e.g., financial assistance, mental health) as well as other issues of concern in their local area (e.g., transportation services).
Figure 5. Map of the regions of the United Kingdom, and Swansea, Wales. Adapted from (Swansea University, n.d.) and (Wojtek, n.d.). Map of the Vale of Glamorgan, Barry. Adapted from (A1Tourism, 1997-2011).
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After discussing the nature and process of the research study with Age Concern’s centre director, approval was given to approach potential participants during the times when the centre was in operation as a cafe (12:30pm – 3:30pm). The researcher visited the centre during cafe times and approached individuals and groups of older adults to recruit participants. After explaining the nature and details of the research to those interested, interviews were arranged. All interviews took place at the Age Concern centre during cafe times and three visits to the centre were required to recruit an adequate sample (see section 4.2.3 Participants, for further information). Participants were informed about issues concerning consent and confidentiality which involved the researcher reading through the information letter (see Appendix C) and having participants sign the consent form (see Appendix D) prior to the interview. A digital voice recorder was used to record the interviews to allow for verbatim transcription by the researcher. Background information relating to the international context where participants were recruited from is discussed in the next section.

Background information of the International context – Wales, UK.

In 2007, of all the UK countries, Wales had the highest proportion of people of pensionable age (18.7% of females 60 years and over and males 65 years and over), and people over the age of 85 years (2.4%) (Welsh Assembly Government, 2009a). Furthermore, there were more people aged 65 years and over than there were children (aged 0-15 years) in Wales for the first time in 2010, with a rise in those aged 65 years and over from 17.4% of total population in mid-2001 to 18.6% in mid-2010 (Statistical Directorate: Welsh Government, 2011). The proportion of the population of Wales aged 50 years and over is projected to increase from 37.1% in 2007 to 43% in 2031 (Welsh Assembly Government, 2009a).

Furthermore, in Wales, children (aged 0-15 years) and older people (aged 65 years and over) are classified as dependents and when compared to the working age population, make up the dependency ratio. In 2010, the dependency ratio was higher in Wales (582 dependents per 1,000 people) than any other country of the UK or the UK as a whole (543 dependants per 1,000 people) (Statistical Directorate: Welsh Government, 2011), making Wales of particular interest when considering the impacts of population ageing.

The area of Wales of interest to this research is the Vale of Glamorgan which covers 33,097 hectares with 53 kilometres of coastline, including 19 kilometres of Heritage Coast (Vale Learning Network, n.d.). The main settlements in the Vale of Glamorgan are Barry, Penarth, Llantwit Major, Dinas Powys and Cowbridge. Based on the 2001 Census, the latest population estimate for the Vale is 122,932 (2005 mid-year estimate) with this number expected to remain stable for the remainder of the decade (Vale Learning Network, n.d.). The
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demographic profile of Vale of Glamorgan’s population is that of a steadily ageing population with the greatest increases in the age structure of the population occurring in the older age groups and the largest decreases reported in the younger age groups (The Vale of Glamorgan Council: Directorate of Environmental and Economic Regeneration, 2007). For the period 1991 to 2006, a 43% and 45% increase was reported for older adults aged between 55-59 years, and for those aged over 80 years respectively. For the same time period, the greatest decreases reported were for those under five years (loss of 19%), and those aged between 25-29 years (loss of 25%) (The Vale of Glamorgan Council: Directorate of Environmental and Economic Regeneration, 2007). These estimates are similar to the changes in age structure for the City of Joondalup in Perth, WA (City of Joondalup, 2011c), making the Vale of Glamorgan of particular relevance for seeking complementary data for this research. This trend in age structure of the Vale of Glamorgan’s population is estimated to continue with the number of children (0-15 years) forecast to drop from 25,247 in 2006 to 21,926 in 2016 and the number of people aged 65 and over expected to increase from 21,338 in 2006 to 26,124 in 2016 (Vale Learning Network, n.d.).

4.2.6 Interview procedures.

When participants from all four groups of this research first arrived for their interviews, the nature of the research was outlined. Participants were reminded that the interview was confidential, that they could stop at any time, that they could withdraw from the research at any time and that they would be given the opportunity to ask any further questions. As part of developing rapport with participants (Kvale & Brinkmann, 2009), demographic information was sought by way of a discussion and completion of a brief form requesting basic demographic information (see Appendix E). Information answered on the form also complemented the interview data by providing information such as age, gender, employment, health and relationship status, which added context to the findings (see Appendix Tables E1, E2, E3 and E4 for a summary of the demographic data organised by participant group).

Participants were informed that a nominated number would be recorded on their demographic sheet to ensure confidentiality as well as providing a reference for the researcher. Demographic information, individual transcripts of interviews and all other interview information was de-identified by numerically labelling documents and having all identifiable information (i.e., name) removed. As a further assurance of confidentiality and guarantee of anonymity, participants were informed that their real names would not be used in any part of the analysis process (i.e., transcription to report writing) or would be substituted
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by a non-identifiable number code (Corbin & Strauss, 2008). The duration of the interviews across all four groups of the study ranged from 25 minutes to two hours and 10 minutes in length. A digital voice recorder was used to record all interviews to allow for verbatim transcription by the researcher.

At the conclusion of each interview, brief notes were made on each participant’s interview schedule relating to any issues or concerns of the researcher. Notes were also made indicating responses that generated interesting and/or relevant information for follow up which also later allowed for an audit of information important for data analysis (see section 4.4 Qualitative research and appropriate data validation strategies, for further information). These notes were used to support the analysis by helping to further define and refine responses to the interview questions. On occasion, when dialogue relevant to the research continued between the researcher and participant after the recorder was turned off, the researcher took notes to ensure that information being shared was not missed. On these occasions, verbal permission was sought from the participant to write additional notes.

To ensure anonymity, consent forms were kept separately from demographic information and interview transcripts. Confidentiality of all primary and original data was protected during the research process with all records (i.e., consent forms, transcripts, notes) kept in a locked filing cabinet in the School of Psychology at ECU. All computer files (including external saving devices and memory sticks) were password protected. Only the research supervision team and the researcher had access to these confidential records. In addition, following the required preservation period, all audio recordings will be erased and transcripts shredded at ECU. All computer files (including external saving devices and memory sticks) will be erased and/or destroyed.

4.2.7 Debriefing procedures.

Following all interviews, participants were thanked for their time and provided with the opportunity to ask questions. Participants were also debriefed by allowing time to discuss any concerns that they may have had or through the researcher initiating discussion about any issues of concern. In the instance of any issues arising for the ‘LLS group’, ‘Discontinuing group’ or ‘WA group’, the researcher provided participants with a pre-organised comprehensive list of relevant local services (i.e., counselling services) that participants could make contact with (see Appendix J). This was required in one case (refer to section 4.3 Additional ethical considerations, for further information). In the instance of any issues arising for participants in the ‘Welsh group’, the researcher had made arrangements to follow up any
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cconcerns with the director of the Age Concern centre who would then contact relevant support services through their community network base. This was not necessary for any participants in this group as no issues arose.

4.3 Additional ethical considerations.

Any research involving humans is understandably weighted with moral and ethical issues, particularly interview research where participants' thoughts and feelings are exposed (Kvale & Brinkmann, 2009). As part of the requirement for this research to be undertaken, ethical approval was sought through the ECU Human Research Ethics Committee (ECUHREC). Through this process, issues concerning informed consent, confidentiality and any potential consequences of the research were addressed. While information concerning the informed consent, briefing and debriefing about the nature and purpose of this research to participants and others involved in the process (i.e., relevant centre, program and organisational directors), and confidentiality of data have been discussed elsewhere (refer to section 4.25 Procedure and 4.2.6 Interview procedures), significant information relating to the consequences of this research, as well as the role of the researcher are discussed in further detail in the next section.

4.3.1 Consequences of this research.

The nature of qualitative research lends itself to openness where participants may disclose personal and intimate information, which can potentially arouse mixed emotions about sharing personal information (Kvale & Brinkmann, 2009). In the initial proposal of this research, it was acknowledged that the process of sharing personal experiences of ageing could raise uncomfortable or unpleasant accounts that may have a negative effect on participants. Furthermore, as one of the research aims entailed investigating the experiences of those involved in the LLLS program about their involvement in the program, it was recognised that the discussion might be uncomfortable and remind some participants about unpleasant experiences to which they may have a negative reaction. To manage these issues the researcher ensured that participants overall guided the interview. The researcher also stopped the interview if a participant became distressed and they were debriefed accordingly (refer to the procedures section for further information).

To further minimise the risk of distress, regardless of how the interview was perceived, a debriefing with participants followed each interview to ensure they had not been adversely affected by the experience. In the event that a participant experienced feelings that made
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them uncomfortable or affected them emotionally and they wished to discuss this further with someone, they were provided with a list of services they could access (see Appendix J) to further discuss any feelings and/or concerns they may have. This occurred in one instance whereby when the participant became emotionally upset talking about a particular experience, the researcher allowed the participant to express their feelings and reminded the participant of their right to withdraw from the interview and research. However, the participant decided they wanted to continue with the interview. At the conclusion of the interview, the researcher raised her concerns for the participant and presented the services available to them. The participant commented that they felt relieved to have been given the opportunity to speak about their feelings and situation. Other participants had too expressed a feeling of wellbeing and relief following the chance to talk about their experiences. The opportunity to share their views and experiences was mentioned by some participants as providing a type of therapeutic effect and benefit as they felt they had gained insight into their own thinking and experience of ageing.

4.3.2 Role of the researcher.

Morally responsible research behaviour is based on more than just abstract ethical knowledge and methodological decisions (Kvale & Brinkmann, 2009). This is particularly true in qualitative research involving interviews where the researcher is often the main instrument for obtaining knowledge, the moral integrity of the researcher is of upmost importance (Creswell, 2007; Kvale & Brinkmann, 2009). While this is primarily a result of the researcher’s own knowledge and experience, there are certain actions the researcher can take in regard to presenting findings that provide an accurate representation of the participants’ experiences. While some have argued the practice of qualitative research as inherently dominance free, this is unlikely what participants experience (Kvale & Brinkmann, 2009).

Acknowledging that a power relation exists between the researcher and participants, with the researcher holding the more power, is important (Kvale & Brinkmann, 2009). Recognising this does not discount the opportunity for a free exchange of viewpoints to be shared, rather the focus becomes on how the relationship is established so that the position of power is minimised. This relationship was facilitated in the current research by the researcher’s conscious efforts to establish rapport and trust with participants before interviewing achieved by informing participants about the nature of the research, by collecting demographic information from the participant and by introducing herself to each participant. These actions allowed the researcher to adopt an empathic approach to interviewing and using a semi-structured interview format, the participants’ experiences guided the interview
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making the process more informal and free flowing, which meant that participants could feel comfortable sharing information. Furthermore, remaining transparent throughout the procedure process and ensuring that results are checked and validated added strength and rigour to the conclusions drawn (Creswell, 2007; Kitto, Chesters, & Grbich, 2008; Kvale & Brinkmann, 2009; Liamputtong & Ezzy, 2005; Mays & Pope, 2000). In an attempt to reflect participants’ stories and information as accurately, sensitively and representative as possible, the researcher engaged in different validation strategies (Creswell, 2007) which are discussed in detail in the next section.

4.4 Qualitative research and appropriate data validation strategies

The status of all types of research depends on the quality of the methods used (Mays & Pope, 2000). It has been argued that assessment of quality in qualitative research by the same measures and criteria used to assess the quality of quantitative research is fundamentally and epistemologically flawed (Easterby-Smith et al., 2008; Hammersley, 2007; Kitto et al., 2008; Lincoln & Guba, 2000; Mays & Pope, 2000; Morrow, 2005; Seale, 1999). A main consideration regarding the debate about how quality is best assessed in qualitative research is that the same broad concept of validity and reliability used for quantitative research can still be used as criteria, however they need to be operationalised differently to take into account the distinctive goals of qualitative research (Mays & Pope, 2000). Validity and reliability understood in terms of rigour (thoroughness and appropriateness of the use of research methods), credibility (meaningful, well-presented findings), dependability (making the process through which findings are derived explicit and as repeatable as possible), confirmability (findings represent the situation being researched rather than the beliefs, theories and/or biases of the researcher), and transferability (how useful the findings are to the context and phenomenon under study), are philosophically and methodologically more accurate descriptions of criteria for assessing the quality of qualitative research (Gasson, 2004; Hempel, 2005; Kitto et al., 2008; Lincoln & Guba, 2000; Morrow, 2005; Seale, 1999).

Aspects related to ensuring rigour and credibility of qualitative research include procedural transparency, representativeness of sampling techniques, researcher reflexivity, and the triangulation of data (Kitto et al., 2008; Mays & Pope, 2000; Morrow, 2005). The current research attempted to ensure rigour and credibility by explicitly describing the way the research was conducted including detailing methods with regard to accessing and recruiting participants, developing rapport and trust with participants, data collection and analysis processes and outlining explicitly how ethical considerations were addressed in the research (Kitto et al., 2008; Liamputtong & Ezzy, 2005). Further attempts to increase the rigour and
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credibility of the research, included the researcher engaging multiple researchers to be
involved in the analytical process (Farmer, Robinson, Elliott, & Eyles, 2006; Kitto et al., 2008; Liami
ttong & Ezzy, 2005; Morrow, 2005). Providing a credibility check through the use of
multiple qualitative analysts, allowed for discussion among analysts and provided
opportunities for developing further understanding of the possible interpretations and coding
of the data (Elliott & Timulak, 2005). Having an analytic auditor meant that the researcher
could more readily identify any biases of their own presenting in the interpretation of meaning
(Elliott & Timulak, 2005; Kitto et al., 2008; Liamputtong & Ezzy, 2005).

Triangulation of the data was also a key strategy employed to add rigour to this
research. Initially, triangulation described a set of techniques that arose within a crudely realist
paradigm with empiricist assumptions, however more enlightened methodologists have
perceived it as having a place within a variety of paradigms (Farmer et al., 2006; Seale, 1999; P.
Turner & Turner, 2009). Fundamentally, triangulation involves utilising varying perspectives to
validate, challenge or extend existing findings (P. Turner & Turner, 2009). Triangulation
exercises can deepen understanding as a part of a fallibilisitc approach to research rather than
providing a guarantee of validity, and thus triangulation can offer a way of explaining how
accounts and actions in one setting are influenced or constrained by those in another
(Dingwall, 1997; Seale, 1999; D. Silverman, 1993). This version of triangulation then accepts a
view of research as revealing multiple constructed realities and provides an alternative to
validation by increasing scope, depth, and consistency to results (Cicourel, 1964, 1974; Flick,
1998; Seale, 1999; P. Turner & Turner, 2009). As qualitative research methods rely on linguistic
rather than numerical data, meaning-based rather than statistical forms of data analysis were
employed to represent these multiple realities (Elliott & Timulak, 2005).

One way of triangulating data in qualitative research is by comparing the results from
two or more data sources, for example, interviews with members from different interest
groups (Elliott & Timulak, 2005; Farmer et al., 2006; Mays & Pope, 2000; Patton, 2002; Seale,
1999). In the case of this research, comparing two or more varied qualitative perspectives
included exploring the research questions across four different contexts: an international; and
local community sample of older adults; participants involved in a healthy ageing program; and
participants who had withdrawn from the same program. Comparing different sources also
involved exploring the interview data with other forms of data including the theoretical and
conceptual frames applied to the research (i.e., social constructionism and phenomenology) to
further enhance interpretive rigour and insight into the phenomena of ageing (Farmer et al.,
2006; Kitto et al., 2008; Mays & Pope, 2000). Understanding participant constructions of
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meaning involved including context and culture into the debate. Therefore, contextual grounding is essential for understanding the meanings that participants make of their experiences, particularly when exploring research from a social constructionist theoretical framework (Morrow, 2005). Contextual issues such as policy were therefore examined for how they influenced the data. Furthermore, a critical analysis of the data also involved increasing consciousness about issues of power and oppression highlighting the potential of the research to create change primarily by exploring and making visible those who benefit from power and how power is exercised (Guba & Lincoln, 1994; Morrow, 2005; Patton, 2002).

To ascertain dependability of the research, the process through which findings were derived was made explicit. This revealed consistency across time and analysis techniques which allowed the process to be as repeatable as possible (Morrow, 2005; Patton, 2002). This was achieved primarily by tracking the emerging research design through the use of a journal which created an audit trail or detailed chronology of research activities, processes, and influences (Flick, 2006; Morrow, 2005). A self-reflective journal was also used throughout this research process to record the researcher’s experiences, reactions and emerging awareness of any assumptions or biases (Flick, 2006; Morrow, 2005). As auditing is also an exercise in reflexivity, keeping a journal was a useful strategy for establishing confirmability and trustworthiness of the research (Seale, 1999). Reflexivity is essentially about how data are co-constructed during collection through the influence of both the researcher and the participants and offers a methodological log of research decisions (Corbin & Strauss, 2008; May & Perry, 2011). Thus the researcher was able to maintain a sensitivity to the ways in which they, acting as an instrument in the research process, shaped the collected data (May & Perry, 2011; Mays & Pope, 2000). A further reflexive strategy utilised in this research was the use of peer debriefers who were used to reflect the researcher’s response to the research development (Flick, 2006; Kitto et al., 2008; Morrow, 2005). This process provided a way to manage subjectivity and demonstrate authenticity as co-analysts were able to monitor the “fairness” of the data, that is, representing participants’ viewpoints equitably and avoiding bias of the researcher’s interpretations or those of only a few participants (Guba & Lincoln, 1994; Morrow, 2005; Seale, 1999).

Therefore, reflexivity involved a self-critical account of how the research was conducted and a demonstration by the researcher that they are aware of the sociocultural position they inhabit and how their values might affect the selection of the research problem, research design, and collection and analysis of data (Grbich, 1999; Kitto et al., 2008; Lincoln & Guba, 1985; Mays & Pope, 2000; Seale, 1999). These approaches to subjectivity have also been
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referred to as “bracketing” (Husserl, 1931; Morrow, 2005; Peshkin, 1988). This includes researchers making implicit assumptions and biases overt to themselves and others. For this reason, it was also important that through the research process, the “distance” (i.e., power differentials) between the researcher and participants was acknowledged and discussed (Creswell, 2007; Kvale & Brinkmann, 2009; Mays & Pope, 2000). Engaging in this reflexive process, provided acknowledgment that research is never objective and the belief that quality research should result in findings that represent as closely as possible the situation being researched as opposed to the values and biases of the researcher (Gasson, 2004; May & Perry, 2011; Morrow, 2005). Essentially this allows the reader to confirm the adequacy of the findings and address any issue of subjectivity in the research (Flick, 2006; Morrow, 2005).

Assurance that the research has presented adequate data and findings is largely dependent on processes undertaken during data analysis including specific verification steps. By employing adequate disconfirming evidence and adequate discrepant case analysis, the researcher was able to make repeated comparisons and revise key assertions or categories until they accurately reflected the experiences of the participants (Morrow, 2005). A deliberate search for disconfirmation helped to combat any tendency of the researcher to seek confirmation of their preliminary or emerging findings (Grbich, 2007; Green & Thorogood, 2004; Kitto et al., 2008; Liamputtong & Ezzy, 2005; Mays & Pope, 2000; Morrow, 2005). This was aided by constantly being immersed in the data from data gathering; transcription of the interviews; and continued, repeated readings of the transcripts; listening to the recorded material; and reviewing of notes and other data (Flick, 2006). The use of co-analysts again become important here as a further step of verification of the data as well as for identifying the complex relationships among categories, including various levels of abstraction (see Figure 6). Verifying the data in this way also included grounding categories and/or themes in examples and organising categories to provide coherent understanding of how they fit together so as to provide a data-based narrative and underlying structure to organise the phenomenon for the reader (Elliott & Timulak, 2005; Morrow, 2005).

An important way to improve the quality of explanations in qualitative research is to search for, and discuss elements in the data that appear to contradict emerging explanations of the phenomena under study so as to refine the analysis until all or a vast majority of the cases under investigation can be explained (Liamputtong, 2009a; Mays & Pope, 2000). The result should exemplify an interpretation-quotation balance whereby a balance between the researcher’s interpretations and supporting evidence by way of quotations from participants is achieved. Using the actual words of participants’ accounts was therefore essential to
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persuading the reader that the interpretations made were grounded in the lived experiences of the participants. Clarity in presentation of these interpretations was aided by the use of subheadings and tables to guide the reader (Morrow, 2005). As a result, providing a clear account of the process of data collection and analysis through the use of diagrams to aid understandings, explicitly outlining procedural information, and engaging in peer auditing procedures, increased the dependability of the research (Flick, 2006; Guba & Lincoln, 1994; Mays & Pope, 2000; Seale, 1999).

Conceptual generalisability and transferability refer to how well the findings of the study inform contexts that differ from that in which the original study was undertaken (Green & Thorogood, 2004; Kitto et al., 2008). Qualitative data however cannot be said to be generalisable in the conventional sense to other populations or settings, but rather transferability refers to the extent to which the reader is able to generalise the findings of a study to their own contexts. This is achieved by the researcher providing sufficient information about their role in the research (i.e., as a research instrument), the research context, process, and participants, so the reader is able to decide how the findings might transfer to their own context (Morrow, 2005). Research is therefore deemed relevant when it adds to knowledge or increases confidence with which existing knowledge is regarded (Mays & Pope, 2000). When the research report is sufficiently detailed for the reader they are able to judge whether the findings are applicable to similar settings and how transferable, relevant, and useful the findings are to the context and phenomena under study (Kitto et al., 2008; Mays & Pope, 2000). Through the strategies and techniques previously discussed in this section (i.e., reflexivity, journal reporting, auditing, detailed and explicit detailing of the research process, peer debriefing and checking), the researcher was able to present sufficient information for the research to be considered relevant, transferable, and useful to the research context and the phenomenon of ageing.

Therefore, quality or validity in qualitative research is to a certain extent paradigm bound with standards of trustworthiness that emerged from, and are most congruent with particular paradigms such as those in quantitative research (Easterby-Smith et al., 2008; Hammersley, 2007; Kitto et al., 2008; Lincoln & Guba, 2000; Mays & Pope, 2000; Morrow, 2005; Seale, 1999). However, certain qualities are also indispensible regardless of the research paradigm such as reflexivity, issues related to adequacy of the data and to the interpretation and presentation of data (Alvesson & Sköldberg, 2009; May & Perry, 2011; Morrow, 2005). Subsequently, as in quantitative research, to ensure rigour and quality in qualitative research, systematic; self-conscious research design; and data collection, interpretation and
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communication, was required (Flick, 2006; Mays & Pope, 2000). By using the following strategies, that is, triangulation of data sources and different interest groups, engaging co-analysts, peer debriefing, auditing of the research process, and maintaining reflexivity throughout this process, the researcher was able to achieve a transparent and thorough account of the research process and associated findings. The process for how data were analysed and interpretations verified is discussed in the next section.

4.5 Data Analysis

Employment of an exploratory qualitative design to address the research aims and questions relating to older adults’ social constructions and experiences of ageing relies on inductive processes such as “thematic analysis” whereby themes emerge from informants that provide rich context bound information (Creswell, 1994; Kvale & Brinkmann, 2009). In considering thematic analysis as a tool for analysis of interview data allows for the identification, examination and reporting of themes within data and provides the foundation for describing “rich” information (Braun & Clarke, 2006; Kvale & Brinkmann, 2009; Liamputtong, 2009a). Themes within the understanding of a thematic analysis are considered representative of a level of patterned response or meaning which is considered important in relation to the research questions (Braun & Clarke, 2006). As the theoretical frameworks of phenomenology and social constructionism guided this research, the ways in which individuals make meaning of their experiences and how the broader social context influences these meanings were of particular interest. Therefore, thematic analysis offers a theoretically flexible approach to analysing qualitative data (Braun & Clarke, 2006; Elliott & Timulak, 2005).

While there are distinct phases involved in thematic analysis, it is important that the phases are recognised and used as a guide rather than a “step by step” approach so as to allow flexibility to fit the research questions and data (Elliott & Timulak, 2005; Patton, 1990). Therefore, although there were six main phases to analysing the data, for each interview, data collection and analysis occurred simultaneously and the procedures outlined by each phase were used as tools rather than directives in order to retain the “dynamic” nature of qualitative analysis (Corbin & Strauss, 2008). The analysis process as a result was driven by insight gained through interaction with the data (Corbin & Strauss, 2008; Elliott & Timulak, 2005). The six phases involved, becoming familiar with the data; generating initial codes; theme development; reviewing themes; defining and naming themes; and producing a report on the
Exploring the Lived Experience of Ageing findings (Braun & Clarke, 2006; Rapley, 2011). This process of data collection and data analysis is illustrated in Figure 6 with each phase discussed separately in detail in the next section.

Figure 6. Data collection and data analysis processes.

4.5.1 Familiarity with the data.

Prior to, and during the conducting of interviews, the researcher became familiar with relevant technical literature in the field of ageing (i.e., journal articles, policy documents, previous research) to enhance sensitivity to subtle nuances arising in the interview data (Corbin & Strauss, 2008). Relevant non-technical literature was also collected throughout the research process (i.e., newspaper articles, memos, conference material). This meant that when
certain concepts continued to appear in the data their significance could be noted in relation to comparisons against already existing concepts in the literature (Braun & Clarke, 2006; Corbin & Strauss, 2008). This allowed the researcher to track thought processes and to remain cognisant of the reasons for the familiarity of certain concepts. As mentioned previously, this also allowed the researcher to “bracket” personal subjectivities in order to maintain sensitivity to the raw interview data (Corbin & Strauss, 2008; Husserl, 1931; Morrow, 2005; Peshkin, 1988) and to build a repertoire of similar and contradictory constructed meanings by participants (Liamputtong, 2009a; Rapley, 2011). The main form of questioning during this audit of information was how concepts were the same as, or different from, those discussed in the literature (Corbin & Strauss, 2008).

After the interviews were conducted, they were transcribed verbatim by the researcher to ensure accuracy of each participant’s responses and to stay true to the interviews original nature (Braun & Clarke, 2006; Elliott & Timulak, 2005). This provided a valuable way of becoming familiar with the data (Braun & Clarke, 2006; Flick, 2006). Additional written notes were also made during and at the end of the interview in order for the researcher to record her own understandings and potential biases (Creswell, 1994; Elliott & Timulak, 2005; Mays & Pope, 2000). This memoing approach allowed the researcher to document thoughts and insights as they occurred during the interviews and also acted as an important validation strategy for checking understandings and interpretations of the data (Denzin & Lincoln, 1998; Flick, 2006; Rapley, 2011).

In order to become familiar with the depth and breadth of the content, the researcher immersed herself in the data by repeatedly reading the content of the transcripts in an active way (Braun & Clarke, 2006). Upon the first reading, the entire data set (all 59 interview transcripts) were read in their entirety and initial ideas, thoughts and analytic interests noted and any biases and questions arising for the researcher also continued to be noted (Elliott & Timulak, 2005; Rapley, 2011). This process facilitated reduction of the data later in the analysis into smaller units to assist in the search for factors that contributed to participants’ experiences and construction of meaning (Creswell, 1994; Liamputtong, 2009a; Miles & Huberman, 1994).

As identified in section 4.4 Qualitative research and appropriate data validation strategies, a journal was kept throughout the data collection and analysis process to ensure rigour of the data. Keeping the journal over the length of the research process and noting memos about the data collection and analysis of data facilitated verification of conclusions
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drawn which supported the dependability of the data (Flick, 2006; Golafshani, 2003; Guba & Lincoln, 1994; Kitto et al., 2008; Mays & Pope, 2000; Morrow, 2005; Rapley, 2011; Seale, 1999). This is illustrated in an example entry made by the researcher, “...after writing down my initial thoughts after reading through the transcripts for the first time today, I reflected back on notes I kept while conducting the interviews some 8-12 months ago and noticed my notes actually alluded to the same thoughts and ideas I was having after reading the transcripts through”. Taking notes and memos during and after the interviews, facilitated an audit trail of results and conclusions drawn (Denzin & Lincoln, 1998; Flick, 2006). Employing this type of reflexive approach acknowledges that the researcher is part of the setting and context they are trying to understand and analyse and as such, it was essential for identifying the discourses that influenced the researcher’s own views about the world and participants (Grbich, 2007; Kvale & Brinkmann, 2009; Liamputtong & Ezzy, 2005; May & Perry, 2011; Mays & Pope, 2000).

The more aware the researcher was of the subjectivity involved in data analysis the easier it was to remain sensitive to how this might be influencing interpretations. Furthermore, since insights are continually stimulated by further experiences it was important to keep a log of these experiences as this meant the researcher was able to concentrate on, and consider the participants worldview by immersing herself in the data (Corbin & Strauss, 2008).

As the researcher moved forward in the data analysis process, experiences throughout the research process continually shaped and informed the data and subsequently influenced how the researcher responded to the data. It was important for the researcher to have some background knowledge (i.e., through immersion in the data and engagement in research networks in the area) in order to know whether what was being seen in the data was significant and in order to be able to discuss important connections between concepts (Corbin & Strauss, 2008). Of particular relevance, the researcher’s exchange experience in Wales, provided opportunity for the researcher to immerse herself in the field of ageing which consequently influenced how the data were viewed and interpreted. For example, discovering similarities of the ageing experience across cultures contributed to the generation of ideas and themes underlying the data and influenced how the researcher reflected on the role of different government systems and policy in the area of ageing.

4.5.2 Generating initial codes.

In considering the theoretical and epistemological focus of this research, coding of the data was dictated by a particular interest in themes that related directly to the research questions (Braun & Clarke, 2006). Analysis within a constructionist paradigm focuses on the identification and examination of underlying ideas, assumptions and conceptualisations that
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shape and inform the content of the data (Braun & Clarke, 2006; Kitto et al., 2008; Mays & Pope, 2000). Through this approach, there is a focus on how meaning and experience is socially produced and reproduced within a wider socio-cultural context (Braun & Clarke, 2006). As description is basic to conceptual ordering (organisation of data into discrete categories according to perspectives and dimensions) (Creswell, 2007), first an initial list of ideas about what was in the data was recorded (Elliott & Timulak, 2005; Liamputtong, 2009a). The researcher then re-read the transcripts but this time produced initial codes from the data (Braun & Clarke, 2006; Elliott & Timulak, 2005; Flick, 2006). Codes are labelled units of meaning that allow the data to be thought about in new and different ways in relation to the context (Graneheim & Lundman, 2004; Liamputtong, 2009a). These meaning units are parts of the data that communicate sufficient information to provide a piece of meaning to the reader (Elliott & Timulak, 2005). This was achieved by identifying features of the data that appeared interesting or pertinent to understanding the experiences of the participants and coding was recorded by highlighting and writing notes, significant concepts, statements and interpretations directly onto the relevant section of the transcripts (Braun & Clarke, 2006; Liamputtong, 2009a; Miles & Huberman, 1994). This process is important to qualitative research as it allows for the organisation of data into meaningful conceptual groups (Tuckett, 2005).

The entire data set was worked through systematically as outlined above allowing full and equal attention to each transcript. This also formed the basis for repeated patterns or themes to form across the data set (Braun & Clarke, 2006; Liamputtong, 2009a). This systematic process minimised the risk of generating themes from only a few vivid examples and ensured that the coding process was thorough and inclusive (Braun & Clarke, 2006). While this process was conducted manually for all data, the use of the computer software NVivo, version 8 was also utilised to identify and name selections of text within each interview transcript to assist in collating all coded data together within each code. To ensure that the context of the coded data was not lost, much of the relevant surrounding data were retained during transfer of the coded data (Elliott & Timulak, 2005). This was also done in recognition of the importance of retaining all accounts, even those contradictory in nature, so that tensions and inconsistencies were not ignored across the data set and instead informed the overall analysis (Braun & Clarke, 2006; Grbich, 2007; Green & Thorogood, 2004; Kitto et al., 2008; Liamputtong & Ezzy, 2005; Mays & Pope, 2000; Morrow, 2005). As identified earlier, contradictions in the data are especially important in qualitative research as they can ensure that the uniqueness of people’s experiences and stories are represented as opposed to
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overvaluing generalisation of these accounts. This is important for facilitating credibility and trustworthiness of the research findings as condensations and abstractions of the data are more transparent meaning the established arguments for the most probable interpretations presented are made clear allowing the reader to look for alternative interpretations (Graneheim & Lundman, 2004; Grbich, 2007; Green & Thorogood, 2004; Kitto et al., 2008; Liamputtong & Ezzy, 2005; Mays & Pope, 2000; Morrow, 2005).

4.5.3 Theme development.

Following the identification of codes within the data, the underlying meaning of these codes eventually require linkage on an interpretative level (Elliott & Timulak, 2005; Graneheim & Lundman, 2004). The underlying threads of meaning through codes are called themes, and they aim to describe aspects of the structure of experiences that are not objects or things but rather answer the question of “how” (Graneheim & Lundman, 2004; Liamputtong, 2009a). In order to re-focus the analysis on the broader level of themes rather than the detail of codes, the researcher utilised a question-ordered matrix to further reduce the data into a manageable working size and to represent the key identified information across participants’ responses (Miles & Huberman, 1994; Sonn & Fisher, 1996). Advantages suggested for the use of a matrix include the ability to reduce the data and display it in a logical way allowing the researcher to systematically view the responses and further note any patterns, themes, commonalities and or contradictions across the questions and data (Banyard & Miller, 1998; Miles & Huberman, 1994). Essentially this allowed analysis of the already identified codes to be compared and considered in combination to form overarching themes (Braun & Clarke, 2006; Elliott & Timulak, 2005).

As potential themes were considered, they were placed with already identified similar themes with significant statements allocated to categories or listed under relevant themes (Liamputtong, 2009a). In looking at the relationship between codes, themes and different levels of themes, some codes were found to fit into more than one topic area, which prompted the generation and organisation of master themes containing sub-themes and this process further assisted in the verification and re-defining of any existing themes (Braun & Clarke, 2006; Graneheim & Lundman, 2004; Rapley, 2011; J. A. Smith, 1995). Despite having a sense of the significance of themes at this point, no data were abandoned as it was uncertain whether the themes would remain or whether further separation or combining and refinement would be needed (Braun & Clarke, 2006). Furthermore, as qualitative research is interested in the different aspects of the examined phenomenon, idiosyncratic aspects were retained to allow the opportunity for them to inform the study in different ways (Elliott & Timulak, 2005).
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4.5.4 Reviewing themes.

Concepts and themes derived from data provide the foundations for analytic method representing impressionistic understandings of what is being described in the experiences (Corbin & Strauss, 2008). Concepts were then used to group and organise data through varying levels of abstraction. Lower level concepts relating to higher order concepts or categories of meaning were devised and a primary goal of reviewing the data set in this way was to identify higher-level concepts which feed directly back to the data bringing with them the detail of description (Corbin & Strauss, 2008; Elliott & Timulak, 2005). Themes were initially identified within the explicit or surface meanings of the data but the analytic process then progressed from description to interpretation whereby the researcher began to theorise the significance of the patterns and their broader meanings and implications (Braun & Clarke, 2006; Patton, 1990). This process also involved identifying the features that gave the themes their form and meaning with broader assumptions, structures and meanings theorised as underpinning what was articulated in the data (Elliott & Timulak, 2005). From a constructionist perspective, meaning and experience are socially produced and reproduced (Gergen, 1985, 2011) and therefore theorising about the sociocultural contexts and structural conditions that enabled the individual accounts about experiences of ageing were important and guided the further refinement of themes (Braun & Clarke, 2006; Liamputtong, 2009a).

In addition to the use of a question-ordered matrix in earlier stages of analysis, the process of refining and ordering conceptual interpretations of the data was made possible by cutting up sheets of paper containing extracts of all the coded data and organising it across larger sheets of paper, which had been ordered and separated by the overarching themes identified thus far (see Appendix K for an example of this process). Making the process visual in this way made it more dynamic and allowed for movement back and forth of significant statements and ideas across the identified themes. This enabled the researcher to review the level of the coded data extracts, reading all the collated extracts for each theme together to identify a coherent pattern of thought. This also provided a visual representation of the interpretations made by the researcher for the co-analysts to verify (Elliott & Timulak, 2005; Kitto et al., 2008; Mays & Pope, 2000; Morrow, 2005). In some instances during this process, for those themes that appeared to require further development, the creation of a new theme resulted. This process occurred until the researcher was satisfied that the themes adequately captured the essence of the coded data. Themes were then assessed as to whether they made sense in regard to the entire data set which also allowed for the identification of any additional data within themes that had previously been missed at earlier stages of coding. Re-coding and
refinement of the themes continued until the researcher considered that the themes provided an overall representation about the data (Braun & Clarke, 2006; Corbin & Strauss, 2008).

4.5.5 Defining and naming themes.

By this stage of the analysis, the central themes had been identified and allocated working titles but it is through this last stage of refinement that nomenclature used in the final analysis was decided. This was achieved by analysing the data within each theme, identifying the essence of each theme and determining what aspects of that data each theme captured (Braun & Clarke, 2006; Tuckett, 2005). Defining and naming the final themes involved identifying what aspects of the data each theme captured; identifying what was of interest about the content of each of the collated data extracts presented; and assessing why this was of particular interest (Braun & Clarke, 2006). For each individual theme, a detailed analysis was written and assessed for how it fitted into the bigger picture of the story that each theme expressed in relation to the research questions. This allowed the researcher to identify any overlap between themes and to see if further sub-themes could be identified within any of the themes. Identified sub-themes were added to provide structure to complex themes, which demonstrated a hierarchy of meaning within the data. Through the above process, the scope and content of each theme could be described and themes could be clearly defined for what they were as well as for what they were not (Braun & Clarke, 2006; Holloway & Todres, 2003).

Previously extracted quotations from participants considered of significance, were then compiled to illustrate meaning reflective of the described themes.

Therefore, dependability and credibility of the data was demonstrated through various means of peer debriefing and verification as discussed throughout this section (Chwalisz et al., 2008; Denzin & Lincoln, 2000, 2008; Janesick, 2000). Authentication of the data and further preclusion of researcher bias was also achieved through a series of formalised meetings to peer check meaning, and interpretation of the data (Golafshani, 2003; D. Silverman, 1993). Through this process, transcripts and analyses were compared for agreements (D. Silverman, 1993) and considered against the process and content of the overall research (Chwalisz et al., 2008). Checking interpretations made about the data in this way provided confidence in how well processes of analysis addressed the intended focus (Graneheim & Lundman, 2004). As identified in the section on qualitative research and appropriate data validation strategies, credibility of the findings were further assessed through data triangulation which involved the cross checking and reviewing of journalised data and the examination of research questions across different interest groups (Farmer et al., 2006; Grbich, 1999; Janesick, 2000; P. Turner & Turner, 2009). Tracking the emerging research design through the use of a journal also
Exploring the Lived Experience of Ageing resulted in the creation of an audit trail or detailed chronology of research activities, processes, and influences examinable by the researcher and the researcher’s supervision team (Flick, 2006; Morrow, 2005). As auditing is also an exercise in reflexivity, it was not just important for maintaining the credibility of the research but it was also a useful strategy for establishing confirmability and trustworthiness of the research (Flick, 2006; Lincoln & Guba, 1985; Seale, 1999).

4.5.6 Producing a report.

Descriptions may seem objective but are not, as they reflect some personal, political or organisational stance and can carry moral judgements (Corbin & Strauss, 2008). Key to a phenomenological study is the researcher taking the data through several step of reduction and ultimately developing a description of the experiences about the phenomenon that all individuals have in common (i.e., the “essence” of the experience) (Creswell, 2007), as well as identifying contradictory information across the groups (Erikson & Erikson, 1997; Grbich, 2007; Green & Thorogood, 2004; Kitto et al., 2008; Liamputtong & Ezzy, 2005; Mays & Pope, 2000; Morrow, 2005). A phenomenological approach to analysis consisted of identifying a phenomenon to study; acknowledging and positioning the researcher’s own experiences; collating data from several persons who have experienced the phenomenon; analysing this information by reducing it into significant statements and/or quotes; developing a “textural description” (i.e., what participants experienced in terms of ageing), and a “structural description” (i.e., what contexts or situations have typically influenced or affected the experience of ageing for participants) and a combination of the two to convey an overall essence of the experience (Caelli, 2000; Creswell, 2007; Moutsakas, 1994). Furthermore, given the influence of a social constructionist perspective, this process also involved identifying the features that gave the themes their form and meaning in regard to how they were influenced by social processes and the broad assumptions, structures and meanings theorized as underpinning what was articulated in the data. Therefore, through the outlined processes above, the researcher was able to produce a composite description of participants’ experiences and compile a discussion on the findings and interpretations which is presented in the next section.
Chapter 5: Findings and Interpretations: The experience and social construction of ageing – perspectives from Western Australia and Wales

Chapter 5 introduces the findings and interpretations of this research. The aim was to identify and discuss the factors important in understanding participants’ experiences and social constructions of ageing for the four groups in this study: ‘the LLLS group’; the ‘Discontinuing group’; the ‘WA group’; and the ‘Welsh group’. A further aim was to identify and interpret how participants attribute meaning to their experiences of ageing. As a significant finding from analysis of the data was the commonalities in experiences and constructed thoughts about ageing across the four groups in this study, the chapter presents the research results collectively, and where relevant, findings unique to a particular group are discussed independently. The chapter begins by outlining the major themes and sub-themes identified through the data analysis process. Each section of this chapter commences with an outline and summary of the identified major theme and continues with a discussion on the related sub-themes using excerpts from participants’ responses to illustrate these findings and interpretations. Throughout each section, current research and literature, relevant to the identified themes and sub-themes are integrated into the discussion.

5.1 Identifying themes

A primary aim of this research was to explore how community dwelling older adults residing in Perth, Western Australia (WA) and in Barry, Wales in the United Kingdom (UK), as well as older adults involved in a healthy ageing program - both those currently involved and those who had withdrawn from the same program - experience and socially construct ageing. A further aim of this research was to review all participant groups’ experiences collectively to identify any unique differences and/or commonalities in experience and socially constructed thought. Through the process of thematic data analysis (as outlined in Chapter four: Methodology), a significant finding from analysis of the data was the commonality in experiences and constructed thoughts about ageing across the four groups. Five major themes with related sub-themes were germane to this finding: primed thought (consisting of sub-themes the “lucky” view, comparisons with others, healthy ageing, and decline and loss); connectedness (consisting of sub-themes, the value of groups, supportive relationships, and religion and spirituality); social values (consisting of sub-themes, generational interactions, ageism, and resource allocation); negotiating transitions in ageing (consisting of sub-themes, life-stages and events, the dependence-independence continuum, the ageing body, and attitude and acceptance); and agency and influence (consisting of sub-themes, meaningful
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roles, and personal control and perceived worth) (see Table 14). Consistent with research questions one and two, the identified themes represent salient factors contributing to participants’ experiences and constructions of ageing across the four groups of this study. Each of these themes and related sub-themes is discussed separately in the next section.

Table 14

*Major Themes and Related Sub-Themes for all Four Participant Groups*

<table>
<thead>
<tr>
<th>Major theme</th>
<th>Related sub-themes</th>
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<tr>
<td>Primed thought</td>
<td>The “lucky” view</td>
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<td></td>
<td>Comparisons with others</td>
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<td>Healthy ageing</td>
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<td></td>
<td>Decline and loss</td>
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<td>Connectedness</td>
<td>The value of groups</td>
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<td></td>
<td>Supportive relationships</td>
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<td>Religion and spirituality</td>
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<tr>
<td>Social values</td>
<td>Generational interactions</td>
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<td>Ageism</td>
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<td>Resource allocation</td>
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<td>Negotiating transitions in ageing</td>
<td>Life-stages and events</td>
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<td>The dependence-independence continuum</td>
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<td>The ageing body</td>
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<td>Attitude and acceptance</td>
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<td>Agency and influence</td>
<td>Meaningful roles</td>
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<td>Personal control and perceived worth</td>
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5.2 Theme one: Primed thought

While age and ageing are related to biological phenomena, their meanings are socially and culturally determined (Coote, 2009; Hareven, 1995). “Cultural products”: images of ageing which reflect the beliefs and values of the particular historical periods during which they are
Exploring the Lived Experience of Ageing made (Hepworth, 2002), help to make sense of the experience of ageing (Estes et al., 2009). Subject to historical change, those images give meaning to life and, as such, cultural products have a symbolic nature that is interpretive (Barkway, 2001; Hepworth, 2002; Ray, 2007). Considering meaning as being constructed in social interaction with the world means that certain language, used to describe thoughts, feelings and emotions, directs how people relate meaning to their experiences (Edwards, 1997; Gergen, 1985; Stenner, 2009; Talja et al., 2004). Identifying the explicit terminology used to describe experiences and assessing the sub-textual meaning underlying descriptions given by participants, were essential to understanding how meaning and experiences had been socially constructed (P. Berger & Luckmann, 1991; Semin, 1990; Stenner, 2009; Taylor & Bogdan, 1998). Investigating the ways in which people articulate meaning and reflect on their experiences related to ageing revealed that certain social cues may have primed participants to consider and reflect on their experiences in particular ways. Therefore, the first major theme identified across all participant groups was primed thought. Sub-themes identified to illustrate these constructed thoughts and experiences include the “lucky” view, comparisons with others, healthy ageing, and decline and loss. These sub-themes are discussed in further detail in the next section.

5.2.1 The “lucky” view.

A specific comment made by participants across all four groups was that they felt “lucky” for having made it as far in life as they had in terms of their age and health. Some participants believed that luck was the key to having had a good experience of ageing with some participants articulating living to see old age in good health as being a blessing, “I’m very blessed, I think, I’m very blessed and lucky to of lived so healthy for this long” (Welsh = 7[line 253]), and “getting old is a journey that’s how I look at it...I’ve had the wonderful chance of being born and live...if you’re lucky enough to get old...and some people don’t get there so that’s good isn’t it.” (LLLS = 3[line 1339]). Older adults’ assignment of luck to their overall understanding and experience of ageing has also been illustrated in international research (Gunnarsson, 2009; Pond et al., 2010). In an in-depth study, investigating how a relatively healthy sample of 20 older adults experience everyday life in Sweden, several participants indicated feeling “lucky” in life, expressing gratitude for the fact they felt favoured by having had a full life, even when it was acknowledged that life had sometimes been “rough” (Gunnarsson, 2009). Another study, using discourse analysis to examine 60 New Zealand adults aged 55-70 years about health promotion, health and ageing, revealed that participants’ construction of health and illness was to varying degrees considered beyond one’s control with
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responses indicating luck, good fortune and God as contributing to health outcomes (Pond et al., 2010).

With the concept of luck being associated with chance, good fortune and randomness, for participants taking this view and reflecting on their ageing experience in terms of luck, their actions could be considered as having minimal influence on the outcome of their situation. This perspective may underplay the relative “good” they have done in their life to ensure a current positive, and/or healthy life situation (i.e., through regular exercise and a consistent healthy diet), or may imply a belief that one has no control over one’s destiny. The later is illustrated by one participant’s reflection on ageing, “well, ageing there’s good and bad, like everything else...there’s not much of a compensation if you are not well...I sort of feel physically okay, it’s quite a privilege to reach this age.” (Discontinuing = 6[line 10]). Therefore, viewing health in ageing as related to luck has implications for locating the responsibility for maintaining (good) health.

The health locus of control refers to an individual’s generalised expectancies of the extent to which their health is the result of his or her behaviour (internal control) or a result of other forces independent of themselves (external control) (Newall et al., 2009). It can impact on how people feel about health, and relate their experiences (Wiesmann & Hannich, 2010). Furthermore, external causal beliefs, including fatalistic externality (the result of good luck, chance or fate), have been found to promote a passive approach to friendship development and affect social participation, subsequently resulting in greater loneliness (Newall et al., 2009). Therefore, it could be interpreted that for participants in the current study, who viewed their good health as the result of luck, minimise the role of human agency in determining their own health and wellbeing.

Interestingly, more people from the ‘LLLS group’ viewed good health as related to luck. This is surprising as those in the LLLS program could be assumed to have a higher internality (they view their health as dependent upon their own behaviour), as evidenced by their decision to participate in a healthy ageing program. This contradicts other findings, which suggest that when an individual’s expectation is that it is worthwhile to maintain engagement in health-promoting activities, it is because they hold the belief that they are not a victim of fate (Wiesmann & Hannich, 2010). The fact that a majority of participants from the ‘LLLS group’ believed that luck played a key role in their state of health implies a fatalistic externality to health, meaning that they do not attribute credit to their role in maintaining their own health.
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Another reason for the consideration of luck as central to how some participants recount their experiences of ageing could be that they compare their situation to that of others in seemingly similar positions in terms of life quality and health, or those whom they are familiar with such as family. Seeing others, whether it is parents or peers, who do not or did not appear to be faring as well as themselves seemed to reaffirm some participants’ belief in luck as accounting for their own experience of ageing. For example, “in recent years it’s seeing friends of a similar age dying and that sort of thing, made me think about my own mortality… I realise some people aren’t as lucky as I’ve been health wise.” (Discontinuing = 1[line 9]). Similar findings from a study drawing on qualitative data about people’s experiences in managing and coping with changes in ageing revealed that participants used various mechanisms to retain a positive self-perception and social presentation including making comparisons with others. By telling stories of other’s misfortunes or illnesses, it enabled participants to evaluate their own coping positively (Tanner, 2007). Such self-affirmation was also conveyed by participants in the current study by referring to their “good luck” or “good fortune” as accounting for why they were doing well. Therefore, by participants maintaining a positive attitude and perception it is likely that they were also able to maintain a sense of control over their own ageing process.

In summary, while luck can be viewed fatalistically to reflect on one’s life situation, when used in a self-affirming way to create a perception of doing well, it can enable people to construct their situations more positively and may also allow one to maintain a sense of agency and personal control. This means that while a majority of participants in the current study referred to luck as important to their ageing experience, the purpose of describing their experiences in this way was likely to reflect both internal and external loci of control regarding their health and wellbeing. Furthermore, the purpose and outcome of making comparisons with others are also varied. The types of comparisons participants make, and their purpose are explored further in the next sub-theme.

5.2.2 Comparisons with others.

Age, like gender and ethnicity, is a marker for self-identity and the categorisation of others. These categories provide social group membership and benchmarks for comparison, which individuals will often do in search of a positive identity (Giles, McIlrath, Mulac, & McCann, 2010). Comparisons made to one’s own or other age cohort, often reflect beliefs about key developmental tasks and adherence to culturally determined social clocks associated with a particular age group (Giles et al., 2010; Hepworth, 2002). Stereotypes attributed to certain age groups can also form expectations and beliefs about how we view our
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future selves, for example, the expectations that young adults have of elderly people (i.e., recluse, senile, perfect grandparent) can form part of their own future identity (Giles et al., 2010; Heckhausen & Krueger, 1993).

In the current study, comparing ones’ experience of ageing to that of others was a key feature of participants’ responses and reflections on ageing. Referring to the past in order to articulate, evaluate and understand current experiences was a common form of reflection with participants across all four groups frequently relating their own experiences of ageing against experiences of those close to them.

I just think I’ve got another birthday and that’s what my mum reckons too now that she’s over nearly 90, she said she suffers from TMB which is too-many-birthdays...you see my father died at 70 and I’m going on for 70...so I’m counting on turning out like my mother, I hope rather than my father. (Discontinuing = 3[line 50]).

Predominantly, comparisons were made against that of one’s parents but close friends and peers were often referred to also. For some participants, reflecting on their parents’ experiences of ageing primed their thinking and shaped their constructions about ageing. For example, “my mother died when she was 73, and my father died when he was 80...my grandmother died when she was 95 so...I passed me mother and I haven’t caught up to my father and perhaps I’ll go past me grandmother.” (Discontinuing = 8[line 15]). Therefore, most participants used their parents’ ages at death, or others in their family as a guide for their own life expectancy.

Another common way for participants to relay their experiences of ageing was to relate to views they held about ageing from when they were younger. Often across the lifespan, people may undertake a life review and take stock of changes that may have occurred in their belief structure (Giles et al., 2010). This process can positively or negatively affect wellbeing and, when dealing with the results of such a review, one may compare against others primarily to avoid negative outcomes (Giles et al., 2010; Kwan, Love, Ryff, & Essex, 2003; Lindenmeyer, Griffiths, Green, Thompson, & Tsouroufli, 2008). This may translate in a change in attitude, behaviour or symbolic expression (i.e., dressing young), as illustrated by the following participant’s reflection on their own change in perspective on ageing.

I used to think you’re young, you grow old and then you die...now I am old it’s not simple, you know and I feel as alive now as what I did when I was young...I didn’t expect that...like my mother’s generation, they were old when they were 50, they acted old, they dressed old and they thought old, where as now, I don’t know it’s a big awakening...I am experiencing what my mum and father did, but I got a better, a different perspective to life, life’s for living it’s not for dying. (LLLS = 2[line 249]).
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A common way participants described this change in view about ageing was to compare a set age today as being the standard for an earlier set age in the past such as “60 is the new 40” or “80 is the new 60”. “Well I’m 60 so I think 60’s probably the old 50, like years ago, 60, years ago was really...people now days to me at 80 are equivalent of a 60 year old” (WA = 2[47]) and “in the last few years they seem to have come out with the idea that the 40s are now the new 30s...I think that is how a lot of people are feeling that they’re ten years younger than the age that their parents used to be.” (Discontinuing = 3[74]). Conceptualising ageing in this way reflects that we are living longer and as such, there have been shifts in the expectations about age appropriate behaviour.

When I was younger...anybody over 50 were really old...people didn’t live so long, their life expectancy wasn’t so long and, they were older then. Somebody of 65...I thought they were antiques but now there are so many people living so much longer, you see people in their 90s who get about quite well and quite cheerful. It’s good. (Welsh = 8[31]).

Moreover, people’s expectations for their own experience of ageing had shifted with most participants stating how they thought attitudes had changed over time regarding how older people are considered and in turn, how they considered themselves as people of a similar age. Frequently, making these comparisons was empowering for participants as some realised their construction of ageing had been based on earlier outdated assumptions that conflicted with their own lived experience of ageing. “Twenty years ago when you got to 65, you just curled up in a ball and sat in a chair...well at 60 I went back to university...now doing honours...there are quite a few other people doing those things and intending to do something with them” (Discontinuing = 1[95]) and “I remember growing up, the old people were just kind of old and decrepit, they just, potted around in the garden and they didn’t really do a lot of activities, I think it’s changed a huge amount.” (WA = 1[82]).

Images that participants held of older people from their younger days such as “sat in a chair” or “stuck in a corner” were typical of the ways they reflected on the ageing experience. These observations implied that older people in the past were considered to reach a certain point whereby society considered them old and therefore no longer useful, which often resulted in their withdrawal from society. Consistent with earlier psychosocial theories such as disengagement theory (Caelli, 2000; Cavanaugh & Blanchard-Fields, 2006; Cummings & Henry, 1961; McPherson, 1990), older adults in this research reflected upon images of older adults they had known as becoming withdrawn from society when trying to understand their own ageing experience. However, withdrawal was not considered an acceptable option for participants as assumed by the theory, but rather withdrawal was viewed as problematic and
exploring the lived experience of ageing representing an undesirable state. While disagreeing with the assumptions of the theory that older adults choose to withdraw from society and social activities as they age, participants often recognised that these impressions from growing up did still influence their current thinking about ageing.

If people think about age and how old they are, I think a lot of them go back to their childhood and they see old people kind of stuck in the corner, rotting away because they’re not doing anything...they equate age with that...it’s almost kind of a childhood experience that they carry through with them in their mind...I saw people like that. (LLLS = 10[line 127 & 160]).

On occasion, this reflection on understandings from childhood and other earlier assumptions influenced by people in their family about ageing resulted in confusion and disappointment for participants because their experience of ageing was different from what they had come to expect. For example, “I’ve been in hospital three times this year and I am just so annoyed about it, my grandfather lived to be 103, my mother 89, my father 85...and I’m just annoyed that I’m turning into a bit of a [sick person].” (Discontinuing = 4[line 101]). Other research, on the health narratives of midlife women’s concept of vulnerability to illness, yielded similar results. Some felt betrayed when they found themselves unable to lead the active lives of their parents, as this contradicted their expectations of ageing (Lindenmeyer et al., 2008).

While comparisons with parents strongly influenced how participants constructed meaning about their own ageing experience, when comparisons were made with peers, it was often during discussions about death and mortality. When others around them suffered from illnesses (e.g., cancer), some participants reverted to the “lucky” philosophy as they questioned what their friends had done to deserve such a fate. For most, this created a fear of their own mortality.

I know some of my friends have had some fairly bad experiences with...Alzheimer’s or cancer or something. I’ve lost a lot of friends, like they’ve died from the age of 49, 59, 69...so it gives you a little bit of a startle when you see your mates sort of going, so that’s not really a fun time. (Discontinuing = 3[line 183]).

Research suggests that people who compare themselves favourably with others, tend to experience better health outcomes, especially later in life (Bailis & Chipperfield, 2002, 2006; Bailis, Chipperfield, & Perry, 2005; Frieswijk, Buunk, Steverink, & Slaets, 2004; Heidrich & Ryff, 1993a, 1993b; Kwan et al., 2003). Older individuals who judge their health or physical capacity more positively, even upon receiving information threatening to their self-concept, and who see themselves as better off than the average person their age (known as a downward
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tend to adapt more successfully to failure or threat, and report greater life satisfaction and less psychological distress (Bauer, Wrosch, & Jobin, 2008; Wills, 1981). Consequently, making downward social comparisons has been shown to be self-protective by alleviating the negative emotional consequences of stressful encounters and threats to self-esteem (Bauer et al., 2008; Heckhausen & Brim, 1997; Wills, 1981).

Furthermore, research has shown that older adults increase their reliance on downward social comparisons over time compared with younger adults (Bauer et al., 2008; Heckhausen & Brim, 1997; Heckhausen & Krueger, 1993; Heckhausen & Schulz, 1995). It is suggested that this is because with age we tend to prioritise emotion-regulation goals, or secondary control responses to psychological threats, that is, responses that are targeted at internal processes to minimise losses in primary control (behaviours directed at the external environment). Therefore, findings from the social comparison literature align with theories of successful ageing which focus on striving for personally meaningful goals such as those that fulfil needs for belonging, competence or control, by identifying that making downward social comparisons can sustain an individual’s motivation to fulfil such goals (Bailis & Chipperfield, 2006; Carstensen, Pasupathi, Mayr, & Nesselroade, 2000).

Another example of downward social comparisons enabling participants to positively reflect on their own experiences occurred when they explored childhood memories and experiences of significant historical periods. Unique to participants’ social constructions of ageing from the ‘Welsh group’, was the influence of being alive during “war times” which carried forward in their thinking about ageing and health. Nearly all participants from the ‘Welsh group’ referred back to the influence of the war (World War II) when telling of their experience of ageing. “With the war years, we didn’t have all this fast food stuff...it was a healthy diet and I think it put us all in good stead” (Welsh = 6[line 77]), “well, it [life back then] was, I always say much more peaceful though the war was on but I think it was much more a leisurely pace” (Welsh = 8[line 163]), and “during the war, I was called up and I was twenty and I worked all through the war...I’ve never sat back, even now I do all my housework, my washing, my cleaning and everything...I don’t sit around.” (Welsh = 5[line 41]). As well as acknowledging how having lived through a world war made them appreciate their life more, often participants from the ‘Welsh group’ also acknowledged that for their parents, growing up during war times was relatively tough and consequently, this affected how participants made sense of their own experiences today.
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Of course during the war we were rationed and I think that is part of the healthy process because when we were young we did eat healthily, there were no junk food, and our parents had allotments so we had home grown…we couldn’t over feed ourselves, when the food came we were glad of it you know. (Welsh = 7[line 83]).

That reflection on historical periods can influence a way of life illustrates the power that social and historical events can have over constructing meaning about experiences. This is further illustrated as participants from all three of the WA groups (the ‘LLLS group’, ‘Discontinuing group’, and ‘WA group’), who explained that they had emigrated from the UK after spending their childhood there, raised the influence of the war when reflecting on their lived experience of ageing. “[War] affected my life, very badly in the early days, being separated from my wife...but after the war we were together all the time...but that, that affected me badly” (LLLS = 13[line331]), “I did not ever believe that I would make old bones...during the war, I didn’t believe I would survive it...that’s when I started to try and hang on to life as it were...I certainly didn’t think that before the war” (Discontinuing = 7[line 120]), and

I think its very different from what, the age we are...the war years and after the war, and you know you’ve always had to you know struggle along and do things for yourself which I think helps you, to build you as a person I think...whereas, it’s like my daughter you know hasn’t got the, although she’s very educated, but she hasn’t got the simple things to me...common sense. (LLLS = 14[line 64]).

Of particular interest about the way participants commonly reflected on ageing with reference to the past, is how influential past events and particular times in history were in influencing their identity. It also highlights potential for the formation of more positive constructions into people’s thinking about their health and ageing process as they can use such comparisons to self-enhance their own positioning and experiences. Furthermore, the effects of making downward social comparison may not only be mediated by family and peers, but as findings from this study indicate, significant events in history can also influence such self-evaluation – a finding that warrants further research.

Findings from this current research support the idea that experience construction and meaning making are influenced by social structures and historical contexts with understandings dependent on interpretation (Crawford, 2006). Furthermore, this research suggests that social comparisons allow individuals to self-evaluate in relation to others (Festinger, 1954; Kwan et al., 2003; Tanner, 2007). Behavioural norms resulting from such beliefs allow for the creation of “possible selves” which reflect feared and hoped for future outcomes for ourselves and provide a way of thinking about, and planning for the ageing process (Giles et al., 2010). Findings from this study support previous research about the use of
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Social comparisons as a strategy to self-enhance one’s own position and experiences. They also suggest that making comparisons with others and to significant times in history is a common way for older adults to relate to and understand their own experiences of ageing. Another way for participants to make sense of their experiences, was revealed in how policy and health messages in wider society influenced participants’ own understanding of ageing. Specifically, the socially constructed concepts of “healthy ageing” and “decline and loss” are discussed next as separate sub-themes relating to participants’ experiences of ageing.

5.2.3 Healthy ageing.

The concept of healthy ageing is based on the holistic definition of health provided by the World Health Organisation (WHO), that is, one inclusive of physical, mental and social wellbeing (Australian Institute of Health and Welfare, 2007). However, variations in the term’s usage have resulted in and reflected conceptual disparities in the literature (Bryant, Corbett, & Kutner, 2001; Cardona, 2008; J. E. Lang et al., 2005; Peel et al., 2004). Findings from the current research revealed that the term’s use in policy development and program delivery has influenced participants’ own construction of meaning about ageing. Participant responses and understandings highlighted the influence of dominant social discourse and health messages on priming people’s thinking about their own experiences.

When asked about the concept of healthy ageing, a common finding across the four participant groups was that they felt they were responsible for maintaining good health as they aged. This was particularly evident within the ‘LLLS group’.

Healthy ageing I think is self explanatory, don’t expect someone to walk in the door and give you a $1,000, don’t expect someone to walk in the door and give you a healthy ageing bloody miracle, you’ve got to do it yourself. (LLLS = 9[line 379]).

Participants from the ‘LLLS group’ probably articulated this belief more often, and more strongly given they had made the decision to involve themselves in a healthy ageing program with the intention of improving their health and wellbeing. The term “healthy infection” was also used by one participant to articulate the wide-reaching benefits of taking responsibility for one’s own health.

If the powers to be could grasp the fact that encouraging people to look after their health...becomes infectious because you can feel it doing you good and it then will grow like an infection, a healthy infection if that’s not a contradiction in terms, not only will they save themselves money, they will have a lot healthy population. (LLLS = 9[line 382]).
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Understandings about healthy ageing expressed by participants from the other two groups located in WA, suggest that within the WA context, healthy ageing is considered an individual responsibility and related strongly to physical concerns. “Healthy ageing, I do it already...stretches and walk to the shops” (WA=8[302]), “you’ve really got to take responsibility for keeping yourself as healthy as possible...I’ve been going to hydrotherapy, I do stretching and mobility and aerobic exercises...healthy ageing I think is absolutely crucial” (WA = 11[657]), and “keeping yourself physically active...helps with the ageing process.” (Discontinuing = 9[169]). This understanding of healthy ageing is consistent with some of the main strategies used to promote healthy ageing in WA (i.e., physical activity programs) (Living Longer Living Stronger COTA, 2012a; Office for Seniors Interests and Volunteering, 2006, n.d.) and more widely across Australia (Cardona, 2008; Commonwealth of Australia, 1999). Recent research has also shown health to be pervasively constructed as a responsibility of the individual, with this discourse heavily co-articulated with a biomedical discourse which delineates specific practices of health promotion as related to health outcomes (Crawford, 2006; Pond et al., 2010; Sanders, 2006). While taking self-responsibility for one’s health can be empowering, it has been recognised that in taking this approach, it can also foster a moral landscape whereby becoming ill is seen as a personal failing and as a sign of individual irresponsibility (Cardona, 2008; Pond et al., 2010).

Evidence that finding meaning in ageing is a co-constructed process was further highlighted when reviewing understanding of healthy ageing among participants in the ‘Welsh group’. While participants across all four groups acknowledged and made reference to keeping active through physical means as being important to healthy ageing, the participants from the ‘Welsh group’ more strongly identified with the role of diet in healthy ageing. “We have a healthy lunch, we have healthy breakfast...we have to control the diet...he [husband] had high cholesterol but that’s well controlled...because we eat properly” (Welsh = 10[125]), it means don’t eat junk” (Welsh = 4[247]), “I suppose it means eating sensibly” (Welsh = 9[184]), and “healthy ageing I haven’t given it much thought...I suppose you’ve got to be more careful as you get older, [with] what you eat.” (Welsh = 8[116]). In reviewing the key healthy ageing strategies promoted by the government for older adults ageing in Wales, it is evident that “healthy eating” is one of the priority areas along with “emotional health and wellbeing” and “physical activity” (Welsh Assembly Government, 2005, 2008, 2009a). The variation in understandings about healthy ageing across the Western Australian and the Welsh community contexts appears to reflect the dominant health promotion discourses within those contexts. Accordingly, findings from this research illustrated that dominant discourses
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influenced participants’ own construction of meaning in ageing. What is of particular interest for future investigation is understanding what makes older adults more responsive to one aspect of health promotion discourse over other aspects that claim to be of equal priority to promote across different contexts (i.e., physical activity, nutrition, emotional health and wellbeing).

Therefore, findings from this current study revealed that constructs such as healthy ageing influence people’s thinking about their own health behaviours and affects how they relate to their own experiences and understandings of ageing. Assumptions underlying a healthy ageing approach highlight how policy and programs referring to such concepts can prime and influence peoples’ own construction of meaning in ageing and thinking about how they “ought” to behave. In the case of participants’ responses in this research, a healthy ageing approach has been interpreted and understood around notions of individual responsibility for health, primarily through healthy eating and being physically active. However, believing one has full responsibility of their health outcomes can minimise the role of social and political institutions in ensuring good health and wellbeing (Cardona, 2008; Holstein & Minkler, 2003; Sabelli et al., 2003). For this reason, it is important to be mindful of how certain discourses become the dominant ones and to question whose needs they serve so that informed judgements about one’s own health behaviour and ageing experience can be made. The next section extends this discussion by reviewing the construct and sub-theme of decline and loss in relation to participants’ experiences of ageing.

5.2.4 Decline and loss.

Interest in ageing in the nineteenth century saw a shift from earlier concerns around attaining longevity to a discussion on the medical symptoms of senescence and was therefore primarily concerned with clinical and biological evidence and the laws around the development of cells and tissues (Featherstone & Wernick, 1995). By the late nineteenth century, ageing began to be seen as a period of decline, weakness and obsolescence (Cristofalo et al., 1999; Featherstone & Wernick, 1995; Goldsmith, 2010). Consequently, “decline and loss” is a phrase often used in reference to a medical model approach to health (Estes & Binney, 1989). This medical approach to health and ageing was reflected in participants’ responses in the current study with many participants notably using similar phrasing when relaying some of their own experiences and definitions of ageing. For example, “it’s a case of wearing out and not being able to do as much now as I used to do...just the case of slowing up I think...slowing physically and as they say the wear and tear” (LLLS = 15[line 26 & 185]) and “well quite literally it’s [ageing] the process of getting old and the running down of all your
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faculties, mental and physical and emotional, every aspect so the gradual, running down and eventually breaking down.” (LLLS = 17[line 14]). Others also made direct references to the increased involvement of the medical world that came with their experience of ageing.

“Personally, you feel like you can’t do as much as you did before or like you’ve got to start going to the doctor, you’ve got to start taking medication...the only solution to any complaint is medication or bit more medication...that’s a negative.” (LLLS = 12[line 360]).

Findings from the current research suggest that participants’ thoughts about ageing are primed by popular discourses used in society to describe health and ageing. In particular, concepts such as declining health and experiences of increased involvement with the medical world indicate that a medical approach to health and ageing continues to be a pervasive dominant discourse. This was evidenced by participants frequent telling of their experiences of ageing in terms of ill health and a focus in their discussions on biomedical concerns. When reflecting on their own ageing experience, most participants felt you were only “old” if you were ill suggesting that ageing is commonly viewed as synonymous with medicalised notions of health. For example, “getting old...the health issues that ageing brings, in my case...the limitations that impose bad health, it puts on one as one gets older so I guess that’s ageing for me, declining health” (Discontinuing = 5[line 9]), and “I think about illness with ageing, how am I going to be, in a couple of years, well I get a bad foot and my bones when I’m walking and it makes me, unhappy.” (Welsh = 12[line 103]). Part of this thinking can be attributed to the way in which health is socially constructed in society with a focus on health promotional adverts and the media identifying risk factors and preventative medicine to counter such declines in health in ageing (Cardona, 2008; Lindenmeyer et al., 2008). This has been argued to lead to a situation whereby the body is permanently at risk and needing monitoring and intervention, which can heighten a sense of vulnerability to future illness and make individuals seem personally responsible for their own decline (Armstrong, 1995; Holstein & Minkler, 2003; Lindenmeyer et al., 2008).

The characteristics attached to oneself in relation to age is referred to as age identity, and the extent to which age is important to a person’s overall identity impacts on one’s behaviour and the social roles considered important to them (Bailis & Chipperfield, 2006; Giles et al., 2010; Krause, 1999). The current research found that certain events consciously and unconsciously activated participant’s age identity by making them feel their age, or older, or younger. For example, talking with health professionals, having to document one’s age, noticing changed appearance in friends, experiencing aches and pains and having different experiences in ageing from what had been primed or expected, all influenced participants’
Exploring the Lived Experience of Ageing thinking and experiences of ageing. A study investigating how three generations of Americans comprising a sample of 570 respondents construed the salience of their age in respect to feeling their age, feeling younger and feeling older, found that age could be made salient frequently, easily, and in a wide variety of contexts, and that salience triggers were lifespan comparative (Giles et al., 2010). Similar to participants in the current research, events that triggered feeling one’s age and feeling older were mostly associated with physical and cognitive decline for the older respondents in the study highlighting an adjustment in age identity from probable past self to possible self, and likely future self.

Other research has shown that perceptions of vulnerability to illness are influenced by the salience given to personal experience of illness in a person’s family. It has been reported that a personal experience of the way parents aged and coped with illness influences a person’s expectations of their own future health (Bury, 2001; Lindenmeyer et al., 2008). A recent qualitative study exploring midlife women’s health found through the women’s autobiographical narrative, that they were very much primed by the context of the illness history in their family as to their own perception of vulnerability to illness (Lindenmeyer et al., 2008). The role that the experience of illness in the family played in shaping perceptions of vulnerability in these women was further highlighted by the fact that from the 69 women interviewed who mentioned family; there were only four cases where expressed concern about illness was not present in their family. Furthermore, for those women who remarked on a likeness between family members, likeness was a reason for worrying about contracting a similar condition and therefore fostered the development of an image of a self permanently at risk (Armstrong, 1995; Lindenmeyer et al., 2008).

The experience of seeing others suffer with illness, especially parents, was also central in shaping how participants in the current research constructed meaning about their ageing experience. Losing one’s mental capacity through such conditions as dementia and Alzheimer’s disease, was described as one of the most concerning and fearful things about ageing for many participants across all four groups, especially for those who had witnessed a similar fate within their own family.

_The most influence was my mum went into nursing care with dementia which was eventually Alzheimer’s, and in those seven years...looking after her and things like that, that really hit home to see how I, I could possibly end up...that’s probably the biggest fear about ageing I have, not dying fast you know just to, to linger on and ooh it’s just awful._ (LLLS = 16 [line 78]).
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For most, this concern was about also experiencing a slow and sad death but primarily concern was not for participants themselves but for those who would be left with the burden of care should they become unwell, with this concern based on what they had either experienced or witnessed. “I need to look after myself more so I can look after other people because I would like to starve off anything making me a burden for my children...so that they are really established and well on their way.” (WA = 14[414]).

Findings further support the argument presented elsewhere by this research that the dominant social discourse concerning physical limitations, changes in health status with ageing, and personal experiences with illness, primed participants’ thoughts about ageing as a time of decline and loss. Discussions about the decline and loss aspects of ageing were largely a result of primed thinking and influence from social discourse as reflected by participants speaking about these aspects first. However, while participants often started the interview with comments about experiences related to physical limitations and declines in abilities to do things, as the interview progressed, the focus shifted to discussion of the more relational aspects (i.e., relationships with others, emotional needs) of their experience. This encourages further thinking about how society does view and promote health. The emphasis participants also placed on the psychological and social aspects of wellbeing in ageing suggest it would be of benefit to include a stronger focus on health messages in the community that incorporate these other important aspects. Shifting the focus in this way has the potential to significantly alter people’s perceptions and understandings around ageing, and therefore has the potential to influence the experience of ageing more positively. Relational aspects important to participants’ experiences of ageing are discussed further in the next major theme connectedness.

5.3 Theme two: Connectedness

The major theme connectedness encompassed the importance of feeling and being connected with other people to participants’ experiences of ageing. Recent multidisciplinary research in the social sciences has highlighted the importance of relationships for psychological wellbeing in ageing (Cacioppo, Hughes, Waite, Hawkley, & Thisted, 2006; Gray, 2009; Gunnarsson, 2009; Kafetsios & Sideridis, 2006; F. R. Lang & Carstensen, 1994; G. C. Smith et al., 2000), with salient connections in people’s lives described as forming the basis for all human existence and the phenomenon of connectedness bringing quality to life (Register & Herman, 2010). Although the concept of connectedness is not new, the idea in relation to
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older adults still requires further development (Register & Scharer, 2010). While previous research has focussed on personal relationships as facilitating connectedness (Kafetsios & Sideridis, 2006; Register & Scharer, 2010), the theme connectedness for participants in the current study involved more than just aspects of participants’ personal relationships. Though supportive relationships based on intimacy and mutual support were important to participants, connectedness was also facilitated through group connections (i.e., aspects of shared history with others); religion and/or spirituality; familiarity and a sense of belonging to a wider network and/or community; and feeling empowered by this sense of belonging. Each of these aspects of connection added depth and purpose to participants’ experiences of ageing and were important for defining what ageing meant to participants. To explore the complexity of this theme, three sub-themes were identified that detail the above varied aspects involved with connectedness for participants in this study. The sub-themes identified were, the value of groups, supportive relationships, and religion and spirituality.

5.3.1 The value of groups.

Participants from all four groups recognised the importance of keeping active and involved in activities that facilitated some type of group interaction, whether it is through physical activity or more social by intent. Rather than the focus being on the type of activity, the very nature of groups, the interactions that occur within them, and the direct and indirect support that can result from being involved in a group, was acknowledged and described as offering many positive outcomes in the general experience of ageing. This is illustrated by one participant’s discussion about the power of group dynamics for motivating behaviour and the wider benefits that can come from “group energy”.

You get these groups of people going out all dressed up walking...I think that’s great you know, they wouldn’t do it by themselves...some people they won’t do it unless it’s in a group, well I can’t meditate properly unless I’m in a group...I find it a little bit more successful if I have that group energy, because I have to I can’t be doing something else I have to sit and do that, I think the group energy is good and I mean it’s like weight watchers and all those programs you give each other incentive and help. (WA = 3[491]).

This example highlights how the social aspects of being involved in groups can help facilitate the primary reason for the group’s operation, whether it is exercise, dieting or other health-related behaviour requiring motivation and support.

When asked about understandings of healthy ageing, participants in the ‘LLLS group’ associated the program, and groups in general, as being important to healthy ageing. In addition, those in the ‘LLLS group’ found the interaction with others in the group as important,
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if not more significant, than the physical benefits from being involved in the program. This was illustrated not only by comments from participants but also by how often the social aspects of the group were discussed. In particular, participants involved in the ‘LLLS group’ and the ‘Discontinuing group’ when asked about their experience of being involved in the program, in most cases mentioned how much enjoyment they got from being in the group in a social sense. More detailed aspects of being involved in the LLLS program are discussed in Chapter six, however the extract below typically illustrates why participants valued being in the group.

“That’s my motivation…I thoroughly enjoy it, not just the exercises but the group...we have a good laugh...and if we stand around talking for half hour with our exercising then it doesn’t matter anyway, because we’re interacting with people.” [LLLS = 1][line 103]).

Similarly, participants from the ‘Welsh group’ often talked about their attendance at a local cafe - also in operation as a community service for older adults, which facilitated a sense of belonging alongside its primary purpose of offering useful educational information about ageing issues. The social interaction facilitated by the cafe was highlighted by all participants as being important for wellbeing, “it’s quite good for people you see all the chaps here they moan and groan and trying to put the world right but it’s good for them” [Welsh = 8][line 130]), and, “it’s finding things to do really, through the winter because I think you go downhill fast stuck in a house not meeting people, we came down here and we all just say ‘what’s your name’ and exchange stories.” [Welsh = 2][line 110]). Having access to relevant educational material also proved empowering for some.

I saw this cafe...I thought, I don’t belong in here but [I] kept coming in, you get to know one another, used to do cholesterol tests, blood pressure...it’s good because you need help and so it’s a good place to come...we wouldn’t have known what to do so it’s nice. [Welsh = 9][line115]).

Therefore, being informed about issues important to them and being able to interact with peers appeared to facilitate a sense of belonging and connectedness for participants.

Participants from the ‘WA group’ particularly acknowledged the importance of keeping involved with others to facilitating a positive experience of ageing. For some, seeking this type of social interaction was a way of finding and accessing support to deal with issues they may have been experiencing where there was a lack of support services in the community otherwise. In one participant’s experience, finding suitable support services for the type of mental health issues she and others she knew were dealing with proved difficult and resulted in the formation of a self-help group in an effort to proactively address issues they were experiencing.
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They’re [people in self-help group] depressed and you know, as though they’re not acceptable... the attitude to everything to do with mental health is bad, we’ve found that with our own experience with our group I mean... one woman was going to St Charles Gardner and the psychiatrist was seeing her for 15 minutes. Fancy travelling all that way from here, I mean what can you do in 15 minutes, that’s really rude and this woman was really suffering too. (WA = 9[line 285]).

Through the shared experience of the group, this participant felt a sense of connectedness and belonging, which subsequently allowed them to work through issues where existing services were not adequate or could not assist.

Furthermore, participants from across all four groups raised the notion of being engaged and involved in community and with people as being important to ageing well. “When I retired... I was looking for something to mentally, to give me some things to think about and do and keep up with, and to have contact with other people.” (Discontinuing = 12[line 187]). Some participants also articulated that they felt much could be learnt from others despite age, gender or interests given the opportunity, again highlighting the importance of groups for facilitating growth, wellbeing, and connectedness.

For me I wouldn’t want to be grouped with just one age group because I love the interaction of all the age groups... you know that everyone can sit there and have a really great conversation and range you know, be a good 40 years apart in age group in some cases, I really enjoy that and I think we all learn from each other, see different viewpoints. (WA = 5[line 352]).

The value and benefit of engaging in groups facilitating various functions as highlighted by participants in this research affirms the importance of connectedness to their experiences of ageing. These findings also highlight the relevance of programs primarily designed for other uses such as physical activity and educational awareness as also providing important social and psychological benefits. Ways in which participants discussed groups as being valuable illustrated that support can come in many forms including motivation, a shared history facilitating a sense of belonging, being kept informed, and support to maintain involvement in community. For these reasons, additional outcomes of group engagement and participation such as those mentioned should be highlighted, considered and cultivated in the future development and promotion of programs designed for older adults. Connectedness associated with more intimate and personal relationships is discussed in the next section, which addresses the sub-theme supportive relationship.

5.3.2 Supportive relationships.

A key feature of relating and connecting with others that contributes to psychological wellbeing and good health, is social support (Grundy & Sloggett, 2003; Kafetsios & Sideridis,
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2006). Findings from the current study strongly illustrate the importance of social support for wellbeing and quality of life in ageing. In addition to the earlier discussions on the value of groups for participants’ wellbeing in ageing, the importance of social support through more intimate relationships emerged frequently and in different ways across all four groups of participants. In particular, from participants’ experiences of ageing and from what they considered their needs to be in the future, maintaining close relationships was discussed more than any other aspect.

I want to maintain a good relationship with my wife, with my kids, I want to be in a situation where I can assist my kids financially as well as sort of in terms of social and emotional stuff...I’d like to have the time to be able to have relationships with my, with people who I care about, wider family and friends. (WA = 4[line 144]).

Focussing more attention on relationships in older adulthood was discussed by participants in relation to having more time to do so as work and other distractions became less of a priority. A frequent comment by participants across all groups was the positive aspect of retiring from work in relation to the time it allowed to spend with their partner and on other relationships in their life. “I suppose retiring, both of you being able to do, and have a little bit of free time and be able to go out and do what you want and you just, enjoy each other’s company and be together.” (LLLS = 14[line 155]). Therefore, participants in this study were found to regulate their social networks to optimise the emotional experience in their relationships (Carstensen, 1992; Carstensen et al., 2000). Consistent with socioemotional selectivity theory, which emphasises developmental changes in social networks and psychological wellbeing, increasing age was associated with managing social contexts through a greater investment in emotionally meaningful social relationships for participants in this current research (Carstensen et al., 1999; Schaie, 2001). The increased ability to prioritise relationships and the desire to place importance on making connections with people in later life is illustrated by one participant’s reflection on her relationship with her granddaughter.

There’s a regard from her to me as a person...that’s been a real plus for me...I’ve actually said to her, recently I’ve seen people who’ve lost someone and they’ve died and the person searches themselves...and wonder if there isn’t something else we could have done...I’ve watched that and you can be reassured that there’s nothing more you could have done for me I said...and I think those things should be said more because it saves anguish you know, people are so avoiding the real stuff of life...never engaging with the real humanity that we are. (WA = 9[line 533]).

Findings from the current study are consistent with recent qualitative research examining the processes involved with connectedness for 12 community-dwelling adults (Register & Scharer, 2010). It was found that the desire to be with people and having
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relationships with family and friends, were of primary concern to participants in regard to facilitating a sense of connectedness as this provided a mechanism to engage in life in meaningful, positive, and purposeful ways (Register & Scharer, 2010). Furthermore, other research has signified the importance of connectedness in areas such as mental health, indicating that the quest for meaning in life is grounded in a need to be connected and to feel useful, and cared for (Gunnarsson, 2009; Livingston et al., 2008; Moore, 1997). The findings and interpretations from the current research are consistent not only with significant gerontological literature (Rowe & Kahn, 1987, 1997), but also with recent research on connectedness (Gunnarsson, 2009; Livingston et al., 2008; Moore, 1997; Register & Scharer, 2010).

Investing more in emotionally meaningful relationships for participants in this current research commonly referred to strengthening family bonds, however there is an assumption that older people need their families most (as opposed to other sources of support) (J. Reed et al., 2004). Although participants in the current study frequently mentioned the importance of family relationships in facilitating a positive ageing experience, it was also acknowledged that it is important to keep boundaries with family and to ensure that one has special relationships and interests outside of the family.

"You still have to have some sort of quality of life and something you’re interested in yourself, apart from your family as well so you’re not really dependant socially on them...I garden...I’ve been learning Indonesian...I belong to a gym...none of my family are involved in any of that stuff, so I think you have to make your own interest as well because they find it a great burden if they have to provide for you socially as well, and as you get older you don’t have the same sort of contribution to make to their social activities because I’m not really all that interested in what they do, like they do things that are quite to me a waste of time (laughs). (WA = 9[line 503])."

As the above example illustrates, ensuring one has other interests and relationships highlights the different interests among older adults and supports the existing literature that development from middle-age and late-life is essentially one of greater heterogeneity (Magai, Consedine, Krivoshekova, Kudadjie-Gyamfi, & McPherson, 2006) - an important point to reflect on when designing and implementing programs designed for older adults and an ageing population.

The importance of supportive relationships to the lived experience of ageing was further demonstrated by participants across all four groups expressed concern and worry associated with dying before their spouse. The thought of leaving ones’ partner behind and thinking about how their partner might cope in that situation was of great concern to...
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partnered participants. These findings are supportive of previous research reporting spousal loss as one of the most distressing life events (Carr, 2009; Holmes & Rahe, 1967). Furthermore, for participants who were married, most described their partnership with their spouse as the most positive aspect about their experience of ageing and subsequently, they believed their relationship was the most important factor to having a good quality of life as they aged. Consistently, finding a good partner in life or as described by some, the “right mate”, was considered by participants to be the key to happiness. “He [son] didn’t have the right mate...and I did and that’s what I am saying, we’re growing old together and we’re happy...if ever I lost her I don’t know what I’ll be...that’s a terrible thought.” (Discontinuing = 8).[line 255]). These findings concur with research which has found that having a positive partnership is a significant component to quality of life (Bowling & Gabriel, 2004); as well as important to social capital (Gray, 2009). Findings were also consistent with other research indicating the absence of this type of connection found to be a key determinant of loneliness and social isolation amongst elders (Wenger & Burholt, 2004; Wenger, Davies, Shahtahmasebi, & Scott, 1996).

The importance of having intimate connections and relationships with others was further identified by accounts of experiences where supportive relationships were missing in people’s lives or when participants had experienced the loss of someone close. Participants related that it was because they felt they did not have a close relationship with someone that they experienced feelings of loneliness. For one participant this also manifested as a negative view towards life and ageing.

Well it [ageing] means that your life’s over, that’s what I think, but there’s not much to look forward to, different if you have got a husband, you’ve got a loving husband and you can share your ageing together...you hear and see a lot of people who are going around Australia trips and things like that at my age, younger maybe probably in their 60s they start and you’ve always got somebody there you know but when you’re on your own, you don’t sort of, you’ve just got nothing to look forward [to] really have you. (LLLS = 5).[line 13]).

Furthermore, in the case where a spouse had passed on, loneliness and depression often resulted and in some cases, the emotions associated with their loss dominated the discussion about their experience of ageing.

I tried to get back there [the LLLS program] after [wife] died...I didn’t go because I just didn’t feel up to it...that still affects me and at times when I’m watching movies...and some of the movies have situations where someone has died (tears in voice) woman, wives and ah, I start getting wet eyes, I suppose that will happen for a long...I mean people say it’ll get better, they’ve been through it...and they say that they are
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widowed, ten years ago, five years, seven years whatever...that old saying that time heals everything that’s not true I don’t think. (LLLS = 13[line 398]).

For this participant the sense of loss and subsequent connection with his spouse over ruled any other experiences he may have had throughout his life and the focus of conversation was on the immediate pain of the event of losing his partner.

In review, while there is some discrepancy in the literature as to the frequency and intensity of emotions and emotional states such as sadness, anger and depression in later life (Magai et al., 2006), from the current study provision of support suggests that adulthood is characterised by powerful emotional experiences and expression when personally meaningful experiences are sampled with the strength of this emotionality not subsiding over the adult years as suggested by some research (Gross & Levenson, 1997; Lawton, Kleban, & Dean, 1993). It was not only the loss of spousal relationships that resulted in powerful emotions but also in the case of losing a child. This is illustrated by one participant’s experience of losing her son. For this participant, the event of losing her son and the process leading up to his death caused such emotional stress that she felt she had become old and had deteriorated in health because of the experience which also resulted in a negative reflection on her experience of ageing.

As a mother it is very difficult to comprehend…I find it difficult to process, which makes me feel older…It was suddenly as a parent, as a mother in particular, you’re not included in the process anymore, you, you sort of, the doctors don’t speak to you…it all becomes quite you know you’re just a, a visitor and I find that very stressful I must be honest and I think I deteriorated…I think I get more poisoned in the way of the end of my life. (LLLS = 6[line 30]).

Recent research examining how social networks influence the practical and emotional support available to people aged over 60 years in Great Britain, found that there was relatively poor support amongst those who were childless or had been continuously without a partner, while relatively strong support was found amongst those who had frequent contact with other people, who interacted with neighbours, and who regarded their neighbourhood as a supportive social environment (Gray, 2009). The participants in the current study who had lost partners, did not have children, had few or no family or other existing supportive relationships, mostly relied on the community for support and to make connections with others. “There are a lot of sad people out there, I live on my own but I don’t feel alone because…I’m in the National Seniors…we just meet every month…but mainly it’s to get together, be friendly to them.” (Discontinuing = 10[line 50]). In instances where participants did not feel that they were the type to join community programs or be active in their community, they still recognised that staying involved and connected with something was an important aspect for their wellbeing.
and made for a more positive ageing experience. The example below illustrates this point about connectedness but also draws attention to an observed gender difference in how men and women facilitate connections with others.

I’m not a “joiner”, I do like social interaction but I guess I like it more on my terms...I feel I want it to be purposeful in some way and I would like to choose the people I’m doing it with...but I think being connected is really important, I think for one’s social and emotional wellbeing, being connected to society in various ways is really, really important...I am also aware that women do it much better than men and it seems to be a much more natural thing for women whereas with men it’s much more, if you’ve got a wife or partner they tend to drag you into that and that’s good to a certain extent certainly my natural tendency would be oh it’s all too much trouble. (WA = 4[line 199]).

Gender differences in terms of opportunities and capacity to connect with others in ageing were echoed by another participant’s response.

They’re [men] normally not about relating so much anyway and there’s something wrong because most of them are dead (laughs) I go to the [National] Seniors there’ll be 400 people there and I suppose maybe 12 of them are men...when I was nursing and I used to go into the ward and the woman would all be, used to be knitting and crocheting and cutting out recipes and all that and the men would be sitting there, it made a big impression with me, in the men’s ward there was nothing happening...they didn’t even talk...but women were still involved in the family and still trying to do what they could. (WA = 9[line 131]).

Gender differences in maintaining supportive relationships and social connections were particularly evident when it came to participants discussing retirement. Preparing for post retirement to ensure there were still opportunities for interaction with others was recognised as an important aspect to staying connected and important to participants’ experience of ageing.

He [husband] was valued, very valued but I know that there are others that I’ve spoken to who just say, walked out, they never missed me, never ever rang me nobody could have cared less if I dropped dead on the spot...that’s bad, and of course also I think we older people are a bit dumb sometimes, you know that you’re going to retire, you make absolutely no preparation for it, now in the work sense he [husband] didn’t, but he had another life outside of the work so I think that is a very big issue that people are not sort of making other opportunities for themselves outside of their work, or haven’t got another life. (Discontinuing = 6[line 515]).

For some participants, especially male participants, work provided opportunities to interact with others and when they retired, these connections were often lost. For some participants, there was some apprehension associated with this prospect.

I’m not looking forward to retiring because it’s another group of people that I am associating with...I’ve always been in groups I like to be in groups...I think people that stick to themselves do themselves an injustice really...when I retire, god I can’t even
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*think of stopping work, I love work I would never ever not want to go.* (Discontinuing = 10[Line 265]).

Therefore, findings from this current research are consistent with significant gerontological literature (Rowe & Kahn, 1987, 1997) and offer support for the importance of supportive relationships, social support and connectedness for wellbeing and quality of life in ageing (Bowling & Gabriel, 2004; Gray, 2009; Grundy & Sloggett, 2003; Gunnarsson, 2009; Kafetsios & Sideridis, 2006; Livingston et al., 2008; Moore, 1997; Register & Herman, 2010; Register & Scharer, 2010). However, additional qualitative research further investigating the processes by which social contacts and social support are generated and sustained, would facilitate a better understanding about the role and benefit of social support in later life (Gray, 2009). This would also allow researchers, policy makers, and other relevant service providers, to better address the needs associated with an increasing older population. In addition, while work has been identified as important for generating and sustaining social contacts and support, another key aspect identified in this research as important to the process of how social support is generated and sustained in later life, was evident in participants’ discussions about religion and spirituality in their lives. Aspects important to these discussions are described in the next sub-theme.

5.3.3 Religion and spirituality.

In addition to social and intimate relationships, some participants across all groups in the current research mentioned their faith as being the thread that underlined their experience of ageing. For these participants, their faith provided a sense of connectedness to life as well as influenced their philosophy towards ageing. These findings are consistent with other recent research which has highlighted that various aspects of spirituality were apparent in processes identified as involved with connectedness for a sample of community-dwelling older adults (i.e., having something to do; having relationships; having a stake in the future; and having a sense of continuity) (Register & Scharer, 2010).

Faith in the context of the current research was influential in different ways to participants. For some it was considered as providing the basis for a positive attitude, which facilitated acceptance with life. For others their faith provided a sense of purpose and offered peace.

*My Christian faith...I’ve always known that I’ve had hope for the future, whether I am dead or alive, so that in itself has taken care of my, any worries that I might of had...and it’s given me a purpose, it’s the purpose, I think...if you’re just working towards your own personal satisfaction, your satisfaction of your family and the satisfaction of seeing your kids do well, I think you head yourself up for a lot of...*
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I think if I wasn’t a Christian, I would probably be fairly scared of what’s in the future. (Discontinuing = 6).

Participants in the current research, who were not decided upon a religion to follow, disclosed still having looked into different forms of religion and spirituality for understanding and meaning in life to assist in adapting and coping with ageing.

Looking back I’ve met a few Buddha’s...very calm, very passive...quite a good existence...had I known that twenty years ago I might have changed my way of thinking to Buddhism, they seem to be a very, well I mean they seem to be a very passive race...why can’t we all live a peaceful existence, a happy peaceful existence. (LLLS = 11).

Another participant’s story of how her faith helped her to reconstruct a difficult experience into an opportunity to help others affected by similar experiences further highlights the benefit of encouraging a focus on existential belief systems and personal meaning orientation in health and ageing.

It helps if you are a Christian, because when hard things come you have support, invisible support...when you’ve been through the hard things, you’re more able to help people going through the hard things...I wouldn’t want to lose my child, son, but my neighbour lost her son some time ago and she didn’t know about ours and I called to see her and she said “nobody understands” and my husband said “she does”, and I was glad, not that I’d lost my son but glad that I’d experienced what I did and as you get older of course you’ve been through so much and so you are a more valuable person...the more you’ve been through the more you have to give. (Welsh = 10).

For this participant, faith and belief in a higher power provided her with support and a sense of connectedness during difficult times. Consequently, this experience of a higher plateau facilitated transformation, that is, it helped her to convert a given reality into a new potentiality. Similarly, this type of transformation has been found by other research to enable the capacity to deal with difficult personal and situational circumstances (Reker & Woo, 2011). This process also allowed the participant in this study to recognise how she could support others by transforming her personal pain and life experience into a positive by helping others to cope with similar experiences of trauma.

Participants’ perspectives on the importance of creating meaning from sources that go beyond self-serving interests such as that illustrated above, have been shown by other research to result in higher levels of social, psychological, and emotional wellbeing (Erikson & Erikson, 1997; Gatz & Zarit, 1999; Grossman, 2007; Reker & Woo, 2011; Schroots, 1996; L Tornstam, 1989; Wadensten, 2006) and is supportive of the concept of gerotranscendence (Erikson & Erikson, 1997; L Tornstam, 1989). Regarded as the final stage of maturation, during
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the process of gerotranscendence, the individual is thought to experience a redefinition of self and of relationships with others by way of a decrease in self centeredness and a shift from a materialistic view in life to a more transcendent one through the process of self-reflection (Gatz & Zarit, 1999; Schroots, 1996; Wadensten, 2006). Achieving gerotranscendence implies attaining wisdom, with changes in the perception of time, space, and objects bearing a new understanding of fundamental existential issues (i.e., increased affinity with past and coming generations) (Schroots, 1996; Wadensten, 2006). The benefits of taking a transcendent view of life has also been illustrated by recent research examining how different patterns of sources of meaning in life affects the psychosocial adaptation of older adults. One study which involved 120 community-residing older adults in Canada completing various self-report measures (i.e., physical health status, life satisfaction, personal meaning orientations, existential regret in life, depression), found that older adults who derive meaning from self-transcendent sources which focussed on committing to personal, interpersonal or social development, also possessed many positive psychosocial adaptive qualities, such as, a greater purpose and coherence in life, less depression, and feeling more in control of directing their life (Reker & Woo, 2011).

The findings from the current study support previous research highlighting the importance of addressing existential needs such as spirituality in ageing and offer support for a more holistic approach to health (World Health Organization, 2002). The search for a deeper meaning as one ages as illustrated by the findings from this current research is consistent with current psychosocial developmental literature, particularly ideas about gerotranscendence (Erikson & Erikson, 1997; Gatz & Zarit, 1999; Lavretsky, 2010; Schroots, 1996; L Tornstam, 1989; Wadensten, 2006). This approach to health and ageing is also supportive of current wellness models which focus on creating balance between specific dimensions of health, one of which includes the spiritual (Gordon, 2006; Larson, 1999; McMahon et al., 2010; National Wellness Institute, n.d.; Pettit & Peabody, 2008). The degree to which gerotranscendence increases over time, or how accepting society is of recognising the role of spirituality in maintaining and facilitating good health, is largely dependent on various aspects of culture (Wadensten, 2006) and the values inherent within them. Salient social values depicted from participants’ experiences from this current research are explored in further detail in the next major theme.
5.4 Theme three: Social values

Images of old age are informed by underlying social values and express a widely varying range of social attitudes towards old age (J. Reed et al., 2004). Social values become particularly evident when the claims of different groups come into play (Estes et al., 2009; J. Reed et al., 2004). For example, the notion of reciprocity is concerned with the process of reward for contributions that a group of people make. If the idea of reciprocity is time limited, that is, only current contributions are acknowledged, then older people are placed in a vulnerable position, especially if they are no longer working or do not have active social roles (Havighurst & Albrecht, 1953; Lewis, 1984; McPherson, 1990; J. Reed et al., 2004; Wadensten, 2006). Western society, often described as being youth-orientated, can further position older people as an unpopular choice for resource allocation (J. Reed et al., 2004). Reflecting on findings from the current study, participants’ accounts of their experiences of ageing often revealed how they were affected by interactions with others in the community and by society based on assumptions made about their age. Often these stories were told through participants’ observations of how other older adults were treated in particular ways because of their age or perceived age, but mostly it was participants’ personal accounts of their own experiences that were discussed. This section aims to relay these accounts through the identification of three sub-themes namely: generational interactions, ageism, and resource allocation.

5.4.1 Generational interactions.

In talking about experiences in the wider community, participants in the current study reported interactions with younger people as being predominantly negative. Often participants were left astounded by the pervasiveness and explicitness of ageist attitudes through their interactions and experiences with younger people in community settings, which facilitated a very “us and them” approach to how these interactions were viewed. “Sometimes the young ones don’t give us credit...you know you’re too old to have an opinion but I suppose that’s attitude from the young to the older people.” (Discontinuing = 9[line 34]). Such experiences often led participants to consider how others view them, subsequently also causing them to reflect on how they must present to others as a person of a certain age regardless of how they may have felt on the inside. “There are others [young people] that think you know, we’re idiots where just, we’re going down the drain, downhill, we don’t know, they don’t think that we have collected a lot of knowledge in our head.” (LLLS = 5[line 365]) and “somewhere it has to start with a regard for older people and ageing...because we are human
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beings and by birthright are valuable...if that was from school age up then people could look forward to being a valued member of society as they got older.” (WA = 9[line 684]).

A common example provided by participants of a situation where young and old were forced to interact in the community was on public transport. The example of not being offered a seat on a train and being forced to stand was mentioned often as an illustration of how participants felt they were treated and subsequently regarded by younger people.

We got onto the train to come home and...all the Asian kids jumped up and gave us a seat...I just thought how sad it was that the others just sit there and ignore you, not that I would expect you stand up for me, I wouldn’t...it’s just a bit of an indictment on our society that we’ve lost that ability to care for one another and I see that a lot now. (Discontinuing = 6[line 130]).

Reflection on such instances often revealed a sense of disrespect or inconsiderate behaviour by younger people towards older adults through lack of acknowledgment and regard. Significantly, these experiences were only related by participants from the three groups in WA (the ‘LLLS group’, ‘Discontinuing group’ and the ‘WA group’), which highlight that these issues may be context specific to the Western Australian community.

There’s a lack of respect, my husband found when he was on the train, on crutches...the people wouldn’t stand up for him, there would be school kids with their back pack on the seat beside them, fit young men...but he had grey hair and he was stooped and he had crutches...he had a hell of a time getting a seat on the train, regularly...and there would be signs up there, these seats are priority seats for seniors and disabled...he had to leave home a quarter of an hour earlier and go change the train station he went to so he could get the train [that] wasn’t full and it was the same on the way home...so yes I think WA is really bad for it. (WA = 11[line 435]).

The type of issue described by the participant’s response above, was not mentioned by participants in the ‘Welsh group’, further indicating that it is potentially a locally contextual issue that needs further consideration and investigation.

While interactions with younger generations were commonly reflected upon negatively, this was largely dependent on the type of relationship participants had with the person. Positive interactions where participants felt valued and included only occurred when the participant had a close affiliation with the younger person, usually this was either through family connections or a long-term working relationship (i.e., in the workplace or at university). When older people had or continued to have a working relationship or more intimate connection with younger people this view changed with participants often commenting on being treated with respect and equality. “They don’t think I’m old (laughs), you know I relate to a lot of young people because I work with them, I think they’re all right” (Welsh = 10[line 98]),
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and “I thought that would be one of the stumbling blocks when I went to university and yet the young people just accept you as another student.” (Discontinuing = 1[line 145]).

Therefore, findings from this study suggest that when interactions between different generations occurred in settings where there was a shared interest or goal, then the interaction was more positive, but when there was no perceived gain of engaging in the interaction, then older adults often experienced being ignored or disregarded. While this represents deeper societal values (i.e., respect, compassion), it is also reflective of how groups can become marginalised if there is no perceived value in interacting with a particular group (i.e., older adults) (Havighurst & Albrecht, 1953; Lewis, 1984; McPherson, 1990; J. Reed et al., 2004). This may reflect ideas about what is considered as contributing to a society, and what is therefore perceived as more valuable (J. Reed et al., 2004). Externally explicit displays of these values, and the associated impacts, are discussed in greater detail in the next sub-theme ageism.

5.4.2 Ageism.

To introduce the context of this theme, the following account of one participant’s experience is presented to illustrate the multiple systemic layers of impact that ageist attitudes and behaviours can have on the experience of ageing.

I had the most embarrassing thing happen to me...when the pensioners have their get together in Perth I went in for that...it’s my vintage woman widows who are suffering the most because we couldn’t have super and a lot of our husbands didn’t have super and we had children and we’d raised them. I’ve got an order of Australia medal...and I’m a justice of the peace and it doesn’t give me any money so when it finished they were saying we’re sending this petition off to the government...so I just wrote a little note saying...I was unable to pay my fees for membership...Millsey picked it up, the morning announcer on 6PR and his secretary phoned...”would you come on air in the morning and just talk about being a pensioner”...I said “yes”...I went on air and [they] said “we’ve got some good news for you we’re going to pay for your membership to the justices and the order of Australia”. I was horrified, I said “it’s not about charitable handouts it’s about the government recognising the fact that we’ve lived here, paid taxes and to treat us with some respect”, I was mortified...but the public were reacting because people were wanting to sponsor a pensioner, that is denigrating, that’s not what we want...we don’t want handouts. (Discontinuing = 4[line 330]).

This account is illustrative of the layered nature associated with ageist attitudes and behaviours ranging from the interpersonal, to the macro level of government. In the current study, participants’ lived experiences and observations of other people’s experiences of ageing often revealed accounts of older adults being subject to such ageist attitudes. These included beliefs and behaviours demonstrated explicitly and implicitly in various social settings, through direct interactions with others in the community, by specific behaviour towards participants, at
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institutional and organisational levels, through different social media, and through the actions, and inactions of government.

Underpinning any aspect of an “ism” is a differential value being placed on something, be it skin colour, gender or age (Bytheway, 2005; J. Reed et al., 2004). In Western developed countries in particular, ideas about what contributes to society (and hence what is considered more valuable) are generally linked to material contributions and independence from the need for support from the rest of society with value increasingly placed on what people do, and not on who they are or what they believe (Estes et al., 2009; J. Reed et al., 2004). This type of valuing could be interpreted as a sign of a self-destructive society as illustrated by one participant’s reflections.

*My father decided that a sign of ill health creeping into a society was when you no longer had a majority, respect and care for the very, very young at the beginning of life…and respect for the older, the other spectrum of life and a society that doesn’t cultivate that was unhealthy and it would gradually turn in on itself and become self-destructive and lose a sense of community and values…the whole world has become more consumer orientated, more materialistic...an over concern with materialism, an unhealthy occupation with it does not bring happiness. (WA = 14[line 143]).*

Valuing towards function-ability can also lead to less financially productive people becoming socially excluded, and dominant groups in society are then better able to maintain control over subordinate groups (Estes et al., 2009). Retirement from paid employment, expectations of withdrawing from political decision-making, and assumptions about the gap between the values of old and young make it increasingly difficult for older people to find a role that is valued outside their own family and sometimes even within it (Estes et al., 2009; J. Reed et al., 2004). Ageism can therefore be experienced in different ways such as through other people directing policy and resources or on an interpersonal level in everyday interactions with intent difficult to ascertain as discriminating behaviour can hide under a mask of benevolence and caring (e.g., comments made about how “lovely” old people are can be patronising), or can be openly derogatory (J. Reed et al., 2004).

In one sense, ageism can be viewed as a process of being judged “old” which then infers the measurement and classification of age in some way. A common variable used to measure age in ageing research is one’s chronological age, however it is the categorisation of appearance and how this relates to age that is much more malleable as it is socially constructed through different mediums in society (e.g., media) (Bytheway, 2005; S. Katz & Marshall, 2003). Experiences of implicit ageism for participants in this study were often represented by messages expressed in various forms of media about older people. “The way
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The media portrays us at the moment, we shouldn’t really be here anymore...we’re just really quite a nuisance, we cost money, we don’t produce anymore...and I think...at times I start to feel that, you get sort of, perhaps a bit treated as a patronising” (LLLS = 6[line 143]) and “that’s what the media do, they stereotype people, older people, they’re bloody useless, ‘they don’t pay that much tax anymore’ that sort of thing...it’s portrayed that way in the media, but I think it’s part of our culture.” (LLLS = 9[line 195]). This type of implicit ageism was further illustrated by one participant’s experience with the marketing of services specifically targeted for older adults. Instead of promotional elements focussing on the targeted group, marketing was instead driven by the selling of youthful images and ideals.

They [media] like to often make older people invisible, for example, I started a walking group up at the Whitfords shopping centre and it appealed very much to older people and that was the intention...and the shopping place provided a place where they were less likely to injure themselves, they could go for a cup of coffee afterwards and [it] very much appealed to older people...but when they did all the promotional materials they only featured young people doing the walking group, there were no pictures at all of older people and obviously why promote it to younger people because it’s not likely to appeal to them but they just didn’t want to use older women’s images...it was just that the image didn’t comply with their corporate image. (WA = 13[line 150]).

Some participants expressed their concern of treatment of older adults in our (Western) society by making cultural comparisons. “Cultures, particularly South East Asia, India, Pakistan, those countries, older people are respected more than they are here. If older people are respected here, it’s because it’s somehow a structure to do that rather than a culture.” (WA = 15[line 244]). Participants made these comparisons through their knowledge of Eastern perspectives on ageing as well as relating to experiences with their own cultural experience. “I don’t think the Australian culture...nurture the elderly like some of the Asian countries do and really respect the elders and look after them, it’s more...everybody do their own thing look after themself.” (WA = 5[line 130]). For one participant who identified as Indigenous Australian, the concept of respect was discussed as an important element of how older adults have traditionally been considered and treated within Indigenous culture.

Age gives an individual the aura of respect...I’m speaking now mainly from an Indigenous perspective...when I was a youngster it was part of growing up to respect your elders...a lot of older people are put into homes that doesn’t happen so much in Indigenous communities as such, so in other cultures as well where older people have the respect and their opinions are sought I think that’s a benefit that’s sometimes lost in the Western world where there’s such an emphasis on materialism and you know having a good job and having a nice car...there’s not enough time to spend with grandparents or with parents even. (WA = 12[line 13]).
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From this participant’s experience, respect for elders was still a valid and exercised concept, and this experience informed their reflection on what they considered a Westernised view on the valuing of older people. That is, one that places greater value on more material aspirations above looking after family and elders. This offers support for the further development of the theory of gerotranscendence (Achenbaum, 2006; Erikson & Erikson, 1997; Jonson & Magnusson, 2001; Lewin, 2001; Schroots, 1996; L Tornstam, 1996; Lars Tornstam, 1999; Wadensten, 2005; Wadensten & Carlsson, 2003) and suggests that to encourage the valuing of older adults in our society and community may require a modification of various aspects of culture.

Participants in this study across all four groups also reflected on experiences of ageism whereby ageist attitudes were explicitly witnessed and experienced. The most common examples of the situations where this type of behaviour was encountered included the workplace setting, particularly during the interview process when applying for jobs. “You just don’t get a look in with jobs, you really just don’t...and I could hardly say I’m 27 on a job application, I’m not going to the extremes to try and cover that up” (WA = 11[line 422]) and “I would get a phone call saying ‘you sound like exactly what we want can you come down for an interview’ and you would walk in the door and see the change in attitude once they realise your age.” (Discontinuing = 1[line 138]). Explicit forms of ageism were also described by participants who reflected on the language and discourse used by the media about older adults.

Very sadly it [media] portrays people as victims, obviously ageing is a biological thing but what happens to your body, you do have an influence on, just seems rather passive, you know you are a problem or you have a problem, there are resources here or marketers want to sell you something, so let’s put them in a negative [rather] than a positive position. (LLLS = 17[line 90]).

In summary, findings from this study suggest that ageist behaviours and attitudes were prevalent in participants’ experiences of ageing. The treatment and attitude towards older adults experienced by participants revealed how layered discriminatory behaviours can be. This type of behaviour was explained by some participants as a result of a cultural manifestation of Western ways and a preoccupation with a valuing in society on what people do rather than what they believe or who they are (J. Reed et al., 2004). Culture was considered important to how older adults were regarded with the values of Western society described as lacking care and respect for older adults at an individual, social, and political level. Ageist messages were discussed as primarily facilitated through social mediums such as the media and experiences in the workforce. Therefore, social values and ageist beliefs became more transparent when exploring participants’ experiences of interactions with other groups in
Exploring the Lived Experience of Ageing in society (i.e., younger generations). This also became evident in participants’ discussions concerning the distribution of resources in society amongst different groups. How resources are allocated in society as related to participants’ experiences of ageing is discussed in further detail in the next sub-theme.

5.4.3 Resource allocation.

While implicit and explicit forms of ageism provide examples of how a society can devalue and marginalise older people, how resources within a society are allocated and distributed can further reinforce marginalisation and the creation of minority groups. Demarcating older people by specifying their unique needs and problems can result in separating older people from others in physical and social ways (Biggs, 2001; Estes et al., 2009; S. Katz, 1996; Powell & Biggs, 2000; J. Reed et al., 2004). For example, retirement policies are illustrative of such processes whereby structural inequalities can be well hidden as seemingly benevolent practices but can also be interpreted as excluding older people from the job market. Similarly in the case of pensions not generally equating to salaries, older people inevitably experience reduced incomes, which can subsequently affect their activity choices, social participation (Biggs, 2001; J. Reed et al., 2004), and opportunities to experience meaningful decision making power (Paley, 1997; Prilleltensky et al., 2001). While power is not all about money it can be seen as symbolic of influence and control and if power is something that is socially negotiated then anything that weakens the negotiating position of older people (as evidenced by many ageist assumptions), limits their power (Estes et al., 2009; Prilleltensky & Fox, 2007; Prilleltensky et al., 2001; J. Reed et al., 2004). Therefore, creating messages based on a premise that a group of people are no longer productive to the wider economic values of a society marginalises that group and impacts on how they are valued and regarded, and can lead to the formation of structural inequalities (the personal impact of this is discussed in further detail under the major theme agency and influence).

Structured inequalities commonly manifest when older adults are portrayed as problematic and seen as taking resources away from other groups, which in turn can reinforce stereotypes and systematically classify their needs as being the problems of old age rather than shared problems across society (Estes et al., 2009; J. Reed et al., 2004). Participants across all four groups of this study expressed feeling no longer valuable to society with each example suggesting aspects of structural inequality. Examples primarily included experiences that involved leaving the workforce as well as treatment in medical and health related situations. Retirement from work or having to leave work prematurely, were common experiences that highlighted how participants felt they were passively excluded or forced to
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withdraw from society. This has also been indicated by current ageing literature (Ranzijn, Carson, Winefield, & Price, 2006; J. Reed et al., 2004; Townsend, 2007; Walker, 2009b).

*I would have loved to of kept working but once you get to 65, they don’t insure your life...if you dropped dead at work you wouldn’t get anything, they’re asking me to work but they won’t sort of insure you so you know it’s bad...we didn’t have much say in that so I mean you had to retire.* (LLLS = 7[line 98]).

Exclusion was not instigated or desired by participants as earlier psychosocial theories of ageing would suggest (Cavanaugh & Blanchard-Fields, 2006; Cummings & Henry, 1961), but rather it was imposed upon them. Participants also commented on experiences with the health care system that left them feeling devalued and marginalised. “They’re operating on 90 year olds these days, so the technology is there but I think there’s people making decisions as to, well is this person going to be a useful person in society, should we spend a lot of money on this person” (Discontinuing = 5[line 482]) and

*I had an experience at the hospital yesterday, the advice to older women is give up having your pap smears when you’re about 60 because if you haven’t had a problem up till then you won’t and that’s not my experience...I did have a problem and I said to the doctors yesterday, it’s about time that advice was changed because I would of had a very slow painful death...then they very nicely explained to me, well it takes about ten years to come on so if you stop, like if you got it say at 65 well you’d be 75 before you needed an operation and they stopped themselves from saying well you know your life’s over, it sort of came out but was quickly drawn back and said “oh we wouldn’t want to give a 75 year old an operation”...how dare they decide when they can cut off help.* (WA = 9[line 75]).

“Medical ageism” as experienced by some participants in the current research, has also been described by previous research characterised by doctor’s and healthcare provider’s tendency to give less aggressive treatments and withholding a full range of treatment options based on age characteristics alone (Ory, Kinney, Hawkins, Sanner, & Mockenhaupt, 2003). While this type of behaviour may be considered as acting in the best interests of a patient it can also be viewed as overly judgemental and involve negative labelling leading to differences in access to needed medical care.

Furthermore, participants from the ‘Welsh group’ commented that they felt they were perceived as being a drain on resources, specifically on the National Health Service (NHS) as well as the economy, “they call us ‘coffin dodgers’...think we ought to be put to sleep at 70, I think the government think that as well because we’re a big drag on the economy.” (Welsh = 2[line 145]) and

*I feel sorry for people getting old in this country because we haven’t got the facilities to cope, to look after the old and I’d hate to end up in an old people’s home...I don’t want...*
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to bring politics into it but I don’t think the government we’ve got now have done the village people any favours, they’re looking after immigrants, asylum seekers, terrorists, than looking after the village people...and make no mistake I’m not a racist...but when we get people in here that all take everything out of the system and not putting anything back in that does annoy me. (Welsh = 3[line 67]).

Concerns regarding how the Welsh government allocated resources to older people were echoed by participants in the ‘WA group’ but were raised through the example of expecting more from our government in terms of resources for older people.

Something needs to change...I’ve got daughters coming on and I seen them now looking towards old age with apprehension...people shouldn’t have to be concerned with what’s going to happen to me when I’m old that should be well taken care of by our community and that surely should be our goal as a community, as a government...making sure that everyone has the best quality of life...there are enough resources in this country to make a serious difference. (WA = 9[line 635]).

The above examples of participants’ experiences in relation to the healthcare system and workforce where they felt portrayed as a drain on resources is also reflected elsewhere by governments and notions of “structured dependency”; the view that older people are disempowered by their exclusion from work and subsequent reduced spending power (J. Reed et al., 2004). For example, in 2000, Age Concern (a British campaigning charity) launched The debate of the Age to focus attention on the needs of a growing proportion of older people in society (Age Concern England, 2001). Although well intended as a humanitarian debate about how best to meet needs, Reed et al. (2004), believed that the figures presented on the proportions of older people alongside figures about the declines in younger people working and paying taxes to support them presented a mixed picture whereby older people were seen as deserving of help and respect but also portrayed as a drain on resources. One participant from the current study believed that these notions of structured dependency were going to change as the power returns to a majority in numbers of baby boomers coming through. This idea highlights that people are conscious of the power that can come with influence.

I don’t think ageing has got a positive image, I interpret it as, in a sense you get side lined...you become irrelevant, and not just in terms of, you may not participate in the workforce or you know you don’t have the spending power...the perspective of the older person isn’t given as much weight as maybe the perspective of younger people is, but I think that’s changing because I think you know I’m in the baby boomer generation and the baby boomer generation has influenced every single thing that they’ve ever gone through so maybe we will actually influence that perception. (WA = 4[line 54]).

The provisions a society makes for the care of different groups can be reflective of deeper societal values towards that group. This can also be reflective of a government’s policies and focus at the time. In the case of services and care facilities for older adults, the
impression given by participants across all four groups was one of distaste and fear about the prospect of care services available to them. “I find them [retirement villages] horrifying, that I think is a distortion of life as it exists but it fulfils a need, there is a grave need for accommodation for elderly people, particularly sick, elderly people” (Discontinuing = 7[line 192]) and “In the paper the other day I’d seen two people they cello-taped, taped him blind, a man’s mouth up and [put on the] floor to sleep, an Alzheimer’s patient to think that could happen to an old person.” (Welsh = 3[line 143]). There was also a realisation about the need for particular services when it came to talking about their experiences with care issues in ageing.

Aged care is sort of a neglected area...you know people are looked after to a point but they’re just treated like a number...cost you an arm and a leg...Baptist care a lot of them are run by religious people some of them are privately owned, they say it’s not about money but it is about money...so they keep the profit margins up and then sort of cut down on staff. When my parents were there I used to go every day do their washing bring their special treats and that in because they just didn’t have the time to actually look after them. (Discontinuing = 11[line 52]).

One participant also related her daughter and other younger people’s apprehension and anxiety about the future of their own later life care in light of the hype about an ageing population and the potential impact on resources.

It’s not healthy for the younger people coming on, my daughters are nearly 50 and they’re thinking like what am I going to do, they’re checking out around the nursing homes...one daughter said to me, “oh this place is quite good” she said, “you can come and go as you like” I said “you can!” You know how dare they, you’re not a prisoner. (WA = 9[line 233]).

In review, findings from this study revealed that one way in which a society’s social values become evident is by looking at how resources are allocated across groups. Workplace practices, healthcare provision, government planning and policies, and care facilities were all examples given by participants across the four groups of this study that illustrated different issues with resource distribution and allocation that affected their experiences of ageing. Often these experiences revealed structural inequalities that affected whether they felt valued. Participants’ responses from this study provide support for current literature that suggests that structural inequalities - explicit and implied - affect older adult’s social participation and opportunities to experience meaningful decision making (Prilleltensky et al., 2001; J. Reed et al., 2004). How older adults internalised these experiences and negotiate such changes in ageing is discussed in the next two major themes, negotiating transitions in ageing and agency and influence.
5.5 Theme four: Negotiating transitions in ageing

Later life is a period replete with transitions and change. Often these transitions involve challenges associated with loss such as the death of friends and partners, retirement from work, and decline in physical and cognitive functioning (Kwan et al., 2003). It would appear that experiences of irreversible losses in old age should have a negative impact on subjective life quality (Rothermund & Brandstädter, 2003), however despite the associated challenges faced with later life, as individuals age, their focus on acquiring gains and adverting losses appears to become more balanced (Lockwood, Chasteen, & Wong, 2005). Expecting that there will be more losses in their future development, older adults have been found to report the establishment of more goals aimed at preventing losses than reported by younger adults (Heckhausen & Brim, 1997; Heckhausen & Krueger, 1993). Participants across all groups in the current study appeared to weight their experiences of ageing by countering the gains and losses they experienced. Negotiating changes in this way appeared to function as a way of coping with change in ageing. In terms of losses and acquisitions experienced in ageing, participants spoke about the increase in physical changes and associated limitations of these changes, but often countered these aspects with gains experienced discussed in terms of freedom and wisdom. The transition of different roles such as becoming a grandparent, and retiring from work, were also frequently discussed by all participants as significant events influencing their experience of ageing. To explore the varied aspects involved with negotiating such transitions and associated gains and losses in ageing, the following sub-themes were identified: life stages and events; the dependence-independence continuum; the ageing body; and attitude and acceptance.

5.5.1 Life stages and events.

In western society, ageing is represented and referred to in developmental stages including, childhood; adolescence; and young, middle and older adulthood with each stage socially recognised as encompassing specific age groups and accompanied by particular cultural characteristics (Bytheway, 2005; Featherstone & Wernick, 1995; Hareven, 1995; Hepworth, 2002; Sabelli et al., 2003). Participants’ experiences of ageing in the current study were often defined through significant milestone events such as retirement and having grandchildren. Particular events seemed to provide guidance to most participants as to when the next phase of their life would occur which also then presented some expectations around certain age points. “Things like my children getting married, having grandchildren and retiring from full time work...[that’s] how I would see ageing, if you do those things it sort of means...”
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you’ve got to a certain stage, it’s a continuum...it’s a part of the life cycle.” (LLLS = 12[line 18])

and

I would see that [ageing] as a very natural process that applies to all living things...has different developmental stages, signposts along the way...and you look for analogies, you look at the seasons and you think of something like the springtime of your life as a human being and the summer...the autumn...and the winter of your life...you identify with all of what is going on...and I’m very accepting of that and I do like to reflect on what has gone by...about where I am now and to look ahead...to the future. (WA = 14[line 8]).

The discovery of a stage is complex often beginning as a distinct condition among certain social classes or groups with this information then made public and popularised on a societal level (Hareven, 1995). Following this, professionals further define and formulate the unique condition of such a stage of life which then typically translates as a part of popular culture (Estes et al., 2009; Hareven, 1995; Powell & Biggs, 2000). If the conditions peculiar to this stage seem to be associated with a major social problem, the stage can also then become institutionalised, that is, institutions are established to meet the needs of the stage and to address the associated problems arising (Estes et al., 2009). Public activities such as this in turn determine social identity in old age (Estes et al., 2009; Phillipson, 1998; Townsend, 2007). For example, old age has been institutionalised by a rite of passage – retirement, and in most Western societies by the commencement of social security and pensions (Estes et al., 2009; Hareven, 1995). Much of adult life is contingent on work and subsequently, retirement often involves other changes such as living arrangements and social networks. Most participants across all groups in the current study supported this claim as they recognised stopping work or retiring from work as a definitive time in life when society decides you are old. “When you retire and you have to get your seniors card and all these types of documents that tells you that your ageing and you’ve got to follow the lead as it were and make a means, a go for the best.” (LLLS = 11[line 65]).

Another common life event requiring negotiation for participants in the current study was the experience of losing relationships either through the death of a loved one or through changes in a person’s achieved social networks resulting from events such as retirement. A discrepancy between an individual’s desired and achieved social networks and changes in a person’s achieved social contacts (i.e., retirement from work, widowhood) can precipitate loneliness and has been related to other negative health outcomes including depression (Cacioppo et al., 2006; Newall et al., 2009); a loss of self-worth and quality of life; as well as having financial and relational implications at the family level (Ranzijn et al., 2006). Spousal
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Loss has also been consistently reported as one of the most distressing life events (Carr, 2009; Holmes & Rahe, 1967). Participants across all four groups in the current study often expressed the difficulties in facing and adjusting to the loss of loved ones. For example, “losing family of course, you know...(pause - voice softens) my mother, my sister, two brothers and that’s ageing, when my son died I felt ten years older...I really did” (Welsh = 10[line 37]), “depression in age is terrible especially if you’ve had a partner for a lot of years and you lose them, mentally you just don’t want to know about it” (Discontinuing = 10[line 85]), and “you wake up in the middle of the night and you’ve dreamt of somebody and they’ve gone and then you think of people around them and they’re gone too...you say gosh I’m facing this.” (WA = 10[line 7]). For one participant, the event of losing her son contributed greatly to her feeling older.

Over the last few years in particular, I feel far more debilitated and tired to what I had anticipated or would foresee, of course for all sorts of reasons...I lost my eldest son three and half years ago which was quite an upsetting experience...I tend to go back to his life, which makes me work hard at times to think you know, why didn’t I know this or why...as a mother is very difficult to comprehend...I find it difficult to process, which makes me feel older. (LLLS = 6[line 25]).

Part of negotiating and balancing the losses associated with life events was acknowledgement that the timing of some of these events often provided a sense of freedom to participants. A sense of freedom resulting from changes in work life (i.e., retirement), related to a freedom in time as well as a freedom of mind for many participants. Freedom of time was strongly associated with being able to engage in activities that participants identified as enjoyable and often more time was the direct result of retiring from full time paid employment, “the degree of freedom of choice of what you do and when you do, you don’t have to get up to get to work...and you don’t have be so time conscious regarding routines in your life.” (WA = 7[line 105]) and “[retirement] meant freedom that I could do what I wanted to which was brilliant...yeah I think that’s the freedom to be able to do what I want to do having worked all my life that’s probably the biggest change within me.” (WA = 11[line 12]). Some participants, while enjoying the freedom of time to do more things, reflected on the irony of having limited capacity to use the time the way they would like to, “it has got its advantages, I’ve got a bit more time to read a book I guess, on the other hand whatever asked of you it takes you longer to what it did before.” (LLLS = 6[line 77]).

The freedom of mind aspect of participants’ experiences was often associated with dropping the standards and expectations that others were perceived to place on participants and not being concerned with what other people thought of them. Consequently, this created a sense of freedom to be and to do what one likes. For example, “I learnt to swim when I was
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61, I think that has, that has made me feel a lot more, free I suppose and think okay I’ve done this I can have a go at something else” (Discontinuing = 2[line 31]) and “you don’t really care what people think that much about [you], as you would have when you were young, the approval you do need but I don’t know somehow it’s not so sharp a need.” (WA = 9[line 445]).

As already identified under the major theme connectedness, participants from all groups reflected frequently on how relationships had become more important, if not the most important aspects of their lives as they aged. Retirement and changes in work responsibilities in the later years of life were described by participants as providing a sense of freedom and stopping work meant that participants were able to spend more time on their relationships. For example, “I love being at home with the wife I mean a lot of people say keep her out you know but it’s different for those you know, I mean she worked all her life... yeah we love being together again you know.” (LLLS = 7[line 220]). Therefore, the freedom of mind and time to spend doing enjoyable things allowed connections important to participants’ experiences of ageing to be nurtured and strengthened.

Therefore, the lifespan is more than a biological occurrence formed through cultural beliefs and images, it also provides an intellectual key to how general discourses of existence are organised (i.e., social and political terms) (Biggs, 2001, 2012; Bytheway, 2005; Estes et al., 2009; S. Katz, 1995). While events such as retirement were frequently noted for the sense of freedom (i.e., freedom of time to spend with loved ones), that they brought, there were also many emotional challenges precipitated by the same and other life events typical of later life, such as the loss of relationships and connections as a result of retirement and widowhood. Changes in relationship dynamics are explored in further detail through the concepts of independence and dependence in the next sub-theme.

5.5.2 The dependence-independence continuum.

Dependence and independence are important themes for people at any age, however the two terms are laden with cultural values that affect thinking about ageing and growing older (Lowy, 1989; Plath, 2008). Typically in Western societies, independence is associated with personal autonomy and is highly valued while dependence is frequently associated with old age and seen as profoundly problematic (Cordingley & Webb, 1997; Fine & Glendinning, 2005). Furthermore, dominant understandings of independence in the gerontological and care literature have primarily focussed on the ability to function unaided (Leece & Peace, 2010; Schwanen & Ziegler, 2011; Secker, Hill, Villeneau, & Parkman, 2003) and dependency has particularly been debated as a negative state that should be alleviated wherever possible by
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public policy measures, treatments or other interventions (Fine & Glendinning, 2005). These conceptualisations about independence and dependence were also reflective of participants’ experiences in the current research with findings predominantly indicating dependency as associated with negativity and loss. Participants’ social contexts were especially found to be important in reinforcing meaning associated with independence and dependence in ageing.

For participants in the current research independence was often related to self-reliance and was described as being able to care for oneself and having the ability to do things they were used to doing, “[independence] means that I haven’t got to rely on other people” (Welsh = 5[171]) and “it means that you can manage to get about and do jobs and look after yourself.” (LLLS = 4[203]). It was also common that dependence on others was considered an inevitable consequence of ageing and this was a major concern for participants. “Everyone hopes they don’t need care but realistically...I suppose if you live long enough you’ll probably, get weaker physically and need...going from being self-reliant to dependent seems to come quite suddenly and unexpectedly” (WA = 9[489]) and “it came as a big shock to me this fall and exactly what it meant to me...dependant on other people...I was unable to drive...the loss of not just your independence but sort of what my life was before.” (Discontinuing = 12[13]). For some participants, independence was not only considered as the absence of dependence but was also closely linked to pride and self-esteem and an ability to accept and adapt to change.

I think that independence gives you strength because I know a lot of people that aren’t and they don’t cope so I find if you have the ability to comfort yourself...whether it’s a financial comfort or whatever...I think that’s a big benefit and I believe that I have got that and I have worked very hard to get it and I have to keep it...what I have nurtured within myself. (Discontinuing = 5[380]).

In addition, ability to adapt to change was principally found to be mediated by confidence and a continuity of self.

Independence, acceptance of the fact that you’re somewhat restricted in relation to many things but everything in moderation...the year before last, I was going to walk on the beach, I had walked it a thousand times...I’d walked about 50 feet and walked over some rocks, tore my left toe off so I didn’t come to the beach again that year...I wasn’t confident for a while, now I’ve got my confidence back and I guarantee within a month I’ll be into one of those rock pools somewhere. (Discontinuing group = 7[357]).

Thus, findings from the current research highlight dependency as predominantly associated with sickness and weakness and the value attributed to avoiding dependence was embodied in an ideology of self-reliance consistent with previous research (Secker et al., 2003). However, independence was found to be more closely associated with an individual’s subjective
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assessment of whether their lived experiences matched desired levels of choice and autonomy (Plath, 2008; Secker et al., 2003). Findings from the current research also demonstrate that the two terms are broader concepts encompassing not only self-reliance but also social and psychological factors (Plath, 2008; Secker et al., 2003; Sixsmith, 1986).

With independence associated with individualistic notions of choice and self-reliance, there is ambivalence about acknowledging that dependency is a necessary social condition that ties people together (Fine & Glendinning, 2005; Plath, 2008). Subsequently, debate has emerged regarding the treatment of dependency as an individual attribute or a product of social relations (Fine & Glendinning, 2005; Secker et al., 2003). In addition, it has been contended that older people who are less privileged in terms of embodied capacities and resources are at greater risk of social exclusion given their likely refusal to accept assistance due to a deeply ingrained desire to be independent (Portacolone, 2011). Particular to the current research, it was recognised by some participants that being too independent was not always the most adaptive strategy in ageing as it could lead to issues associated with social isolation.

You can become too independent too, people say selfish but it isn’t, you get used to managing on your own, I’ve been a widow for 28 years...you’ve just got to manage and that’s how you get sort of too independent and it becomes a bit of a curse really because if you meet a new fella they want you to depend on them a little and you’ve lost the knack. (Discontinuing group = 10[line 102]).

It has been argued that to recognise dependency amongst those who need help is a valuable optimising strategy as it can initiate and secure social contact (M M. Baltes, 1996). Consequently, seeking and accepting help from others should be viewed as a positive adaption strategy that can ultimately emphasise care as involving connectedness between people (M M. Baltes, 1996; Fine & Glendinning, 2005). Therefore, the seemingly instinctual desire for independence among older adults can be considered socially produced and reproduced through individualised discourses and social practices (Schwanen & Ziegler, 2011).

Significantly, although independence was important to participants in the current research, desiring and maintaining a sense of independence was not mutually exclusive from depending on others for help or the desire to have someone care for them. “Hopefully I will stay as independent as I possibly can, I currently do have a silver chain lady once a fortnight and I pay for that...as you get older...you need help if you’re on your own” (Discontinuing group = 5[line 479]) and “it means a lot to mean, for me to be as old as I am and I can still get around and my independence and everything, but I’ve got a daughter that lives near me and a
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granddaughter and they look after me too.” (Welsh group = 5[line 7]). This finding reflects that independence can be achieved and maintained concurrently in a context of dependence. This aligns with earlier research which contends that having needs met by one section of the social support network can release people from fears of dependence in other parts (i.e., feeling in control as they are financially and socially independent as a result of enlisting the support of outside services such as assistance with cleaning) (Cordingley & Webb, 1997; Sixsmith, 1986). Moreover, findings suggest that although dependence is commonly connected with reliance on others, independence can be viewed as a subjectively self-assessed experience that is mediated by the social context (Cordingley & Webb, 1997; Plath, 2008) making it is possible to combine high levels of dependence with high levels of experienced independence (Secker et al., 2003).

Furthermore, for participants in the current research maintaining independence was not purely an aspiration for self-reliance but rather it was desired out of concern with becoming a burden to family. “One of the things that concerns me is that if anything happened to me, I’d leave my wife with more problems, that’s possibly the thing most disturbing really” (LLLS = 15[line 216]), “everybody I know that’s older, they would say the same thing, that most people don’t want to be a burden to their family, you want to be able to look after yourself” (WA group = 1[line 139]), “I have no ambition to live to a great age...because sooner or later something’s going to happen and the last thing you want is to be a burden on your kids...that would be the biggest concern” (LLLS = 8[line 153]), and “I’d like to die in bed I wouldn’t like to be a burden to anybody...that would kill me.” (Welsh group = 2[line 79]). Therefore, for participants in this current research the thought of being a burden to family reinforced a negative view of dependence. This aligns with literature that argues the individualising and excluding language surrounding dependency too often connotes negative burdens and deficiencies on the part of the person needing help (Cordingley & Webb, 1997; Fine & Glendinning, 2005; Portacolone, 2011; Schwanen & Ziegler, 2011; Secker et al., 2003).

Although participants’ experiences in the current research reflected a negative view towards dependence in ageing, for most this view was contradictory to their personal belief that dependence on family for assistance and care should be considered natural and acceptable rather than problematic.

She didn’t like being or having to rely on other people to look after her...and I relate to that, I don’t want to be a burden on my kids, not that she was for me, she was my mum and I just used to say to her “you brought me up and you looked after me and everything so why shouldn’t I look after you now you know you’re my mum I love you
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and you’ve done for me all my life now it’s my turn to give back to you”. (WA group = 5[line 80]).

Participants especially acknowledged that sometimes it is important for people to feel they can be depended upon.

I’ve got family who would take care of me, not that I would ever want to be a burden to them if I was incapable...but then sometimes you deny people, if they want to, like my mum I was quite happy for her to come and live with me...for her to spend her last days here she said she couldn’t live with me, but she was very independent...then she got so ill that she had to go to aged care. (Discontinuing group = 11[line 128]).

Participants also acknowledged that sometimes within close relationships, particularly spousal relationships, one partner often creates a need for dependence despite the other partner’s actual level of dependency.

They’ve been made dependant, and I see a lot of that...one partner takes over from the other so makes them a little bit needy and they like it that way, in fact I’ve seen one couple and his wife had been sick, sick, sick and he just doted on her, did everything...but he died about 12 months later, well she sparked up, she got her driver’s license...I’ve seen that so many times but I think it’s human nature to make the other dependant. (Discontinuing group = 10[line 96]).

Thus, findings from this current research illustrate the complex relations between dependence and independence with the two concepts not necessarily being mutually exclusive for participants. In particular, feelings of independence were often preserved even in the circumstance of dependence if support was given in the context of a mutually reciprocal relationship (Cordingley & Webb, 1997; Sixsmith, 1986) and often although independence was valued, so too was having the capacity and opportunity to depend on others and be depended upon.

A further issue related to the sub-theme of the dependence-independence continuum is highlighted by one participant who described their concerns about care for their disabled child should they pass away before them.

There’s a couple of things that I think about...being incapable of looking after yourself at any stage and also my daughter has a chronic disease and although she works full time and does a lot for herself she still needs a lot of help...what would happen with her, for her. (Discontinuing = 1[line 191]).

It is assumed normal that children will grow to become fully independent and surpass their parents in life but in circumstances where parents are required to care for their adult children due to disability or other condition requiring intensive care this is often not the case. This raises important questions as to care options available for those in such situations, both for
the person requiring care and the older adult carer. Furthermore, with older carers predominantly looking after older people, the likelihood of becoming a carer increases with age and highlights the importance of further investigation into the factors that shape patterns of care giving (Fine and Glendinning, 2005). Conversely, the issue of support in the instance where people do not have children or family to look after them is also an issue that would benefit from further exploration.

In review, the social context was seen as playing an important role in fostering or undermining feelings of dependence and independence for participants in the current research, a finding consistent with previous research (Cordingley & Webb, 1997; Fine & Glendinning, 2005; Plath, 2008; Portacolone, 2011; Schwanen & Ziegler, 2011). In particular, it appears that independence is generally uncritically considered as a desired state despite some negative experiences resulting from being too independent such as social isolation (Plath, 2008). Therefore, findings from the current research suggest that it is important to expand the view of independence and dependence as purely opposite ends of a spectrum indicating more or less autonomy and rather recognise the complex relational and systemic understandings of these terms (Cordingley & Webb, 1997; Portacolone, 2011; Schwanen & Ziegler, 2011). A socially inclusive view of independence questions whether it is enough for older people to be managing alone and suggests a need to critically appraise the values informing the promotion of independence, particularly bringing into question structural disadvantages in ageing (Plath, 2008), systemic relationships and people’s struggle to keep up with the moral imperative of independence (Portacolone, 2011). Furthermore, many of the concerns for participants in the current research surrounding dependence and independence were predominantly associated with the ageing body and its functionality making the bodily experience a key issue in understanding the experience of ageing (Sousa & Figueiredo, 2002). Further issues related to the ageing body are discussed in the next sub-theme.

5.5.3 The ageing body.

Images of the human body are more often than not, accompanied by text or comments about the person’s age (Featherstone & Wernick, 1995). The ageing body as outlined by biomedical definitions, is a body functioning at less than optimum levels with maturity marking the beginning of a process of decline and decay, loss and restriction (J. Reed et al., 2004). Through this dominant discourse, younger people (especially women), are warned of the dangers in store and the need to engage in body work to maintain appearance (Featherstone & Wernick, 1995). Similarly, older people are praised if they have managed to preserve their youthful beauty and energy. It is no surprise then that this social construction of
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the ageing body was discussed by a number of participants in this study. Losses were primarily described in terms of limitations imposed by an ageing body or through illness and very much reflected a traditional decline and loss view of ageing. “Physically, because I’ve had arthritis for the last ten years that’s been restrictive on things that I would like to do...it’s just that I am not as mobile as I would like to be...emotionally it’s very hard to adjust to your physical changes” (LLLS = 16[line 14]) and “I thought you kind of got older and you maybe faded away in a funny way...I didn’t realise at that time...that ageing is a slow process of things breaking down...it’s like a car as it gets older.” (LLLS = 3[line 13]).

For other participants, the ageing body brought about a fear of their own mortality and this caused them to feel angry towards the physical changes they were experiencing. “I suppose, with my body there’s an anger about, you see your body getting older and you think hang on I haven’t actually lived yet...it’s probably rage about the overwhelming power of mortality you think yes but I don’t want that and its strange.” (WA = 9[line 217]). Emphasis placed on appearances in ageing was also demonstrated by participants in their community interactions and the assumptions inherent in these interactions because of their perceived age. For one participant, other people’s interpretation of her age and appearance were based on assumptions about illness.

I’ve had somebody in a shopping centre say to me “oh when did you have your chemotherapy?” and I said “I’ve never ever have had chemotherapy”, “well what’s wrong with your hair?” “there’s nothing wrong with my hair, it’s my choice” I find that sad because I do know people who have had chemotherapy and they’ve consequently died...so to approach a stranger because they look at that stranger as a certain age I think, they wouldn’t have said anything if I would be thirty...same as if a certain shape or figure...and I think that is a pity particularly when you get to a certain age where people take the liberty really of stepping more into your personal space...I think it is in poor taste. (LLLS = 6[line 220]).

Aside from the limitations that the ageing body imposed on participants, for some participants, mainly women, physical attractiveness was primarily discussed in terms of their experience of ageing.

I know it’s not deep and meaningful but sometimes I get concerned that you don’t look the same...nobody does but the way that your body, I mean you can exercise till the cows come home and you lose your elasticity...it’s just coming to terms with that...that you’re not young anymore. (WA = 3[line 244]).

Often this was discussed in a negative way whereby a change in physical appearance was considered a shameful experience.
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I look at my arms and I think I don’t know if I can wear short sleeves you know, I feel embarrassed and awkward about them and even your neck and all those type of things...that's a horrible feeling you actually feel a bit sad about that quite a lot...because that also takes your confidence...but then of course if the attitude of the community was well an ageing body is not that out of place in our society, you wouldn’t have to feel worried, it would be more acceptable then you wouldn’t actually be apologising for getting old and feeling, not being so attractive. (WA = 9[line 411]).

Similarly, issues of pride and dignity were reflected by some participants as important to how they managed the physical changes of their body. The need for participants to appear as if these changes were not occurring were important for fear of what others would think and to avoid appearing as if they couldn’t cope. For example, one participant would not get a walking stick, despite the need for it because of fear of what it might represent. “You get frustrated I think as you get older, you get a bit wobbly on your feet....if I’m going to go along the beach I take one of those hiking sticks so that doesn't look like a walking stick, it's all pride isn’t it really.” (Discontinuing = 4[line 120]).

For other participants, unpleasant feelings about their ageing body arose in situations where they were forced to look at themselves such as at the hairdresser. Precipitating these feelings was being confronted with unrealistic images of older women in similar age groups. In particular, for one participant, the issue of magazines containing success stories about 50 year old women in regards to their physical appearance that she felt were not representative of what was average, real or accessible added to her concern.

I HATE the hairdressers you have to sit there and look at your face - oh it’s awful, I mean some women are really positive, well if you believe the articles...how great it is to be old to be 50 and to be, they’re really positive but only the tall, slim good looking ones aren’t they! (LLLS = 16[line 548]).

This experience was not uncommon amongst participants nor is it necessarily a culturally bound experience according to recent research. A study exploring body image among African American and Caucasian adult women ranging from 20-80 years of age revealed that all women interviewed responded to societal expectations of beauty and femininity which demonstrated theoretical constructs such as objectification (whereby individuals see themselves from a critical, external perspective comparing their own bodies to an unrealistic ideal reflective of social norms and stigmas) were expressed (Reel, SooHoo, Summerhays, & Gill, 2008). These findings and those from the current study contradict previous research suggesting that as women transition into midlife, they begin to disassociate themselves with the cultural ideals of beauty and the power of the “external gaze” of others (Apter, 1995), and are less likely to compare themselves with fashion models (Kozar & Damhorst, 2009). Rather
findings from the current study offer support for the notion that psychological consequences of self-objectification includes anxiety and body shame which can potentially lead to psychological conditions such as depression (Fredrickson & Roberts, 1997).

A further observation made by participants about the adjustment to the ageing body, was the change in how men appeared to view women during the process of ageing. However, according to the male participants’ accounts of their experiences of ageing, there was no evidence of change in how women viewed men, as they grew older. Among the female participants, one felt that there was an obvious change in how she was regarded by men because of the changes in her physical attractiveness.

“It’s different, for example...I think when I was younger and probably more glamorous, (laughs) men would react in quite a different way where as now it’s in some ways, it’s just something you accept as you grow older, but it’s just interesting, for example when I used to work in a laboratory, it was very male dominated but when I walked into a room instantly there would be an arm around my shoulders and somebody wanted to know what I was doing at the weekend even though I was married but I know I wouldn’t cause that sort of a stir anymore...it’s not a problem it’s just a sign...that’s part of growing older. (WA = 13[line 104]).

The change experienced by this participant resulted in her no longer feeling regarded as a sexual object. This aligns with other research suggesting that the sexuality of older people is made invisible by society with its preoccupation with associating youthfulness with sexuality (Pangman & Seguire, 2000; Price, 2009). This is further compounded by the focus of images of older people engaging in non-sexualised activities such as knitting and playing bowls (J. Reed et al., 2004). With findings from this study primarily focussed on females’ reflections on their ageing experience in terms of physical attractiveness and the ageing body, it would be of interest to explore further the relationship of ageing and the social construction of older men and masculinity as also suggested by other earlier ageing literature (Fleming, 1999; S. Katz, 1995).

Therefore, perceptions of the body play an important personal and ideological role in the allocation of social identities (Featherstone & Wernick, 1995; Hockey & James, 1995). Changes in images of the self and others’ perceptions seem to create a contradictory relationship between the subjective sense of an inner youthfulness and an exterior process of biological ageing (B. S. Turner, 1995). With the outer body available to collective observation, it is difficult for the individual to avoid an exterior sense of the process of ageing and change (Atchley, 1991; B. S. Turner, 1995). How participants were able to negotiate the external
Exploring the Lived Experience of Ageing processes of their ageing bodies and come to terms with other challenges associated with ageing, is explored further in the next sub-theme *attitude and acceptance*.

### 5.5.4 Attitude and acceptance.

The fact that most domains of living are affected by loss, suggests that old age is associated with an increased risk for adaptational problems (Jopp & Rott, 2006; Schaie, 2001). However, indicators of subjective wellbeing signify that adaptation efforts remain stable during old and very old age with this phenomenon, known as “stability-despite loss”, interpreted as evidence that older people have a high capacity to adapt (Jopp & Rott, 2006). In a study examining centenarian’s adaption to the challenges related to being 100 years of age, it was found that psychological factors, such as self-referent beliefs (i.e., self-efficacy), and attitudes towards life (i.e., optimistic outlook), represented influential predictors of wellbeing, with these factors displaying stronger effects on happiness than resources (e.g., socio-demographic factors, health, cognition) (Jopp & Rott, 2006). These findings suggest that factors underlying psychological resilience are preserved at the very end of the lifespan as well as providing support for the premise that the individual’s internal world becomes more important with advanced age (Gatz & Zarit, 1999; Jopp & Rott, 2006; Schroots, 1996; Wadensten, 2006). Furthermore, despite the assumption that centenarians might perceive their future as limited, findings indicated that an optimistic outlook was very important and essential for happiness in extremely old age with acceptance (i.e., relinquishing control and relying on others) key to adjustment in old age.

For participants in the current study, often perceptions of the gains and losses within their experiences of ageing were mediated by their attitude towards life. With the possibility of losses becoming more salient with increasing age, it is thought that prevention orientations; a strategy of avoiding undesirable end states, are strengthened (Lockwood et al., 2005) (similar to the role that downward comparisons play in adjusting to the ageing process as discussed by the sub-theme - comparisons with others, under the major theme *primed thought*). Findings from the current study demonstrate that prevention orientation strategies do appear to strengthen with age. This conclusion particularly concurs with research that midlife adults are found to have better emotion management and regulation than younger adults (Kliegel, Jäger, & Phillips, 2007), primarily though maintaining hope and optimism (Chapman & Hayslip, 2006), with optimism considered as increasing with age (Isaacowitz, 2005). Participants’ responses to changes and transitions they had experienced with ageing revealed that attitude was important to how experiences were perceived and managed and acceptance was a pivotal component that facilitated more successful and positive negotiations.
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*Part of it [ageing] is the acceptance that you can’t, can’t take on everybody’s problems and it’s time, when you got to sort of have time for yourselves and you can’t just sort of cure everything...so you’ve just got to let things sort of go, and take things day by day, which is a good thing for me because I used to worry terribly.* (Discontinuing = 9[line 285]).

Subsequently, participants’ attitudes dictated the types of issues discussed. Many participants across the four groups commented on an increased ability to accept change and life as being an appealing aspect of ageing mainly because it meant that some of the more negative experiences could be countered and better negotiated in their mind. Acceptance was discussed in terms of it being easier to accept things that came along but it was also discussed in terms of its importance for adapting successfully in ageing to the various irreversible changes that occurred, with these findings consistent with earlier research (Ranzijn & Luszcz, 1999).

One day I had this light bulb moment right for about two years after losing my job, having to retire I realised I had been banging my head against a brick wall or saying this is unfair, this is unfair, it was unfair but it’s just history I couldn’t change it and I realised hey I can still feel the sun on my back, I can still hear the birds, I can still play with my grandchildren that was actually a bonus...I focus on the things that I still can do even though some of them are with modifications and just forget about the things I can’t do. (WA = 11[line 145]).

Responses by participants such as the above examples provide support for the psychological model of successful ageing known as selection optimisation with compensation (SOC) (M. M. Baltes & Carstensen, 1999; P. B. Baltes, 1997; P. B. Baltes et al., 1999; Birren & Schaie, 2001; Birren & Schroots, 2001; Schroots, 1996). Participants’ responses in this study illustrated a system of behavioural actions that helped to regulate management of the dynamics between experienced losses and gains in ageing (M. M. Baltes & Carstensen, 1996, 1999; P. B. Baltes, 1997; Birren & Schaie, 2001; Birren & Schroots, 2001; Schroots, 1996). Previous research has indicated that the use of pragmatic strengths to compensate for other weakened abilities is central to the model of SOC (M. M. Baltes & Carstensen, 1999; Papalia et al., 2007) and that acceptance is an important adaptation strategy to some of the unavoidable changes that accompany ageing (Ranzijn & Luszcz, 1999). Findings from the current research extend these claims with the management of the dynamics of losses and gains found to be particularly facilitated by maintaining a positive outlook and accepting what could not be changed.

Similar to participants’ experiences of an increased ability to accept as a means of coping with changes in ageing, wisdom was also commonly referred to as a positive acquisition that came with growing older. Wisdom was referred to directly and indirectly by participants
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from all four groups and was associated with how participants framed and managed the more complex aspects of their ageing experience. For example, “you’re more, able to adjust to the ebb and flow of things, just more yeah aware of [what] might happen and could happen, it’s not that you want it to happen but I think you sort of have to accept that and move along the path” (Discontinuing = 12[line 172]) and “probably your opinions have come to be a bit more rounded, your views probably got a bit of depth um that you didn’t have when you were younger, wisdom hopefully, I mean to me the ultimate aim of it, all of it is to have grace...a gentle, live and let live sort of thing...and that’s peace then.” (WA = 9[line55]). Subsequently, wisdom further facilitated an acceptance with changes that come with age with participants expressing a greater sense of control over their emotional reactions and using knowledge and experience to improve their wellbeing, even if only at an attitudinal level.

*Just like a penny, a penny has both sides, one is positive and one is negative and so if I can maintain a positive outlook, be it employment, be it community involvement, family relations or relations with my wife...must have a positive outlook, negativity is a curse of wellbeing, you must have a positive outlook and then the aging process, piece of cake. (WA = 12[line 190]).*

Therefore, despite the challenges and losses facing older adults later in life, humans appear relatively well equipped for ageing in terms of psychological functioning (Jopp & Rott, 2006). In particular, psychological factors such as self-referent beliefs and attitudes have been found to predict wellbeing, highlighting that psychological mechanisms constitute an important potential for successfully dealing with constraints and adversity in advanced age (M. M. Baltes & Carstensen, 1996, 1999; P. B. Baltes, 1997; Birren & Schaie, 2001; Birren & Schroots, 2001; Jopp & Rott, 2006; Schroots, 1996) with these strategies described by some participants in this research as “wisdom”. Another important factor important to adjusting well to old age adjunct to attitude and acceptance, is having opportunities to exert meaningful influence and maintain a sense of control and agency over the changes experienced with ageing. These aspects are discussed in the next major theme *agency and influence.*

### 5.6 Theme five: Agency and influence

Participants’ responses across all four groups revealed powerful insights into how they felt they were regarded and treated by others based on their age, particularly in social settings. The implicit and explicit ageist attitudes, beliefs, and behaviours experienced by some participants and issues surrounding the “ageing body” along with other changes associated with ageing as discussed under the themes *social values* and *negotiating transitions in ageing*, also affected participants on a deeper level. The more personal accounts of how these actions,
behaviours, and beliefs were internalised by participants were commonly reflected and expressed as feelings such as “worthlessness”, “vulnerability”, “powerlessness”, and “rejection”. Therefore, ageism does not only entail widespread discrimination against older people but is also a crucial factor in undermining personal value and worth (Ory et al., 2003; Scrutton, 1990). Personal value and worth were also discussed by participants when relating to experiences that facilitated a sense of positive regard. These experiences mostly related to situations where participants felt that they had a meaningful presence in the world either through an influential personal or social role (i.e., work related role), or when participants felt that their opinions and thoughts were sought, acknowledged, and regarded (i.e., in family interactions). To further explore and represent how participants related to their presence in society, interactions with others, and the associated feelings concerning these experiences, two sub-themes emerged from the data: meaningful roles and personal control and worth.

5.6.1 Meaningful roles.

Social roles are considered sets of connected behaviours, rights and obligations expected from and deemed appropriate for a person based on their social position (D. Katz & Kahn, 1978). Subsequently, social roles are defined structurally as a position in a group (i.e., mother, retiree) (Krause, 1999), and these roles offer instructions for how to behave in interaction with others across a variety of domains with some prescribed for specific points in the lifespan based on a society’s social time (Eaton, Visser, Krosnick, & Anand, 2009). The types of changes in social roles occurring during ageing for participants across this study included, becoming a grandparent, becoming a retiree, and becoming a carer for one’s partner and/or parents and children. Self-evaluation that emerges from occupying a particular role is strongly related to forming one’s identity (Krause, 1999). With greater importance attached to some role-specific identities, stressors and changes arising in certain roles are likely to be harmful as they can undermine the identity associated with the role (Krause, 1999; Thoits, 1991).

Findings from the current research offer support for earlier psychosocial theories such as activity theory which proclaimed the importance of social role participation in the positive adjustment to old age (Havighurst & Albrecht, 1953), and that being active and involved in the social context is important to successful ageing (Wadensten, 2006). However, findings from this study indicated that it was not simply staying active that was important to participants’ experiences, but rather that they were included and made to feel valued in the activities they participated in and in the roles they held. For participants in the current study, having a social role that provided opportunities to exercise meaningful influence with others, that is, roles that generated respect were highly important to participants’ wellbeing, self-esteem, identity,
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and overall ageing experience. With midlife considered a unique period in time associated with having a high level of power, influence and responsibility over valued resources and other’s outcomes, when moving from midlife to old age, a decline or change in such powerful social roles can lead to the feeling of loss of personal control (Eaton et al., 2009).

For some participants in the current study, their experience of ageing was defined by their job and for others the experience of retiring from work greatly affected their sense of self-worth. Supportive of previous research (Ranzijn et al., 2006), the impact of no longer working also meant to some participants that they were now limited financially, socially, and had reduced status in society. “Once you retire the whole life system changes you know like you’re tied to an allocated pension, or you’re a self-funded or whatever but you’re confined to that, you no longer have the ability to go buy something and pay it off.” (WA = 6[line 29]). For other participants stopping work translated into having nothing to do which made them feel old, “it never used to enter my mind about growing old...it never hit me until I retired and I thought, I’m getting old but I am old now for sure, because I’ve nothing to do you know, it’s a big blow.” (LLLS = 7[line 135]). While others took a more philosophical view when it came to retirement, “I think when I was growing up you sort of got a sense that you retired and basically waited to die where as I think, people have more resources and there’s a different perspective...just because you retire from work doesn’t mean you sort of retire from life.” (WA = 4[line 68]).

Related to social roles in ageing, participants’ responses in this study commonly reflected a stereotyped image of the older person. Some participants referred to “playing the role” of an older person meaning conforming deliberately to the stereotype. For some participants it was felt that if they did not play the role of the “nice old lady” or fit a similar stereotype, that it made life more difficult and uncomfortable for others and so by acting “old” it helped some people to feel needed and important.

There is an expectation that when you get older ah you won’t be able to cope so well, and it’s like a self-fulfilling prophecy, you end up almost feeling like you should be like that to make them feel happy like they can rest then, you’re how they know old people are...you’re more dependant and I felt that quite strongly that you might as well do it because it will make a lot less tension in them because they know how to treat you then...you know if you’re still vital or got strong opinions...and they think oh that’s not very nice for an old person. (WA = 9[line 54]).

Another participant, believing that some people “play the role” of the older person because they want or need the attention, meant they actively tried not to act in this way.
One thing subconsciously I’ve decided is not to play the role of an old person...quite a number of people sort of add interest if you like to the way they operate in society you know, oh I’m aged this that and the other or I’m a self-funded retiree and I think blah, blah, blah well I’m not going to do that I’m going to be just me. (WA = 15[line 25]).

Experiences that facilitated a sense of worth for participants included situations where they felt respected and sought after for advice or guidance. One participant felt valued because of their experience of still being approached for their advice. For this participant seniority, and their position and role in the family provided them with privilege and respect, “it’s [ageing] inevitable it has to come but it’s got some great joys, great joys, you know we are so, we get invites to everything our opinions are still sought.” (WA = 10[line 385]). Other participants, who identified as grandparents, felt this role meant that they were valued and respected as evidenced through reflections on their experiences with their grandchildren.

Our grandkids always pop in and one of them said oh you don’t mind coming over the grandparents...you don’t smell like old people (laughing) so they don’t regard us as really old...lavender, lavender and pee it was (laughing)...they will just pop in and I love that because it means that they’re not doing because they have to they’re doing because they want to. (LLLS = 1[line 210]).

Findings from this research thus support earlier claims about the importance of social role and workforce participation to the adjustment to old age (Havighurst & Albrecht, 1953; Ranzijn et al., 2006; Wadensten, 2006). What was important to participants in this research about the social roles they held included participating in activities that reinforced their value as people and that made them feel needed. Although, just “playing the role” of an old person was considered by participants as fake and unsatisfying, some participants still engaged in behaviour considered stereotypical for an older person so as to make others feel needed and important. Other aspects important to facilitating a sense of value and worth in relation to participants’ experiences of ageing are explored in detail in the next sub-theme.

5.6.2 Personal control and perceived worth.

Personal control has been widely recognised by researchers and clinicians as one of the most important predictors of psychological wellbeing in older adulthood (Rowe & Kahn, 1987; G. C. Smith et al., 2000; Thoits, 2006). Personal control involves achieving desired outcomes on one’s own behalf (e.g., choices), and in interactions with others (e.g., expressing needs) (G. C. Smith et al., 2000). It was more common than not, that participants across all groups of this study experienced feelings of worthlessness when relating to experiences where personal control was threatened. A specific term frequently used to express this experience was feeling “invisible”. Feeling invisible was related to experiences where participants felt they had “no voice” and when they felt that their opinions were not acknowledged or being valued
or considered (because of their age). For example, “Sometimes in some company... see we’ve got a one to one and you’re listening, if you were with some younger ones, it’s like as if you’ve not got a voice, you know, I’ve found that sometimes” (Welsh = 7[line 142]), “I have experienced being invisible. I’ve gone to a shop and will be first in line with a few people around me, younger people around me and then the assistant will look over my shoulder and address the guy behind me or address the lady beside as if you were invisible.” (LLLS = 2[line 157]), and “people don’t notice you, you know they sort of say you can get by unless you speak to them if you’re walking along the street you know they look straight over your head.” (Discontinuing = 10[line 216]).

For some participants, to ensure they did not become invisible, they opted to make themselves more visible and present in society by way of drawing attention to them. For example, being a part of groups that actively sought to become more involved and visible in society or by engaging in activities considered typical of a younger person. “Some of them think you’re old and can’t do anything but um I try and dispel that myth by kicking the football with my grandkids, going swimming with my grandkids um, doing those sort of things” (Discontinuing = 2[line 79]) and “the Red Hats society, it’s a worldwide group for women over 50, not exactly behaving badly but you know, carrying on and we wear red hats and purple clothes and all go out together and do things sort of still want to be relevant.” (Discontinuing = 12[line 50]). For other participants, there was a feeling that as soon as you visibly look different and change from being young to old, society acts differently towards you.

As early as my 40s I started seeing the change in how I was treated...it’s very subtle but it’s very strong...when you’re young you can get any job...any medical help and the doctors do treat you as though you’re more worthy of treatment no doubt about it, and I know the difference. (WA = 9[line 115]).

As a result, there was a sense of loss of command and worth socially which caused anger in some participants.

My mother said to me, that she realised that she was ageing when she became invisible in shops and I laughed...until one day I went to buy a handbag and there were two young women behind the counter...they did not look at me, they did not communicate with me...no words at all were spoken and so I thought maybe I’ve started to become invisible...and I’ve noticed it since. (WA = 13[line 90]).

Feeling “invisible” was not confined to just societal experiences but also permeated at the family level. Aside from the feelings of worthlessness experienced in interactions within the community, participants also expressed feeling invisible within their own families, with family functions and gatherings especially precipitated these feelings. “Family have these
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celebrations for birthdays and Christmas and parties and BBQs and they all seem to just acknowledge you but they don’t seem to want to know anything about you, when you get into your 50s or 60s” (LLLS = 11[line 134]), “I was surprised how people look at you when you’re older how you start becoming invisible...absolutely dreadful...if it happens enough, older people don’t give their opinions because they think they’re worthless” (LLLS = 3[line 165]), and “one of the kids was supposed to pick me up and actually forgot me...but the feeling of it is...they’re not seeing you as a real person they’re seeing you as granny...they’re already separating...getting used to cope without you that’s the subtly of it all.”(WA = 9[line 471]).

Also related to having a sense of control about their presence in society for participants in this research was the commonly articulated concern about how they were seen and considered by others in life and in their death. Participants’ experiences across all four groups revealed concern about being considered a certain way by people, often reflected deeper issues of pride and dignity, for example, “well only once I’ve had one large operation and that was thyroids, that was scary, I can remember cleaning my house from top to bottom in case I didn’t come back.” (Welsh = 13[line 35]). Having some personal control over the process of their death was also reflected as important to participants, particularly for those who had witnessed and experienced someone close to them dying in an undignified way due to a lack of personal control over their situation.

We would never subject ourselves to chemotherapy or radiation cause the extra 12 or 18 months it gives you, you live in bloody agony and torture and nausea and pain and...have what little quality of life you got and that just die...you’re just stripped of all your dignity and I don’t think that’s meant to be, particularly in the eyes of your loved ones...I’ve been there for other people I don’t want my family to do [that]...so that’s the thing that affects me about ageing. (LLLS = 9[line 105]).

My wife didn’t know me I used to go up and see her...when she died I was glad, the doctor said to me “Mr. Murphy ah, I’m going to put your wife in a hospital” I said you put her in a hospital three months ago...I think she’s just as bad, just let her go, let her die I said it would be much kinder...I said you’re not killing her just let her die and that’s what they done and she died four days later so and I was glad (starts to tear). (Welsh = 3[line 155]).

Therefore, findings from this study support the importance of feeling valued to one’s psychological wellbeing and sense of control in life (Coote, 2009). Also important was participants’ sense of control over their own ageing processes. Feeling invisible in social and family settings was a common way for participants to express how they felt less valued by others because of their age. These experiences also added to feelings of worthlessness and touched on issues to do with pride and dignity, ultimately affecting participants’ appraisal of their ageing experience. To conclude this section, one participant’s story is presented to allow
reflection on how even when there is a loss in personal control over some aspects of ageing, people can still be made to feel valued, worthy and treated with dignity.

*I was driving down Great Eastern Highway...and I noticed a...senior lady walking along the footpath there...and it was about 5:00pm in the afternoon...because I've worked with frail aged, disabled people, I pulled over and I carry my badge in the car and...I approached the lady and said “look are you lost, or are you okay or where are you going, what are you doing here?” and she said, “I’m going home, I’m going home to Francisco street” and I said to her “well Francisco street is a couple of kilometres in the other direction”...after a little bit of uming and arhing she said “alright”, so I was able to take her back home...I’m not suggesting that hey, I’m the only guy that has respect all I’m saying is that there were many vehicles going past, plenty of traffic and no one thought it was unusual but okay I work in an area with aged folk and I had an understanding but at the same time I believe that if that was me would somebody else go to the same respect to do that for me...but that doesn’t happen today. (WA = 12[line 305]).

5.7 Conclusions

A salient finding from the current research indicated that constructed thoughts about ageing across all four groups of the study were primed by dominant discourses used in society to describe the ageing experience. Findings particularly highlighted that constructs such as decline and loss and healthy ageing, were well recognised by participants and as well as influencing their thinking about their own health behaviours they also affect how they relate to their own experience of ageing. However, while participants initial comments about their experiences of ageing frequently related to physical limitations and declines in abilities to do things, their experiences also reflected that the social and psychological factors impacting on their experience of ageing were of equal, if not greater significance. This was evidenced by the volume of participants’ discussions focussing on issues associated with connectedness such as identifying the value of groups, supportive relationships, religion and spirituality as well as recognising the influence of social interactions including generational interactions, ageism, resource allocation, different life-stages and events, and opportunities to exercise meaningful roles on their experience of ageing. Significantly, these factors affected the level of personal control, value and worth participants experienced.

A particularly noteworthy finding from this research was that it was more common than not, that participants expressed feelings of worthlessness when reflecting on their ageing experience. Feeling invisible in social and family settings was a common way for participants to express how they were made to feel less valuable by others with this also adding to feelings of worthlessness and ultimately influencing their appraisal of their ageing experience. However,
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despite the challenges and losses facing older adults later in life, findings from the current research indicate that participants had good emotion management and regulation primarily evidenced by the maintenance of a positive attitude expressed through the acceptance of change and the regulation of the dynamics between experienced losses and gains in ageing.

Furthermore, how participants construed meaning about their ageing experiences appeared to be predominantly mediated through systemic factors mostly reflected in the context of culture, workplace practices, healthcare provision, government policies, and experiences associated with care facilities. Making comparisons with others (i.e., parents, peers) also allowed participants to construct meaning about their own ageing experience. Making comparisons with others reflected participants’ feared and hoped for future outcomes as well as provided a way of thinking about, and planning for the ageing process. Significantly, social comparisons appeared to not only be mediated by peers and family but also by significant historical events (i.e., war). In addition, the notion of luck was found to mediate participants’ constructions of meaning around their ageing experience with a majority of participants using it to create a perception of doing well, enabling them to maintain a sense of personal control over their own ageing experience.

Therefore, findings from this research support the notion that the lifespan is more than a biological occurrence formed through cultural beliefs and images, it also provides an intellectual key to how general discourses of existence are organised (i.e., social and political terms) (Biggs, 2001; Estes et al., 2009; S. Katz, 1995, 1996; Powell & Biggs, 2000; J. Reed et al., 2004). These findings suggest that participants were primed to consider ageing as a time of decline and loss primarily concerning physical limitations and changes in health status. However, it was the more psychological, relational, and social content of participants’ experiences that was of equal, if not greater significance to their experience of ageing. Importantly, findings from this research provide a particularly strong foundation for the importance of faith, existential belief systems, and personal meaning orientations to the experience of ageing. Predominantly, these findings also suggest that ageist behaviours and attitudes are prevalent in participants’ experiences of ageing with these experiences often revealing systemic and structural inequalities affecting how participants felt valued and regarded. The implications of these findings for ageing theory, policy and practice are reviewed in Chapter 7.
Chapter 6: The LLLS program - Reflections and experiences

This chapter introduces findings about participants’ experiences and reflections of being involved in the healthy ageing program Living Longer, Living Stronger (LLLS). Experiences are discussed from the perspective of participants both still involved in the program (the ‘LLLS group’) and from those who had withdrawn from the program (‘Discontinuing group’). The chapter outlines the reasons leading to participants’ involvement in the program as well as reviews the length of time spent in the program across the two groups. Participants’ experiences in the program are identified and discussed in terms of social interactions and connection (i.e., friendships and camaraderie, positive peer influence); physical aspects (i.e., increased ability and mobility, pain); program structure and operation (i.e., strong leadership and supervision, program time schedule, cost of participation); and intrapersonal determinants (i.e., self-motivation and health beliefs, positive reinforcement). The chapter concludes by summarising participants’ reflections and experiences of being involved in a healthy ageing program with consideration given to the future development of programs designed for older adults.

6.1 Introduction

One of the major aims of this research was to investigate the experiences of being involved in a healthy ageing program as well as to explore the challenges and motivations to remaining involved in a healthy ageing program. To address these aims, participants involved in the Living Longer, Living Stronger (LLLS) program were interviewed about their experiences of being involved in the program. The LLLS program; a local government initiative with key agency involvement from the Department of Health and the Office for Seniors Interests and Volunteering (Office for Seniors Interests and Volunteering, n.d.) (see Chapter three for further information), was designed to focus on the physical aspects of health. However, a critical finding from this research was that the social and relational aspects that evolved through engagement in the program were significantly important to participants’ sustained involvement and positive experience in the program. Participants from both the ‘LLLS group’ (participants involved in the LLLS program at the time of interviewing) and the ‘Discontinuing group’ (participants who had withdrawn from the LLLS program for at least a six month period at the time of interviewing) spoke about the benefits of the social interaction including, facilitating a sense of belonging, building friendships and positively influencing motivation. Other aspects identified by participants as important to their experience in the program included the program’s structure and operation; the physical benefits of engaging in the
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exercises set out by the program; and participants own internal processes such as self-motivation and health beliefs. Aspects important to participants’ experiences in the LLLS program are explored in detail in the following sections of this chapter using participants’ own accounts about their experiences as the basis for discussion. Motivations for becoming involved in the program and challenges experienced by participants from both the ‘LLLS group’ and the ‘Discontinuing group’ including reasons for withdrawal from the program are also discussed with reference to previous research and literature related to participants’ experiences integrated into the discussion.

6.1.1 What led to participants’ involvement in the LLLS program?

For a majority of participants from both the ‘LLLS group’ and the ‘Discontinuing group’, their reasons for joining the program were directly associated with an existing health issue. In some cases this led to participants seeking a General Practitioner’s (GP’s) referral to the program and in other cases, led to participants self-referral to join. Health conditions suffered by participants included osteoporosis, sciatica, lower back pain, and other ailments where strength training was considered as being beneficial for their condition. “I had these two knee replacements, see I’m a physical person...we all need to do a little bit of work, sport, exercise...and I wasn’t sort of doing it after the operation, that’s what bought me down over here. (Discontinuing = 7[line 453]) and

Of course there’s about 200 on a wait list so he [program director] said that if you were to get a referral from your doctor, if you have an existing problem you would jump the queue, well I’ve got osteoporosis, I fracture pretty easy, so we go and get our forms and that’s how we got into it. (LLLS = 8[line 318]).

Other reasons for participants joining the LLLS program ranged from an interest in keeping fit; a desire to lose weight; an interest in taking up specific weight bearing exercises; due to the breakdown or cessation of a pre-existing physical activity group (i.e., a walking group that they were formerly involved in); and as a preventative approach to health in an effort to avoid further or potential issues such as falls. “It gives you a focus, on your health...the physical benefits that you get from doing regular exercise and I think that’s a protection against having more problems when you get older” (Discontinuing = 12[line 334]) and “hopefully by doing it, it’s putting a few years on my life, I took enough off with smoking and that...trying to reverse things...to make my ageing quality a bit better you know.” (LLLS = 1[line 481]).

Other individual reasons noted by participants for becoming involved in the LLLS program included spousal influence and encouragement; a desire to remain active post
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retirement; being made redundant; and to keep busy after the passing of a spouse. “My husband had been a physical worker for all his life...and then he retired and found then that we didn’t do anything...he has never gone and got into something by himself...so we both went together” (Discontinuing = 3[line 510]) and “I’d been made redundant and I was at home desperately trying to get another job...I needed to do something extra and then I heard about the program and they had a big open [day]...so I signed up then.” (Discontinuing = 1[line 323]).

Other participants commented that they initially joined just to be involved in something. “For a long, long time, I’ve, at least a couple times a year I join a program because, you know you’ve got to, you can’t afford to get lazy in your mind.” (Discontinuing = 10[line 151]). For one participant the group also served a specific emotional purpose to manage their anger. “Therapy for me, just to get out and have some purpose, couldn’t get motivated enough to go for a walk every day...I thought okay I’ll combine the two, get out and get rid of some anger or whatever it is that’s there and get physical.” (LLLS = 16[line 258]).

Findings from the current research also offer support for the important role of the media in raising awareness about physical activity programs and health in the general community (Bauman, Smith, Maibach, & Reger-Nash, 2006), as participants mostly became aware of the program through different public and media sources including, Council on the Ageing (COTA) National Seniors, advertising, the local paper, at the program’s open day or through attendance at other forums directed at older adults such as a University of the Third Age seminar.

COTA, through National Seniors because everything like that gets advertised and we get literature about it...and that was quite a number of years ago...about four or five years ago...so now a lot of husbands and wives are coming in, gosh its big now, you know it was just one little room before. (Discontinuing = 10[line 138]).

In effect, findings from this current research suggest that central to participants’ initial reasons for becoming involved in the program, was the conscious intention to improve their health outcomes through engagement in a specific type of physical activity. This aligns with other research which indicates that the decisions associated with physical activity participation are linked with specific social and cognitive determinants of behaviour, primarily explained through constructs such as self-efficacy, self-esteem, outcome expectations, health value and locus of control (AbuSabha & Achterberg, 1997; Elder, Ayala, & Harris, 1999; Jancey et al., 2007; Lee, Arthur, & Avis, 2008; Lucidi, Grano, Barbaranelli, & Violani, 2006; Plonczynski, 2003; Robinson-Whelen et al., 2006). In particular, research investigating the role of constructs implicated in the theory of planned behaviour, in predicting intention to exercise and actual
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participation in exercise classes by older adults involved in a physical activity program, revealed that dimensions of control, that is, perceived behavioural control (recognition that the decision to regularly attend physical activity sessions was directed by the individual) and self-efficacy (personal judgements of one’s ability to successfully perform a behaviour in order to produce a specific outcome (Bandura, 1977, 1997)), were the most significant predictors of behavioural intention to participate (Lucidi et al., 2006). Therefore, research suggests that dimensions of control such as self-efficacy and perceived behavioural control are critical factors in determining decisions to engage in physical activity programs and that these factors may also largely account for participants in the current research decision to participate in the LLLS program.

In summary, the LLLS program initially appealed to participants as it offered a preventative approach to health and a regular, structured program of strength-based exercises that suited their need to keep active and fit as well as their need to counter the effects of any pre-existing health conditions. The program was also seen as offering a venue for participants wanting to become more involved in community activities with some participants’ reason for joining simply for “something to do” or to maintain some type of social interaction. Furthermore, the media and participants’ social networks were important factors leading to their involvement with participants made aware of the program through advertising, their doctor, and/or through their spouse. As a result, the non-physical aspects of physical activity programs such as dimensions of control and in particular, self-efficacy appear to be primary to the development of models intended for health-behaviour change and in reducing psychological barriers to physical activity participation (AbuSabha & Achterberg, 1997; Elder et al., 1999; Jancey et al., 2007; Lee et al., 2008; Lucidi et al., 2006; Plonczynski, 2003; Robinson-Whelen et al., 2006). The length of time participants have remained involved in the program since joining is discussed in the next section.

6.1.2 Time spent in the LLLS program.

After being developed and tested in Victoria since 1999, the concept of the LLLS program was first introduced into WA in 2004 (Living Longer Living Stronger COTA, 2012b), and has continued to operate through the Vario Wellness Clinic since then. Across both groups (the ‘LLLS group’ and the ‘Discontinuing group’), the length of time participants had been involved in the LLLS program ranged from two months to five years (see Table 15). The average length of time participants from the ‘LLLS group’ had been involved in the program up to the time of interviewing (May to September 2008) was, two years and five months. The shortest period of time participants had been involved was one year and six months, and the longest period was
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five years. The average length of time participants from the ‘Discontinuing group’ had been involved in the LLLS program prior to withdrawal was approximately eight months. The shortest period of involvement was two months and the longest period was one year and three months. Length of time in the program was consistent across genders for both the ‘LLLS group’ and ‘Discontinuing group’ with an average of only two months difference in time spent in the program between male and female participants. There also did not appear to be a substantial difference in age across genders and across groups with time spent in the program.
Table 15

Participants from the ‘LLLS group’ and the ‘Discontinuing group’: Time Spent in the LLLS Program, by Age and Gender, 2008(a)(b)

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</table>

Average 29.4 31.7 9.5 7.4

Note. (a) The figures in the table represent data as collected during May to September 2008, and as such, the figures presented will vary in accuracy by up to five months. Time spent in the program recorded in months is also reflective of figures collected at the time of data collection. (b) Half months were rounded up (i.e., six and half months became seven months). (c) This participant is still enrolled in the program but has been involved intermittently for the past 24 months due to the passing of his wife.

Research on attrition in physical activity programs by older adults indicates that at six months, up to 50% of attendees will withdraw (Avers, 2010; Jancey et al., 2007; Resnick & Spellbring, 2000). For participants in the current research, the average length of time before participants from the ‘Discontinuing group’ withdrew from the program was just over seven months. This provides support that the first six months are critical to attrition and that it is
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important to understand participants’ experiences in such programs and the factors contributing to their decision to withdraw so that they can be factored into the development and implementation of future program delivery. Factors pertinent to participants’ experiences in the LLLS program in the current research are discussed in the next section.

6.2 The experience of being in the LLLS program

When questioned about their experiences of being involved in the LLLS program, all participants from both groups reflected on the social environment and the social interactions within the group as being the main factor facilitating a positive experience. In addition, most participants discussed the physical benefits from engaging in the exercises set out by the program. Participants also discussed their experiences in terms of the structural and operational aspects of the program as well as intrapersonal determinants including self-motivation, health beliefs and positive reinforcement. An illustration of the major factors influencing participants’ experiences within the program is provided in Figure 7. Additional factors such as logistical issues (i.e., time scheduling and cost) and problems associated with the physical effects of engaging in the program exercises (i.e., pain) were also pivotal to participants’ overall experience with some of these aspects contributing to their withdrawal from the program. The aforementioned factors contributing to participants’ experiences of the LLLS program are discussed in detail in subsequent sections of this chapter.
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**The experience of being in the LLLS program**

- Social environment and social interactions
  - Friendships and camaraderie
  - Positive peer influence

- Physical aspects
  - Increased ability and mobility
  - Pain

- Program structure and operation
  - Strong leadership and supervision
  - Programs time schedule
  - Cost of participation

- Intrapersonal determinants
  - Self-motivation and health beliefs
  - Positive reinforcement

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**Figure 7.** Factors influencing participants’ experiences in the LLLS program - Perspectives from the ‘LLLS group’ and the ‘Discontinuing group’.

### 6.2.1 Social environment and social interactions.

Despite the physical nature of the program and most participants’ initial reasons for joining focused on wanting to achieve improved physical outcomes, the most salient features to emerge from participants’ responses concerning their experiences in the program were based on social interactions and the social environment. The opportunity to build friendships and to connect with peers was the most frequently discussed aspect of participants’ experiences. The influence of being involved in a group with similar aged peers was an especially important feature of participants’ experiences. Aspects important to participants about the friendships made in the group and the positive influence that resulted from
interactions with similar aged peers are discussed separately in detail in the next two sub-sections.

**Friendships and camaraderie.**

Enjoying social interaction is regularly listed as one of the top reasons older people continue to attend group exercise classes (Avers, 2010; Norman, 1998; Peterson, Yates, & Hertzog, 2008) and furthermore, environmental factors such as social support have been found to affect program attrition (King et al., 1992). In the current research, the most discussed aspect of the program concerning participants’ experiences from both the ‘LLLS group’ and ‘Discontinuing group’ were the friendships formed and the supportive social environment. “The social side of it was good because everybody was friendly and you know looked forward to seeing how everybody else was doing and that sort of thing.” (Discontinuing = 1[line 363]). Social interactions such as that described by participants in the current research have also been shown to increase physical activity levels in both descriptive and intervention studies (Jancey et al., 2007; Kelsey et al., 2000; M. A. Nies & Motyka, 2006; Peterson, Yates, Atwood, & Hertzog, 2005; Peterson et al., 2008; Wilson & Spink, 2006). Benefits attributed to the social environment of physical activity programs as referred to by participants in the current research as well as from previous studies include belonging support; as facilitated through group cohesiveness, and self-esteem support; as mediated through social comparisons with peers (Avers, 2010; Peterson et al., 2008; Wilson & Spink, 2006).

Participants in this current research particularly recognised the positive aspects of being able to meet different people through the group whilst concurrently meeting their physical needs.

*It caters to the need to keep physically active and it’s got the social benefits as well...I think there is a need for social contact with the outside world once you retire, and to meet other people and to be involved otherwise what’s the point you sit in your chair and watch television, I wouldn’t like to do that.* (Discontinuing = 12[line 361]).

Participants often made specific reference to the importance of being able to have fun with each other but also to the feeling of comradeship as the group supported each other.

*We do silly things to each other as well (laughs) and I think that is brilliant actually...it does cheer you up, not only physically is it helpful...it’s great fun, and great comradeship...so it is of great help, I love going...there’s no nastiness, it’s just all fun, for an hour which is absolutely great.* (LLLS = 6[line 473]).
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In most cases, it was this comradeship that maintained the motivation for participants to keep attending. This aspect was also recognised as different to the benefits that participants experienced from being involved in other programs designed to promote physical activity.

“There’s quite a comradeship there now because we all, about 20-24, a couple of them have been there 2-3 years...it’s been a bit of a social spin off for other things really, where you can really get involved with others but I mean I go to Yoga as well...it’s not [got] a social side it’s just go for the yoga and coming away again. (LLLS = 11[line 392]).

For participants in the ‘LLLS group’, as they had generally been involved longer in the program, it meant it allowed greater opportunity for friendships to develop within the group. What was significant to participants about the friendships made in the group was that people “could have a laugh” together and that participants felt they could relate with their peers in the group because of similar interests and especially because they were of a similar age. Age was considered a salient issue for participants’ sustained involvement in the program over involvement in other options to engage in physical activity (i.e., gym), “well socially it’s like, it’s very pleasant...but just the fact it’s, a similar group of people...that they’re of a similar age because I mean there’s no way I want to go to a gym with 25 year olds” (LLLS =12[line 267]), “just meeting people the same age as you, you know” (LLLS =5[line 559]), and “they’re just old people like we are...we’re all the same and I just think it’s fantastic the way that it is only for the older people.” (LLLS = 8[line 391]). The importance of social interaction to the overall experience of the program was further illustrated by some participants from the ‘Discontinuing group’ expressing that this was what they missed most about the program since having left. “She [wife] pulled out because of her knees mainly so I pulled out as well, but I enjoyed it...I miss the interaction with the people...the people that went along to it...got on quite well with them, it was good.” (Discontinuing = 8[line 210]).

Therefore, the opportunity for participants in the current research to interact with, and build friendships with their peers was especially important to their experiences in the LLLS program. These findings offer support for other research which suggests that being involved in exercise groups, which involve formal and/or informal peer mentorship, facilitates greater attrition and motivation of older adults in physical activity interventions (Buman, 2008; Robinson-Whelen et al., 2006). Social influences and in particular, the modelling of behaviour by peers has also been shown elsewhere to positively influence a variety of health behaviours including physical activity participation (Plonczynski, 2003; Wilson & Spink, 2006). For participants in the current research, making comparisons with others in the LLLS program helped sustain their motivation and was also significant to their self-appraisal of being in the
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group as well as more generally to their experience of ageing. The importance of these aspects
of peer influence are discussed in further detail in the next section.

*Positive peer influence.*

Considered a marker for self-identity and for the categorisation of others, age provides
social group membership and offers a benchmark for comparison, which individuals will often
do in search of a positive identity (Giles et al., 2010). Often when comparisons are made to
one’s own age cohort, beliefs about culturally and socially determined behaviours associated
with a particular age group are reflected (Giles et al., 2010; Hepworth, 2002) with these
stereotypes forming expectations about how we view our present and future selves (Giles et
al., 2010; Heckhausen & Krueger, 1993). The opportunity to make comparisons with their
peers was among the most common reflection by participants from both the ‘LLLS group’ and
the ‘Discontinuing group’, about what facilitated a positive experience in the program. Adjunct
to the social support that being in the group offered, the fact that participants had a place to
meet with others with whom they could relate and compare experiences, whether it be
through the commonality of interest in health, or age, was important.

The opportunity to make comparisons with peers had a positive effect on participants’
experiences within the program primarily because it influenced ideas about their own
capabilities. Many participants commented that through watching their peers in the group,
they realised their own potential, which often encouraged them to set higher standards and
expectations for their own health and wellbeing. For others, ability to compare one’s own
situation facilitated a sense of belonging and trust. “*I suppose we learnt about the limits...of
some of the things we could do... we could go on doing it I mean with people in their 90s that
were doing great things so [inspiring].*” (Discontinuing = 1[line 390]). Therefore, making social
comparisons for the participants involved in the LLLS program helped to sustain their
motivation and engagement in the program as the experience became personally meaningful
whereby they were able to fulfil needs for belonging and competence; factors also found to be
important to the tenants of successful ageing (Bailis & Chipperfield, 2006; Carstensen et al.,
2000).

Older individuals who judge their health or physical capacity more positively, and who
compare themselves as being better off than the average person their age have been found to
adapt more successfully to failure or threat, and report greater life satisfaction and less
psychological distress (Bauer et al., 2008; Wills, 1981). Therefore, making comparisons in this
way is considered as serving a self-protective function by alleviating the negative emotional
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consequence of stressful encounters and threats to self-esteem (Bauer et al., 2008; Heckhausen & Brim, 1997; Wills, 1981). For participants in the current research, such comparisons inspired confidence in their own abilities and hopes for the future and allowed them to understand the influence and control they have over their own ageing process. Significantly, making comparisons with their peers also allowed participants in the current research to acknowledge the impact of the program on other members. Often participants mentioned a positive influence on increasing their own motivation was to be surrounded by other older people, in some cases much older than themselves (i.e., 20 years), who seemed to be able to do more than them. “I can see, well I did see various people that come in and... through their involvement they seemed to become more active.” (Discontinuing = 2[line 234]), “there’s a lot of people younger than me but there is a lot of people who are older, I see them and think you know you keep going at it, I’m going to...I want to get to their age and still be coming here.” (LLLS = 7[line 330]), and

I mean this older man... he’s very unsteady and he’s speech is more slower now so I assume he must of had a mini stroke, we don’t know but it is wonderful to see that people still come because they chat, they have other people around them for an hour...again it helps me because, well I’m 73 and he is nearly 86 so... (laughs). (LLLS = 6[line 567]).

Therefore, for most participants, making comparisons with other participants demystified assumptions and negative beliefs about ageing with some reflecting that the program inspired them to consider their own ageing experience convincing them that attitude is key to having a positive experience.

Further benefits highlighted from participants’ reflections about having the opportunity to interact with their own peer group through the program was the emotional support that this offered. It has been well established through participants’ responses about their experience in the program that the social interaction was important to facilitating a positive experience, importantly though the support of the group also extended to deeper emotional needs.

There are quite a few other men, one whose lost his wife not so long ago, and he was absolutely devastated... he talked with me a few times and cried so I eventually asked and he just said to me she had died but what is good about that is that you learn how so many people are so determined to keep going with something... one learns from that... don’t give up... it gives more of a positive feeling... it’s uplifting so therefore you learn from the other people who you know. (LLLS = 6[line 555]).

This emotional connection contributed to this participant’s own perception and experience of the program and further highlights the many benefits of providing opportunities for older
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adults to interact with their peer group. Furthermore, being able to learn from one another, provided encouragement and inspiration for some participants to appraise their own ageing process and on a more outward level, their own commitment to remaining involved in the program.

In addition to the influence of peer support on participants’ engagement in the program, spousal influence was also an important mediating factor for some participants’ engagement in the program. For example, one participant stopped attending the program because his wife had stopped going. This along with earlier findings indicating that some participants only became involved in the program because of their spouse’s instigation highlights the important influence that partners have in the decision-making processes for participating in such programs. Furthermore, research investigating best practice in community-based exercise programs for older adults, found that over one-third of respondents in an exit survey who did not have a close or spousal relationship in the class reported that they did not intend to join the exercise program again (Avers, 2010). Therefore, findings from the current and previous research suggest that social support, as defined in part as a relationship with a spouse and/or family, is a key factor in exercise adherence in community-based groups and are found to be important enablers of social and physical activity (Avers, 2010; Browning & Kendig, 2010; O’Brien Cousins, 2003; van Heuvelen, Hochstenbach, Brouwer, de Greef, & Scherder, 2006).

Although participants across both groups predominantly reflected positively on the social interactions and relational aspects of the program, not all participants found making comparisons with others in the group a positive experience. For one participant, their experience of being treated differently to others in the group left them feeling excluded at times.

*I felt that a lot of attention was placed on certain members, certain people that attended the program, the others were left to drift, I felt like there wasn’t enough interest in you personally which you don’t have to have 100% but seemed to focus on some individuals...it must have been people that started in the program when it first started. (Discontinuing = 9[line 230]).*

For another participant, how they considered themselves socially in society when making comparisons with others in the group, contributed to feelings of isolation and perceptions that they were different to the rest of the people in the group.

*I always feel a little bit, out of this group I think these are all self-funded retirees and people with money that can afford to pay this, it’s $52.80 a month, I mean I’m*
managing because I own my own home and don’t pay any rent...but I sort of still feel sometimes I’m a bit out of my, what do they say, I’m down here, they’re up, I sort of feel as if I’m just a pensioner...I feel now as if there, it’s only for the rich, it’s only for the people who can afford this, this isn’t for all the poor buggers that are walking around with walking sticks. (LLLS = 5[line 683]).

These findings align with the current social comparison literature, which suggests that when people self-evaluate and mentally represent themselves as being “different” from the target they are making comparisons with, particularly if they perceive the target as being “better-off”, then this contrast makes it difficult for the comparer to identify often resulting in a lowering of wellbeing and self-esteem (Bailis & Chipperfield, 2006). This participant’s perceived difference in social status compared with the rest of the group also raises awareness regarding access to such programs. While the social benefits of engagement in programs such as LLLS, have been supported by current findings, it is important to acknowledge that not all older adults may be in a position to participate despite their willingness. Reasons for non-participation may include a lack of finance or because of limits in other resources such as transport, knowledge, information, education and mobility (Ranzijn, 2010). It is therefore important that these factors, as well as other socio-cultural factors, are considered when designing and implementing such programs to ensure inclusivity, maximum participation and benefits to those for whom the services are designed.

In review, for participants in the current research, expectations about their own experience of ageing were influenced by making peer comparisons with others in the LLLS program, mostly in terms of how they considered themselves as people of a similar age. Findings offer support for previous research which suggests that people who compare themselves favourably with others tend to experience better health outcomes, especially later in life (Bailis & Chipperfield, 2002, 2006; Bailis et al., 2005; Frieswijk et al., 2004; Heidrich & Ryff, 1993a, 1993b; Kwan et al., 2003), and that when social comparisons are made whereby a person is unable to identify with the comparing group or person, the comparer’s wellbeing and self-esteem can be negatively affected (Bailis & Chipperfield, 2006). Furthermore, making social comparisons proved a physically empowering experience for some participants as seeing others of a similar age physically achieving more than what they anticipated positively influenced how they viewed their own abilities. Specific aspects related to the physical benefits experienced by participants in the LLLS program are discussed in the next section.

6.2.2 Physical aspects.

The physical nature of the LLLS program meant that participants were expecting to experience physical gains through their involvement. Findings from participants’ responses
about their experience indicated that this was evident for most with participants often commenting on the positive outcomes they had experienced because of engaging in the program on a regular basis. However, for some participants, engagement in the program exercises caused them pain and ultimately led to their withdrawal from the program. Factors associated with these physical aspects of the program experience are discussed in further detail in the next two sub-sections.

**Increased ability and mobility.**

While participants’ responses about their experiences in the program reflected a focus on the social aspects, participants in the ‘LLLS group’ also frequently discussed the physical benefits as contributing to their positive experience of the program. When performed regularly, exercise has consistently been shown to provide significant physical and psychological benefits among older adults (Avers, 2010; Colcombe et al., 2003; Jancey et al., 2006; Jancey et al., 2007; Karlsson, 2002; Lucidi et al., 2006; A. Nies, Chruscial, & Hepworth, 2003; Park et al., 2011). Furthermore, impaired mobility predicts adverse outcomes such as morbidity, disability and mortality and therefore, preserving mobility is considered central to maintaining a high quality of life and is essential to many activities needed for full independence (The LIFE Study Investigators, 2006). Most participants from the ‘LLLS group’ reflected that they felt better able to cope with everyday tasks that required physical effort as a direct result of engagement in the program. Some participants also felt they had more energy while others noticed improvements in strength through the program exercises, which countered the limitations imposed upon them by their respective health condition. “Since I’ve been training over here at the Vario…it enables me to do a heck of a lot more than what I used to do, lifting and that sort of thing” (LLLS = 15[line 177]), “I just think that it is just the best, out of anything I’ve ever done, out of any medication that I’ve ever taken, for me asthma and me heart and that, out of any” (LLLS = 3[line 1325]), and “I mean I knew I was slowing down and I thought it just might bring me back a bit of zip into me you know which it has…I feel a lot better when I’ve had an hour there.” (LLLS = 4[line 222]).

Participants in the current research also commented that their experience of being involved in the program had re-educated them about exercise and as a result they now viewed physical activity more positively, particularly strength-based exercise. “He [husband] can’t believe how good he feels which you do…it’s like an aphrodisiac you go in and you work your insides out and you come out jumping out your skin.” (LLLS = 8[line 311]). For others the experience reaffirmed their existing beliefs about the benefits of doing regular exercise.
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I’m very well aware because of my own personal experience that exercise is essential, not necessarily in a gym but people should do a lot of walking if they’re able to and if they are elderly and retired they should be able to do this and even in the, in their own house...I’ve now got muscles in my arms...and I bet you don’t know any 90 year olds with muscles in their arms (laughs). (LLLS = 13[line 404]).

Consequently, for participants who experienced physical benefits from engaging in the program, there was a sense of ownership over their own physical outcomes and overall health and wellbeing. As such, the experience of being in the program proved an empowering experience for some as they learnt they were in control of their own physical condition, which subsequently had a positive influence on their outlook on ageing.

I can see the benefits...I lost 20kgs which was my target so to me that’s fantastic actually set a target and lose 20kgs, so it’s changed my attitude that I can do something about my physical condition whereas before I did nothing...to me I would think psychologically it benefits everybody, when you are a part of a group and you feel supported...it’s not like you have to put yourself through a marathon regime, you just have to take part in something...it’s just perseverance isn’t it and that’s what with ageing, you start to doubt, your ability to persevere, so it’s given me motivation. (LLLS = 17[line 310]).

Findings from the current research support the importance of older adults engaging in physical activity programs to achieve positive health outcomes (Avers, 2010; Colcombe et al., 2003; Jancey et al., 2006; Jancey et al., 2007; Karlsson, 2002; Lucidi et al., 2006; A. Nies et al., 2003; Park et al., 2011; The LIFE Study Investigators, 2006). The findings also align with results from other programs, particularly those incorporating resistance and strength-based exercise that have demonstrated generalised outcomes including improvement in mobility in conjunction with the core effects intended by the program (i.e., improvements in walking speed, standing balance, leg strength and minimising fall risks) (Hughes et al., 2004; LaStayo, Ewy, Pierotti, Johns, & Lindstedt, 2003; Morgan, Vinrig, Duque, Abdel-Moty, & DeVito, 2004; The LIFE Study Investigators, 2006; Thomas & Hageman, 2003). Although most participants only spoke of the positive experiences associated with the physical aspects of the program, for some it was aspects associated with the exercises that led to their withdrawal from the program. Specifically, issues associated with experiencing pain during engagement in the exercises are discussed in the next section.

Pain.

While a majority of participants across both groups mentioned the physical benefits resulting from engagement in the program exercises, many participants in the ‘Discontinuing group’ experienced physical pain after engaging in the same exercises, subsequently leading to
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their withdrawal from the program. “Sometimes I felt they pushed you and see I had bad knees...they said ‘oh you’ll be alright’, never mind you’ll be alright because I damn well wasn’t alright.” (Discontinuing = 9).[304]) Significantly, almost half the participants interviewed from the ‘Discontinuing group’ stopped attending the program because of the physical pain they experienced after engaging in the set exercises. Health problems and unpleasant sensations including pain and discomfort have also been described by other research as affecting the attrition of older adults in physical activity programs (Corti et al., 1995; Jancey et al., 2007; Resnick & Spellbring, 2000) with pain one of the most frequently cited barriers to physical activity and exercise (Avers, 2010). Mostly pain for participants in the current research was described as being associated with the type of condition affecting the participant or a result of the exercises not matching the needs of the person.

I wasn’t happy with it...I used to hurt too much to want to keep doing it, and I don’t give up things easily but I don’t like hurting and if I am going to hurt every week there’s not much point in coming...I don’t remember sort of being put through anything to see if I could do, we had someone sit with us but not showing you what to do but not actually saying you know how does that feel when you do that? I was really quite frustrated with it I felt it had caused me more grief than was needed...I was just disappointed. (Discontinuing = 4).[195])

Personal pre-and-post assessments documenting a person’s improvements in function ability has been identified as not only important in taking account of any pre-existing medical history (Avers, 2010) but also highly important to older adults’ motivation to continue participation in exercise programs (Norman, 1998). This was evident for one participant in the current research who felt their individual needs had not been met with the belief that this occurred because of an inaccurate initial assessment at the time of joining the program.

I had the assessment and once they had done all the checks and got the doctors report and whatever they said that I would more than likely need a one on one...but they said to have a go anyway so I had a go and I came along...but I found that a lot of times after the exercises I had to go straight to the chiropractor or straight to the oesteo[path]. (Discontinuing = 3).[472])

In addition, for another participant inadequate follow-up procedures for when they had been absent from the group for a length of time led to their eventual withdrawal from the program.

Therefore, although physical benefits were identified as important to participants’ experiences in the LLLS program, some participants’ experience of pain relating to engagement in the programs’ exercises, lead to their withdrawal from the program. In some cases, withdrawal due to experienced pain was necessary despite participants concurrently benefiting socially from the experience. Furthermore, appropriate and regular assessments
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were considered important to some participants’ experience in the program in order for them to fully benefit from the physical components of the program. In addition to the physical and social factors discussed by participants across both the ‘LLLS group’ and the ‘Discontinuing group’, participants also recognised that a positive program experience was facilitated by how the program was structured, organised and operated. Factors related to the programs structure and organisation are discussed in further detail in the next section.

6.2.3 Program structure and operation.

Contributing largely to participants’ positive experience of the LLLS program were factors relating to the structure of the program itself as well as factors relating to its operation. Salient factors included praise for the staff running the program, especially the program instructor with some participants attributing the successful operation of the program to his personal qualities. Participants appreciated that the program did not facilitate a competitive atmosphere and they felt well supervised by staff. The time schedule of the program also influenced participants’ experiences in the program. For some the structured nature of the schedule contributed to a positive experience but for others it led to their withdrawal from the program. The cost to participate in the program was also a salient feature affecting participants’ engagement in the program. These aspects are discussed in further detail across the next three sub-sections.

Strong leadership and supervision.

Factors associated with the operation of the program that facilitated a positive experience for participants included how the program was structured, supervised and organised. Participants commented that it was a “well set up” program, with “friendly, experienced staff”, “leadership”, and had a “rewarding structured program of exercises”. The facilities were well regarded as was the venue and importance was placed on the quality of supervision provided. Participants also spoke about the positive effect of the regimented structure of the program to their overall experience. These factors were expressed as being important to participants from both the ‘LLLS group’ and ‘Discontinuing group’ experience of the program with some participants identifying these aspects as facilitating a safe environment. “I thought it was good, it regimented me...it gave me structure, something to do, for a defined period of time” (Discontinuing =3[line 570]) and “it’s a well set up scheme, you know, like the doctor down there and the assistants are cluey...they are very attentive, you feel safe, you feel you are in a safe environment...and it’s well run...they’ve got them well organised, I like it.” (LLLS = 2[line 323]). It was also noted by some participants that a possible reason for so many men being involved in the program could be that the regimented routine
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style and structure of the program works well for males, “it’s good to be there at a certain
time, the routine thing, particularly as men get older...if there’s a routine that every Monday
afternoon and every Thursday afternoon you turn up here and you do what you’re told,
fantastic” (Discontinuing = 3[line 597]) and “that’s what my husband likes about it, that he
doesn’t have to think, just goes there and this is what we do today and he just does exactly
what they tell him to do every time.” (Discontinuing = 3[line 527]).

It has been argued that the exercise instructor is the most important element of a
successful community-based physical activity program with both personal qualities (e.g., a
positive attitude, and a genuine passion for wellness, exercise and optimal ageing) and more
qualified qualities (e.g., recognised and relevant qualifications, knowledge of exercise
principles) considered of upmost importance (Avers, 2010). This was particularly evident for
participants in the current research who identified the program instructor as a key conduit
for the success of the program. It was recognised by a majority of participants that it was the
competence of the instructor that made for such a positive and meaningful experience.

He’s [program instructor] quite a unique human being I think, he’s, intelligent, he’s
knowledgeable and to combine those two with his interpersonal skills is outstanding,
he’s a real strong catalyst of the whole group, the equipment is good, the people who
are there are friendly and able...it’s very hard to get those, those three qualities
together very hard. (LLLS = 9[line 420]).

Some participants commented further that it was the best program of its nature that they had
attended. It was considered by most participants to be better than attending a regular gym, as
there was no competition for use of machines and equipment and because of the supports and
supervision in place, particularly the leadership demonstrated by the program instructor.

With Dr. Turner in charge, to me that’s a huge bonus because I just like his approach,
honesty and in charge and knowing what’s going on and looking after people, I know
that other places, there’s just a gym and people are largely unsupervised and there’s
no actual progressive program you know...so they’ve created an environment suitable
for our age group and obviously has all the support structures in place...it must be an
ideal case study in this kind of service. (LLLS = 17[line 290]).

Consequently, findings from the current research offer support that staff’s ability to establish a
safe and structured environment including the ability to adapt to differing ability levels is an
important measure of best practice in the delivery of community-based physical activity
programs for older adults as indicated by previous research (Avers, 2010).

Furthermore, creating a personally relevant environment for older adults has been
documented as a vital part of facilitating motivation and compliance in exercise programs for
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older adults (Norman, 1998; O'Brien Cousins, 2003; Peterson et al., 2008). For participants in the current research, factors such as the type of music played helped to facilitate a sense of belonging for participants.

_The crew that’s over there, we get along...we really have a good laugh, the fifties and sixties music they put on you know and you get about, five of you, sort of all singing along so its, you know it’s just good. (LLLS =1(line 468))._

In addition, as illustrated elsewhere by these findings, the program’s design specifically tailored for older adults, also contributed to participants having a greater sense of belonging to the program. “The exercises I thought were always well balanced in terms of who we were...it was adapted to our needs...we didn’t push but we stretched our capacity if you like...the benefits of having supervised exercises to do them properly” (Discontinuing = 12(line 352 & 377)) and

_It didn’t seem to create this atmosphere...I’ve got a thing about people doing exercise and they all look the same...I just don’t want to be part of that and then it appealed that there are proper exercise machines, I do not have to compete with somebody next to me of what I can do. (LLLS = 6(line 445))._

Therefore, aspects related to the structure and organisation of the program were important to the overall experience of participants in the program but importantly these aspects also contributed to their sustained involvement. Factors identified by participants in this current research have also been described by other research as facilitating successful programs (Avers, 2010; Norman, 1998; Robinson-Whelen et al., 2006). In particular, the program instructor’s qualifications, experience and personal characteristics as well as experienced staff to supervise, demonstrated best practice and subsequently this made for a positive and engaging program experience for many participants. Conversely, issues leading to the withdrawal of some participants from the program were also related to the structure and operation of the program. In particular, having a structured, routine program proved a challenge for some participants, particularly when related to time scheduling.

_Programs time schedule._

At the time of interviewing, LLLS classes ran four times a week, twice daily and went for an hour in duration. Participants were scheduled to attend class twice a week with the day and time of the class pre-determined according to the group they had been allocated to during initial recruitment. To achieve exercise benefits, it has been demonstrated that an exercise class should meet two times per week as a minimum and that individual class sessions run from 30 to 60 minutes duration with longer sessions a necessity for resistance and strength-
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based exercises (Avers, 2010). Therefore, given the LLLS program schedule, participants should have been able to achieve the benefits of the exercise and this may have accounted for some participants’ adherence to the program schedule and retention in the program. For some participants though, the time schedule also posed a challenge to staying committed.

For participants in the current research, the restricted time scheduling of the program was a challenge to manage mostly due to their other varied commitments (i.e., university, work, caring responsibilities). “Getting there, once a week I can do always, it’s better to do twice a week but often I’m stuck three days a week working and going to Uni, if there were more spots of time, that would be easier for me.” (LLLS = 17[line 300]). Furthermore, one of the most common reasons for participants in the ‘Discontinuing group’ withdrawing from the program was due to issues with the time schedule. “I didn’t stop because I didn’t enjoy it...[it] was difficult for us...my husband was already involved in a gym...so it was just getting the car and, we only had one car between us which was a problem.” (Discontinuing = 6[line 349]). This finding is consistent with recent research demonstrating that lack of time is the most prevalent self-reported reason for older adults dropping out of supervised clinical and community exercise programs (Jancey et al., 2007; King et al., 1992; Peterson et al., 2008; Robinson-Whelen et al., 2006).

Furthermore, for participants in this current research, the restrictive scheduling of the program posed a particular problem for those who were, or who had become carers for people close to them, as the care-giving role affected their personal time. “I haven’t got back into it because mum went in May and um, just haven’t got around...but I would like to go back” (Discontinuing = 11[line 222]) and “well [our son] had cancer...it was chemo every three weeks, one whole week of chemo which is horrendous, bed ridden...so he was immobile when he first came home from hospital so we went over there just about every day, we became day parents.” (Discontinuing = 9[line 257]). This finding is of relevance to research on caregivers and in particular, older adults and care giving given the increased likelihood that they will be the ones providing informal care for family placing them at greater risk of stress and physical illness, as suggested by previous research (Barrow & Harrison, 2005; Martire, Schulz, Wrosch, & Newsom, 2003; Morse, Shaffer, Williamson, Dooley, & Schulz, 2011; Vitaliano, Young, & Zhang, 2004; Vitaliano, Zhang, & Scanlan, 2003). Future program development would benefit from considering how to accommodate alternate options for caregivers so they have the flexibility and support to maintain their own interests outside of their care giving duties.

Efforts to facilitate more flexible scheduling would also be of benefit more widely as indicated by other participants’ responses about the difficulty in concurrently managing the rigid time
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schedule with other commitments. Adjunct to time issues, other factors affecting participants’ sustained involvement in the program included issues with the cost of attending the program.

**Cost of participation.**

Research indicates that the cost of an exercise program needs to be within reach of participants to ensure minimal attrition (Corti et al., 1995; Godin et al., 1994; Jancey et al., 2006; Jancey et al., 2007; A. Nies et al., 2003; Robinson-Whelen et al., 2006). Findings from the current research support this claim with cost proving a challenging issue for some with one participant in particular believing the program was only for “those with money”. Mostly, participants who lived alone or who were on a pension found attending the program to be a significant compromise to their daily living costs.

“I thought it wouldn’t be too expensive but it was $5.00 a visit or something, it cost me money I really didn’t have...we haven’t had a rise in our pension for a long, long time and we get $540 a fortnight and I pay $300 rent a fortnight so it doesn’t leave me much money. (Discontinuing = 4[line 166 & 212]) and

“I worked it back from a financial point, I wanted to do more and I certainly wanted...get into a pool and for $11.00 a week, I could go to arena and it was only costing me about $5 or $6.00 plus I could go whenever I liked I took the off-peak membership and you could stay all day if you wanted to. (Discontinuing = 5[line 665]).

Therefore, logistical issues such as the program’s time schedule, how the program was supervised and organised as well as the cost associated with attending, were all important factors contributing to engagement of participants in the LLLS program. Adjunct to these extrinsic factors important to participants’ experiences and retention in the LLLS program, intrinsic factors were also found to be important determinants. In particular, intrapersonal factors including self-motivation, health beliefs and positive reinforcement were important to participants’ appraisal of their experience in the LLLS program and are discussed in further detail in the next section.

**6.2.3 Intrapersonal determinants influencing participation.**

Predominantly across both groups in the current research, the social environment, the physical benefits, and factors related to the program structure and operation were all important to participants’ experience of the program and subsequent sustained involvement or withdrawal. In addition to these mediating factors for staying engaged in the program, participants also identified factors associated with health beliefs, particularly self-responsibility for health and self-motivation, as being significant for sustaining their own involvement. Participants also identified the positive reinforcement associated with these factors as an important mediating factor influencing motivation and engagement.
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Self-motivation and health beliefs.

Research examining the psychological and cognitive predictors of health-related behaviours, particularly among older people, suggests that intrinsic factors (i.e., self-efficacy and health beliefs) remain an important predictor of behaviour change (AbuSabha & Achterberg, 1997; Browning, Sims, Kendig, & Teshuva, 2009; Dacey, Baltzell, & Zaichkowsky, 2008; King et al., 1992; Lucidi et al., 2006; O'Brien Cousins, 2003; Plonczynski, 2003). Some participants from the ‘Discontinuing group’ highlighted that promoting programs such as LLLS, was like “preaching to the converted” as it was identified by most participants that they already held beliefs about self-responsibility in maintaining health, particularly through involvement in physical activity groups. “At best I can say it’s only reinforced what I understood because, it’s like if you don’t take your car in for a service, it’s going to break down, full stop.” (LLLS = 9\text{line 453}). Moreover, it was recognised by participants in the current research that people who are not self-motivated or who do not hold the belief that you are responsible for your own health outcomes, may need other types of encouragement to attend and remain involved in programs similar to LLLS.

Most times it’s the people who don’t need it so much that go, those who really, really need it, like they’re overweight and they’re unhealthy and they’re diabetic or whatever, won’t go, so how do you get that person there? You have a look at them down there, they’re all, self-motivated...it feels a little bit like that he’s [program director] talking to the converted...because they’ve already made their own decision for their health and he’s just confirming it all for them but it seems a shame that you can’t get the people that really need to be there. (Discontinuing = 3\text{line 580}).

Other research exploring older people’s individual beliefs and experiences with physical activity has found that active older people (those who were involved in at least three times a week planned or scheduled leisure-time physical activity), felt personally capable, anticipated positive outcomes and were committed and clear about their motives to be active despite life distractions (O'Brien Cousins, 2003). In contrast, older adults who were inactive (no weekly physical activity) were found to have poorly formulated goals of what they wanted to accomplish and found many reasons as to why they should not be physically active and semi-active older adults (some irregular and unscheduled weekly involvement in physical activity) tended to have many positive thoughts and intentions but were tempted by just as many negative thoughts and distractions. Therefore, findings from the current research and previous research examining the relationship between health beliefs and health behaviours in older adults suggest that those who report positive beliefs about exercise, particularly those who believe in their ability to affect change, are more likely to report behaviour change (U. Berger,
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Der, Mutrie, & Hannah, 2005; Browning et al., 2009; Ferrini, Edelstein, & Barrettconnor, 1994; Norman, 1998; O’Brien Cousins, 2003; Resnick & Spellbring, 2000).

Despite the knowledge and understanding that the activities in the LLLS program were beneficial for some participants, self-motivation still presented a challenge to remaining involved in the program. “It doesn’t present a challenge I don’t think except your own, your own discipline, that you’ll be there and its good that, it’s structured that way because, you don’t want to be seen as letting yourself down” (LLLS = 9[line 441]) and “sometimes I feel like I can’t be bothered going but you know say to yourself get out there you know you’ve got to do it.” (LLLS = 7[line 317]). Self-motivation is likely to reflect the presence of self-regulatory skills such as self-monitoring, self-reinforcement, self-efficacy and effective goal setting; all important for maintaining physical activity (AbuSabha & Achtber, 1997; Browning et al., 2009; Dacey et al., 2008; King et al., 1992; Lucidi et al., 2006; O’Brien Cousins, 2003; Plonczynski, 2003). Therefore, any enhancement of self-regulatory skills such as through a well-structured and supervised program as identified by participants in the current research is likely to positively affect participants’ self-motivation. Conversely, when barriers are perceived that are anxiety provocating and that potentially threaten self-regulatory skills, especially self-efficacy, self-motivation is likely to be negatively affected and result in poor adherence (King et al., 1992; Wankel & Thompson, 1977). For example, for some participants it was difficulty with using the equipment and in particular, the weights, machines and physical requirements of the program that presented a personal challenge. “I found it very challenging when I first started because I’ve never used a machine, I’d never even been in a gym...I guess the challenges were just like using mechanical things, don’t know what you’re going to do” (LLLS = 12[line 257]), “it was a gradual building up to be able to be confident with some of the equipment...I think there was only one piece of equipment that I couldn’t actually use, I tried quite a few times” (Discontinuing = 1[line 371]), and

...at first I thought, oh gee I am never going to get to where I am supposed to be I thought the whole thing with fitness was to put more weights on you know until one day one of them said to me, for instance if you put ten kilos on and go hmmhmm (struggle sounds) – useless, you may as well put five on and be able to go right, that’ll do you far more good and that’s when it realised what it was all about...it was still be able to do the exercises comfortable...so it took me awhile to learn that, that was the only thing. (LLLS = 3[line 1235]).

As a result, most participants recognised the need to work within their own limits to ensure they stayed motivated highlighting the importance of not over extending themselves to ensure motivation was maintained.
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It is therefore evident that health beliefs are closely linked to motivation, particularly in the context of attrition of older adults in physical activity programs (Dacey et al., 2008; King et al., 1992; O'Brien Cousins, 2003; Plonczynski, 2003). Future research investigating the determinants of apathy and negativity versus motivation for physical activity as well as further exploration of the social and cultural contexts in which cognitions of older people are reinforced, would add to these current understandings (O'Brien Cousins, 2003). For those participants in the current research who were able to sustain their motivation, often this was because maintaining engagement in the program aligned with their health beliefs and the experienced benefits became self-reinforcing and strengthened those health beliefs. Self-regulatory skills such as self-monitoring were also found to be important mediators for motivation and retention. Additional positive reinforcers for sustained engagement in the program are discussed in the next section.

**Positive reinforcement.**

Key motivators identified by participants for their initial involvement with the program included: a desire to focus on their own health to rectify existing health issues; to maintain fitness; to remain active; and to interact with others. Participants expressed the experience of noticing improvements in their health and wellbeing since being involved in the program in terms of an increased ability to engage in everyday activities requiring physical effort and an enjoyment socially, which overall affected thoughts about their own ageing process and experience. This change in ability and attitude acted as a primary reinforcement for most participants to remain involved in the program. For many participants across both groups, being involved in the program also reinforced the importance of exercise for wellbeing and increased their self-efficacy (Bandura, 1977, 1997) and confidence in their ability to achieve positive health outcomes.

*It probably reinforced the attitude that I had to keep moving...it reinforced me in the area that you need to do weights and you need to keep it up, don’t slack off, because you know I would every now and then...I might leave it for three or four days, I try not to do that...I became more consistent and realised that you need to keep it up.*

(Discontinuing = 6[line 424]).

Participants’ self beliefs, attitudes and perceived behavioural control particularly concerning judgements about their own ability to successfully engage in the LLLS program in order to promote better health outcomes, all facilitated their motivation and acted as positive reinforcers to continue involvement in the program. In particular, as illustrated by past research (Ajzen, 1991; Lucidi et al., 2006), these factors were pivotal in explaining older adult’s self-regulatory capacities to overcome impediments and negative thoughts that otherwise may
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have lowered their intention to participate in the program. For some participants in the current research, their experiences of being in the program also profoundly changed their perspective on ageing with one participant commenting that they now believed it was possible to be “healthy till you die”.

You cannot stop the ageing...[but] I think you can be healthy till you die, as healthy as you possibly can be, till you die I think...you can be your own worst enemy by putting it in your (head) that your getting older...“I shouldn’t be doing this cause of me age” you know that is what a lot of people say...so I think what you can do, with it is, fitter longer or as long as you want even if you’ve got illness. (LLLS = 3[line 126]).

In review, findings from the current research suggest that important changes to some participants’ self-efficacy occurred. Self-efficacy, or one’s confidence of being able to successfully perform a specific activity or behaviour (Bandura, 1977, 1997), has consistently been reported in the literature as an important factor to adherence in exercise programs for older adults (Browning et al., 2009; Jancey et al., 2007; King et al., 1992; Lee et al., 2008; Lucidi et al., 2006; Plonczynski, 2003; Resnick & Spellbring, 2000). With evidence that self-efficacy is strongly associated with the amount of physical activity older adults undertake, and with evidence from the current research suggesting it also acts a positive reinforcer for continued engagement in a physical activity program, incorporating the theory of self-efficacy into physical activity interventions is encouraged. In particular, considering how to facilitate information sources considered important for self-efficacy, such as, performance accomplishments, vicarious learning, verbal encouragement and affective states, into such interventions is considered an important element if participants’ confidence and ability to initiate and maintain physical activity behaviour are to be maximised (Lee et al., 2008).

6.3 Conclusions

There is much empirical and anecdotal evidence regarding the benefits of engaging in regular physical activity to maintain health and wellbeing, especially as one ages (Avers, 2010; Colcombe et al., 2003; Jancey et al., 2006; Jancey et al., 2007; Karlsson, 2002; Lucidi et al., 2006; A. Nies et al., 2003; Park et al., 2011). The concept of health has become primarily synonymous with the physiological aspects or physical states of being and participants’ experiences from this current research provide further support for the importance of physical activity for health. However, the most salient finding to emerge from older adults’ experiences in the LLLS program was that opportunities to interact with peers and build friendships contributed to a positive experience of the program and together with the structural and operational aspects of the program, were the most commonly discussed reasons for remaining involved. These experiences also affected some participants more profoundly by positively
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influencing their attitudes towards ageing by way of recognising their own potential rather than their limitations. This was particularly evidenced by participants staying involved in the program to specifically improve their own ageing experience now believing that a preventative approach to ageing, such as, through continued involvement in the program, provided a good way to keep active and healthy.

In addition, the opportunity to make comparisons with their peers provided a way for participants in the current research to evaluate themselves in relation to others (Festinger, 1954; Giles et al., 2010; Kwan et al., 2003; Tanner, 2007). In particular, participants appeared to use social comparison as a strategy to self-enhance their own experience offering support for previous research which has found that making comparisons with others is a common way for older adults to relate to and understand their own experiences of ageing (Giles et al., 2010). As indicated by previous research (Jancey et al., 2007; King et al., 1992; Lee et al., 2008; Lucidi et al., 2006; Plonczynski, 2003; Resnick & Spellbring, 2000; Wankel & Thompson, 1977), self-efficacy and self-regulatory skills were also found to be important reinforcers and mediators in maintaining participants self-motivation to remaining engaged in the program. Reasons for participants’ withdrawal from the LLLS program included issues associated with personal lack of time, the time schedule, cost of attending and experiencing pain. Findings also revealed individual experiences with poor follow-up procedures and limited (initial and ongoing) assessments. Although some of the above factors led to participants withdrawal from the program, participants from the ‘Discontinuing group’ mostly described the social aspects of the program, such as the opportunity to interact with peers and the friendships made in the group, as contributing greatly to what they liked about the time they did spend in the program. Given that the opportunity for social interaction with peers was identified as important to participants’ experience in the LLLS program highlights the importance of drawing attention to the social benefits of healthy ageing programs, however it also raises awareness as to how those with barriers preventing them from engaging in such programs (i.e., financial) can still access similar options for involvement in physical activity groups with concurrent social interaction.

Despite the promotion of healthy ageing programs largely focussing on the physical aspects of health, findings from this component of the research support a more holistic understanding of healthy ageing (Browning & Kendig, 2010; Bryant et al., 2001). Alongside the physical benefits of being engaged in the LLLS program, participants frequently referred to the social and structural aspects of the program as well as intrapersonal factors as important to their engagement and enjoyment in the program (as evidenced by related research (Avers,
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2010; Jancey et al., 2007; King et al., 1992; Norman, 1998; Peterson et al., 2005; Peterson et al., 2008; Robinson-Whelen et al., 2006; Wilson & Spink, 2006)). Undervaluing these other non-physical aspects important for engagement in health programs, restricts possibilities for addressing the more holistic needs in the promotion and maintenance of health and wellbeing and potentially limits opportunities to facilitate a positive ageing experience. Moreover, findings from the current research offer critical insight based on older adults’ lived experiences that can be used to improve the delivery and implementation of future healthy ageing programs designed for older adults. The implications of these findings about what contributes to an engaging program experience are reviewed in further detail in the next chapter.
Chapter 7: Summary and conclusions - Key research findings, strengths, limitations, and future directions

In this chapter, key findings from this current research are summarised. Findings and interpretations from the data are presented and positioned within the context of the main aims and questions of the research. The significant aspects relating to participants’ experiences of a healthy ageing program are also summarised. Implications of the current research for service delivery pertinent to healthy ageing as well as implications for ageing theory, policy and practice are discussed. To conclude the chapter, strengths, contributions and limitations of the research are reviewed and avenues for future research highlighted.

7.1 Research aims and questions: Key findings

A primary aim of this research was to explore the experiences and social constructions of ageing from the perspective of older adults over the age of 50 years. An additional aim was to explore older adults’ experiences of being involved in a healthy ageing program. Furthermore, the study aimed to explore how findings from those involved in a healthy ageing program varied with the experiences and social constructions of ageing from the perspective of community dwelling older adults locally in the City of Joondalup in the North West Metropolitan area of Perth, Western Australia (WA) and internationally in Barry (a town outside of Cardiff), in the Vale of Glamorgan, Wales, United Kingdom (UK). The aims of the research were achieved using data from in-depth, semi-structured interviews to explore experiences of ageing and the experiences of being involved in a healthy ageing program. Examining participants’ experiences and social constructions of ageing in the context of current conceptualisations of healthy ageing in policy and theory also facilitated achievement of the research goals. This exploratory research was necessary given the current focus on population ageing; as a response to the recent local, national and international research agenda on healthy ageing; and due to the relative dearth of information relating to the lived experience of ageing from the perspective of older adults themselves. The key findings from this research are summarised in the next section and reviewed in the context of the research questions.
7.2.1 Constructing the ageing experience through lived experiences: Implications for theory, policy and practice

Research questions one and two:

1) What are the experiences and social constructions of ageing for older adults over the age of 50 years in the following contexts?
   
   (a) Participants involved in a healthy ageing program (‘LLLS group’)
   
   (b) Participants who have withdrawn from a healthy ageing program (‘Discontinuing group’).
   
   (c) Participants from a local community sample (‘WA group’).
   
   (d) Participants from an international community sample (‘Welsh group’).

2) How do the experiences and social constructions of ageing for older adults vary across the four contexts?

Ultimately, the aim of all research is to contribute to the knowledge base about an area of interest (Mays & Pope, 2000). In the current research, participants’ lived experiences and personal accounts both informed and extended the existing knowledge base in relation to the experience of ageing. A significant finding was that common experiences and thoughts about the ageing process were shared across the four different participant groups. As such, the findings and interpretations relating to research question one and two (as outlined above) were presented collectively. Where relevant, findings unique to participant groups were also discussed independently. A summary of the key findings relevant to research questions one and two are reviewed in the next section and their contribution to contemporary understandings and social constructions about the ageing experience and in particular, are discussed in relation to the implications they have for future theory, policy and practice.

7.2.1 Theoretical implications.

A salient finding of the current research was the evidence across all four participant groups that constructions of the ageing process were foremost primed by wider societal discourses used to describe the ageing experience. Participants’ constructions of ageing were particularly influenced by biomedical discourses prevalent in wider society which emphasised a decline and loss understanding of the ageing process. The prevalence of biomedical discourse towards ageing was described by participants as particularly mediated through the media, health systems, and policy. Findings also revealed that the notion of healthy ageing was highly familiar amongst participants and was found to influence both how participants thought about
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their own personal health behaviours as well as how they constructed meaningful understandings about the experience of ageing. In particular, the international scope of the present study (i.e., participant populations drawn from WA and Wales) highlighted that different and localised understandings of healthy ageing existed. For example, findings suggested that healthy ageing was considered by participants as synonymous with a sense of self-responsibility for health, founded upon localised understandings that this was primarily achieved either through maintaining a healthy diet (the dominant understanding reflected by Welsh participants) or by keeping physically active (the dominant understanding reflected by Western Australian participants). This finding underlined the significant influence of social contexts on the way in which meaningful understanding is constructed about ageing. Moreover, it reinforced how discourses used to describe ageing within different and localised social contexts can influence how older adults relate to their own personal experience of ageing.

Furthermore, participants revealed that making social comparisons with significant others was a salient part of constructing meaning about their own experiences of ageing. Making comparisons with others (i.e., parents, peers, and friends) was found to enable participants to retain a positive self-perception and social presentation through the creation of “possible selves” (Festinger, 1954; Kwan et al., 2003; Tanner, 2007). This tendency allowed participants to reflect on fears and hopes for the future as well as provided a way of thinking about and planning for the ageing process (Bailis & Chipperfield, 2006; Giles et al., 2010). Furthermore, making downward social comparisons appeared to sustain participants’ motivation to fulfil personally meaningful goals such as the need for competence and sense of belonging, a finding that was consistent with previous research (Bailis & Chipperfield, 2002, 2006; Bailis et al., 2005; Carstensen et al., 2000; Frieswijk et al., 2004; Heidrich & Ryff, 1993a, 1993b; Kwan et al., 2003). Moreover, the data suggested that the effects of making downward social comparisons may not only be mediated by peers and family but also by major events in history (i.e., war), a finding that would benefit from further research. Therefore, the current findings both extend and support the existing social comparison literature (Festinger, 1954; Kwan et al., 2003; Tanner, 2007).

The current research reinforced prior literature that has emphasised the importance of social support to wellbeing and the quality of life during the ageing process (Grundy & Sloggett, 2003; Gunnarsson, 2009; Kafetsios & Sideridis, 2006; Livingston et al., 2008; Register & Scharer, 2010). Unique to this research was the finding that social support involved participants investing effort in consolidating emotionally meaningful relationships through the
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strepthing of family bonds and spending more time with loved ones, including friends. It was also found that whilst the data supported previous research that has outlined the role of personal relationships in facilitating a sense of connectedness (Carstensen et al., 2000; Gray, 2009; Kafetsios & Sideridis, 2006; Register & Herman, 2010; Register & Scharer, 2010), participants in the present study linked connectedness with several additional dimensions such as having a shared history with others; having a sense of belonging to a wider network and/or community; and acknowledging the value of belonging to different social/familial groups. Significantly, the importance of faith, spirituality, and existential belief systems and orientations were important facets of the experience of connectedness in ageing for participants. These findings compliment theoretical debate in the literature arguing for the necessity of a ninth stage of human development, that is, the inclusion of a stage that better incorporates the concept of gerotranscendence; the redefining of reality with the perception of time, space and objects bearing a new understanding of fundamental existential issues (Achenbaum, 2006; Erikson & Erikson, 1997; Lewin, 2001; Schroots, 1996; Tornstam, 1989; Wadensten, 2006). Moreover, findings support previous research regarding the importance of recognising and addressing such existential needs in holistic approaches to health and wellbeing in ageing (Grossman, 2007; Lavretsky, 2010; Lewin, 2001; National Wellness Institute, n.d.; Parker et al., 2002; Reker & Woo, 2011; World Health Organization, 2002).

The findings of this research also build upon prominent theories about the importance of keeping socially active and maintaining social roles as individuals adjust and transition into older adulthood (Cavanaugh & Blanchard-Fields, 2006; Cummings & Henry, 1961; Havighurst, 1948; Havighurst & Albrecht, 1953; Lemon et al., 1972; Longino & Kart, 1982; Papalia et al., 2007; Wadensten, 2006). In the current study, participants reported that having social roles that provided opportunities to exercise meaningful influence with others and which generated respect were highly important to their sense of wellbeing, self-esteem, identity and overall ageing experience. Furthermore, life stage events were found to be important markers for participants in understanding their own ageing experience. Despite the diverse challenges faced by individuals as they age in life, findings from this current research suggest that through the maintenance of a positive attitude, primarily by way of accepting that change was inevitable, through maintaining hope and optimism (Chapman & Hayslip, 2006), and by negotiating the dynamics between experienced losses and gains during the ageing process, participants were able to successfully regulate their emotional state more effectively as indicated by previous research (Carstensen et al., 2010; Kliegel et al., 2007). These findings provide support for current lifespan perspectives suggesting that older adults use pragmatic
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strategies to fortify perceived weakness or to overcome losses associated with ageing (M. M. Baltes & Carstensen, 1996, 1999; M. M. Baltes & Lang, 1997; P. B. Baltes & Smith, 1999; Birren & Schaie, 2001; Birren & Schroots, 2001; Papalia et al., 2007; Schroots, 1996).

Encountering ageist behaviours and attitudes was a prevalent concern described by participants in the current research. Often such experiences were described as mediated through significant aspects of social life, which both inform and organised the socio-cultural context in which participants resided. For example, participants indentified that ageist behaviours and attitudes were often encountered through the media; during the allocation of resources by governments; during planning and policy development by governments; in the workplace and in employment practices; and in the provision of healthcare services and care facilities. The lived experience of ageing for participants across the different contexts of this research suggests that interactions with these everyday social structures and systems, affected their sense of self-worth as well as influenced their understanding of how society as a whole perceived them. Prior research has demonstrated that feeling valued is critical to both one’s psychological sense of wellbeing and the feeling that one has control over one’s life as they age (Coote, 2009; Ory et al., 2003). In the present study, it was common for participants to articulate and construct their experience of ageing in terms of feeling a sense of worthlessness. This was especially apparent when participants discussed ageing experiences where their personal control was threatened (i.e., not having a voice, feeling invisible during social interactions). This feeling was not confined to societal experiences but also permeated into the family setting. Therefore, for participants in this current research, their experience of ageing was affected by socially constructed ideas about ageing related to biomedical concerns and issues associated with loss and decline with these meanings mediated by social structures and systems that reinforced ageist attitudes.

The findings from this research were salient for both male and female participants, however some findings prompted the need for further investigation into the different experiences of ageing from a gendered perspective. Specifically, for female participants across the four groups of this study a recurrent narrative existed around physical attractiveness. Of particular significance was ambiguity with previous findings reported in the literature that has suggested that as women transition into midlife, they begin to disassociate themselves with the cultural ideals of beauty and the power of the external gaze of others (Apter, 1995). Similarly, incongruity also existed with prior research that has argued that older women are less likely to compare themselves with fashion models (Kozar & Damhorst, 2009). In contrast, the present study found that female participants continued to relate to such images, a
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tendency which brought about psychological introspection about self-objectification including feelings of anxiety and body shame. Therefore, it was evident that body image perceptions played an important psychological role in the allocation of social identities for female participants in the current study (Hockey & James, 1995). Such findings suggest that future research investigating factors that influence body image perceptions and social identities in ageing for both genders would add depth to current understandings.

In summary, despite psychosocial paradigms existing that emphasise the dynamic and multifaceted nature of the ageing experience, as well as contemporary policy that promotes a positive view of the ageing process, it was evident across all four participant groups that understandings about ageing were heavily influenced by biomedical discourses associated with loss and decline. In many instances, participants were clear that this view of ageing was mediated by both social structures and societal systems that continued to reinforce ageist behaviours and attitudes. Moreover, it was evident that these understandings were reflective of socially constructed ideas about ageing more than a reflection of personal experience. For example, when participants’ experiences of ageing were investigated beyond constructed understandings, personal accounts about their own lived experiences revealed that social, political, and psychological factors were considered of equal if not greater significance. Consequently, findings from this research supports the existing theory and literature suggesting that ageing is a co-constructed experience mediated by social interactions and political forces (Estes, 1993; Estes et al., 2009; Featherstone & Wernick, 1995; Gergen, 1985; Jamieson, 2002b; S. Katz, 1996; Townsend, 1981, 2007). This finding has implications for both policy and practice in the ageing field and may potentially influence how ageing issues are prioritised at a political level.

7.2.2 Policy and practice implications.

Social policy has been described as both aiming to create social spaces that respond to issues and problems by encouraging certain behaviour whilst censoring others (Estes et al., 2009). Ageing policy has historically been constructed in medical and economic terms that portray a problematic view of the ageing experience. In more recent times ageing policy has steadily attempted to promote a positive view of the ageing process through movement away from a primary focus on the premise of loss and decline. The extent of this shift has culminated in the development of a new rhetoric and terms of reference such as “active”, “successful”, “productive”, and “positive” used to describe various aspects important to enhancing a more holistic and balanced portrayal of life quality as individuals age (Cardona, 2008; Peel et al., 2004; Peel et al., 2005). Such terms have also influenced recent healthy ageing policy
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development. For example, the notion of healthy ageing in policy terms has been described as
incorporating an individual, community, public and private sector approach to understanding
the ageing process and as a perspective that aims to improve and maintain the physical,
mental and emotional wellbeing of older adults (Commonwealth of Australia, 1999;
Commonwealth States and Territories, 2000; Prime Minister’s Science Engineering and
Innovation Council [PMSEIC], n.d.). Despite this highly evident transition in the rhetoric and
focus of ageing policy, the findings of the current research suggest that healthy ageing policy
has yet to reach its full potential. In particular, findings demonstrated that a disparity and
disjuncture existed between participants lived experience of ageing and the understandings
and practices both contained in and promoted by healthy ageing policy.

As previously established the biomedical view of ageing has largely constructed ageing
as a problem, a stance that is only further reinforced when policy continues to either passively
and/or actively imply that the absence of disease is the primary marker of healthy and
successful ageing (Cardona, 2008; Peel et al., 2004; Phelan et al., 2004). The current research
found that while societal factors allowed participants to anticipate ageing as a stage in life
centred on experiencing decline and loss, it was also evident that psychological, social and
political aspects of the experience were of equal or greater significance to the meaningful
understandings they constructed about their personal ageing experience. This discontinuity
between the rhetoric in ageing policy with understandings of healthy ageing held by
participants in the current research, suggests that a gap exists between the aims and
intentions of ageing policy with participants’ understandings and lived experiences of ageing.
The findings of this study contend that a need exists to evaluate the way in which ageing policy
is conceived, constructed, implemented, or put another way - collectively “translated” into
action, that closely aligns in a meaningful way with the lived experiences of ageing as had by
individuals.

In recent years significant attention has been given to the role of translational research
in public health systems and the provision of health care services (Oborn, Barrett, & Racko,
2010; Ogilvie, Craig, Griffin, Macintyre, & Wareham, 2009). This focus emerged from
recognition that health systems across the world did not often reach their full potential in the
 provision of health services (World Health Organization, 2004b); that health knowledge did not
always translate in practice (Woolf, 2008); and in some instances a 17 year gap was found to
exist between the generation of new health knowledge and its application in practice (Institute
of Medicine, 2001). Although no single definition of translational research has been agreed
upon, it has been described by the Canadian Institute of Health Research (CIHR) as the
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necessity to translate knowledge generated in the research setting into real-world applications with the aim to improve the health of individuals by the provision of more effective health care systems and services (Canadian Institutes of Health Research, 2004). A key rationale underpinning the focus on translational research by the CIHR is a sense of moral and social responsibility to ensure that the benefit of research flow back to individuals in society, as ultimately, it is they who have funded and enabled health research to occur in the first place.

Therefore, findings of the current research demonstrated that an inherent gap still exists between the translation of current lived experiences and understandings of ageing held by individuals and the capacity of existing social policy to sustain positive social change, practices, and social constructions of the ageing experience. For example, participants reflected understandings about healthy ageing constructed in biomedical terms and as a highly individualistic experience. The risk with minimising the role and influence of broader social and political systems in attaining and facilitating good health and wellbeing is that becoming unwell can be interpreted by individuals as a personal failure rather than bringing to account those other equally significant factors that may be impacting on one’s health and ability to self-care (Cardona, 2008; Holstein & Minkler, 2003; Pond et al., 2010). Hence, further investigation is required into how ageing policy is translated in practice to resolve where the disjunction between policy and lived experiences lies. A benefit of this might be that “taken-for-granted” social practices, social structures, and societal systems that continue to communicate discourses about ageing that contribute to a devaluing ageing experience, are more clearly identified.

This research supports the notion that meaningful understandings of the ageing experience across the lifespan are more than a biological occurrence (Estes, 1993; S. Katz, 1995). Rather, with the influence of social policy on constructing meaning about ageing found for participants in this research, an opportunity presents to modify what becomes the dominant discourse about ageing in the future. With participants’ lived experiences reflecting concerns associated with psychological, social and political factors, this finding suggests that healthy ageing initiatives need to embrace a holistic awareness of all aspects that influence the ageing experience. It was evident that future policy decision making and models of practice are encouraged to focus on the promotion of healthy ageing in a way that more closely aligns with older adults’ lived experiences. An area identified by the present research where policy makers might translate knowledge into practice includes the growing interest in the link between spirituality and psychological wellbeing during ageing, and the incorporation and promotion of these elements into psychological assessment for clinical and therapeutic practice (Gridley,
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2009; Huxter, 2009; Joyce & Symons, 2009; Lavretsky, 2010; Proctor, 2009). Broader strategies may include reviewing the geriatric training of health professionals and the general public about the ageing process as well as educating older persons about their human rights and helping them to play a more active role in securing these rights, such as actively involving them in future research (United Nations Educational Scientific and Cultural Organization, 2006).

Moreover, the current findings suggest that future policy needs to better acknowledge and critically evaluate the interconnected relationship between political, social, and psychological factors in enhancing or diminishing health during the ageing experience (Goodman, 2001; Prilleltensky & Fox, 2007). A critical investigation of the interconnectedness of these factors would allow for an examination of the impact that social mediums such as the media (e.g., television, newspapers) and government policy have on the social constructions held by individuals of their own experience of ageing. Much like the sense of moral and social responsibility held by the CIHR to ensure that the benefit of research flow back to individuals in society (Canadian Institutes of Health Research, 2004), a critical component of this investigation would not just involve critically thinking about society and social structures (Ayers et al., 1998; Prilleltensky & Fox, 2007), but rather it would extend to recognition that those in positions of power that are in support of a more just distribution of resources including health professionals, governments, educators, and the media, need to reconsider the continued emphasis on apolitical factors such as biological determinants and personality traits as defining health status. As illustrated by the current findings, this “fall-back” position continues to overlook the significant influence and accountability of those in positions of power in facilitating or impeding health and positive ageing experiences (Goodman, 2001; Mitchell & Schoeffel, 2002; Prilleltensky & Fox, 2007).

In review, this research highlights the imperative of consulting with older adults about their experiences of ageing to ensure knowledge is better translated into policy and practice in the real world. To sustain such a process, older adults will first need to feel appreciated and as valued members of society (United Nations, 2002). Although recent policy reflects a more positive conceptualisation of ageing, participants in the current research often expressed that their experiences and interactions with everyday social systems and structures devalued their sense of self-worth. As such, findings from this research suggest that a disjunction exists between what policy is trying to achieve and the actual lived experience of ageing. Ultimately, new research knowledge and progressive social policy needs to both resonate with and be accessible by the population that it seeks to positively affect otherwise achieving sustained social change will potentially be undermined and continue to reside in the shadow of dominant biomedical discourses and outdated assumptions. This research highlights the
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significant role of primary qualitative research investigating the lived experiences of ageing across different contexts but moreover, a framework has been provided for movement beyond just informing policy decisions to instead argue that it is equally, if not more important to critically assess how knowledge about the lived experience of ageing is translated into practice.

7.3 Experiences of a healthy ageing program: Implications for future program development

Research question three:

3) What are the experiences of being involved in a healthy ageing program?

(a) What are the challenges and motivations to remaining involved in a healthy ageing program?

The current local, national and international political drive to develop the healthy ageing evidence base (Cacioppo et al., 2006; Commonwealth of Australia, 1999, 2001; United Nations, 1991) prompted this research to not only investigate the lived experience of ageing, and explore older adults’ views on aspects of healthy ageing important to them, but to also investigate participants’ experiences of being involved in a healthy ageing program (Bartlett, 2003; Office for Seniors Interests and Volunteering, n.d.; WA Aged Care Advisory Council, 2003). In the context of the current research, the LLLS program provided an appropriate setting to address the research aim of exploring these experiences.

The design of the LLLS program focuses on the physical aspects of health and as such, participants’ main motivations for becoming involved in the program included to address a current health condition, and as a preventative measure to remain fit, active and involved in community. Among the features identified as important to participants’ experiences from both the ‘LLLS group’ and the ‘Discontinuing group’ included the physical benefits of engaging in the program exercises. Therefore, participants’ accounts of their experiences in the LLLS program provide support for the importance of physical activity for health, particularly strength-based exercise (Avers, 2010; Colcombe et al., 2003; Jancey et al., 2006; Jancey et al., 2007; Karlsson, 2002; Lucidi et al., 2006; A. Nies et al., 2003; Park et al., 2011). Findings also indicated that older adults respond positively to a well-structured, well-organised and age-appropriate program environment with experienced staff that lead, supervise, and communicate well. Participants were more likely to retain involvement when these factors were evident as they facilitated a sense of belonging and safety.
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Notwithstanding these factors, the most salient finding to emerge from older adults’ experiences in the LLLS program was that the relational aspects and social environment of the program were significantly important to participants’ sustained involvement. In particular, the opportunity to build friendships and make comparisons with peers significantly contributed to participants’ positive experience in the program. Findings also suggest that the benefits of designing programs which are constructed around promoting peer based relations, include the opportunity for meaningful social engagement and opportunities to make positive peer comparisons, both particularly motivating reasons for sustained involvement in healthy ageing programs as evidenced by previous research (Bauman et al., 2006; Plonczynski, 2003; Robinson-Whelen et al., 2006; Wilson & Spink, 2006). Furthermore, the social interaction of the group was found to positively influence some participants’ attitudes towards ageing as they began to recognise their own potential rather than their limitations. This was particularly evidenced by some participants staying involved in the program to specifically improve their own ageing experience now believing that a preventative approach to ageing and continued involvement in the program was the best way to keep active and remain in good health.

Participants’ reasons for withdrawal from the LLLS program suggest that where possible logistical issues need to be considered as influencing retention and positive engagement in healthy ageing programs. Among the challenges experienced by participants from both the ‘LLLS group’ and the Discontinuing group’ were sustaining personal motivation, adhering to the time schedule, and becoming familiar with the equipment and machines with these aspects mediated by intrapersonal factors including self-efficacy and self-regulation. The main reasons for participants in the ‘Discontinuing group’ withdrawing from the program were due to cost and time issues as well as issues associated with experiencing pain during, and post engagement with the program exercises. Some participants may not have withdrawn from the LLLS program had there been more flexibility in the timetable and with the cost of attending (i.e., perhaps through identified need arrangements) and if more structured follow-up procedures had been in place. For those participants who experienced pain as a result of engaging in the exercises set out by the program and who subsequently withdrew their involvement, there was a belief by some that this may have been avoided had there been more thorough initial pre-assessments and subsequent follow-up assessments conducted as participants progress through the program. These findings brought to attention the issue of resourcing the capacity of such healthy ageing programs so that they can better support these types of pre-and-post assessment procedures and their ability to make concessions according the needs of its clients. Hence, an opportunity exists for future research to consult with
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program organisers and program staff about their experience of running such programs as well as their perspectives on the experiences of those attending.

In summary, this research offers important feedback as to what influenced participants’ involvement in a healthy ageing program and it invites consideration of the development of current and future programs designed for an ageing population. Specifically, despite healthy ageing programs predominantly linking understandings of healthy ageing with physical aspects of health, findings from this research suggest older adults’ involvement in a healthy ageing program offered more holistic support for individuals with negotiating healthy ageing and the ageing process. Importantly, given the significance of the social, structural and intrapersonal aspects that participants described as important to their experience in the LSSS program, such factors should be prominent when promoting healthy ageing and affiliated healthy ageing programs. Undervaluing the relational aspects and social environment that accompany participation in health programs limits the possibilities for addressing the holistic needs of individuals and the maintenance of health, psychological wellbeing, and a positive ageing experience. These findings again reinforce and emphasise the importance of consulting with older adults about their experiences of ageing during the planning, development, and implementation of future healthy ageing programs.

7.4 Strengths and contributions of the research

This research has been responsive to the need for gaining contemporary perspectives, understandings, and social constructions of the lived experience of ageing. This is also timely given the current local, national and international political agenda for promoting healthy ageing. Although the current research did not initially set out to be an international comparison study, a significant strength of the current research methodology was that it allowed for the extension of this research beyond international boundaries resulting in data collected from two separate countries. Deriving themes from data collected from participants in Wales as well as data collected from participants in WA, made it possible to demonstrate the influence of localised socio-cultural contexts on the construction of meaning that participants formed about their ageing experiences. In particular, a salient finding was that issues asserted by participants in the context of WA were also found to have relevance to participants in Wales, highlighting the widespread significance of the findings as well as the unique contribution of this research.
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A further strength of the current research was the involvement of older adults to source information about their experiences of ageing. With individuals best positioned to report their understandings of the social experiences that they encounter in life (Denzin & Lincoln, 1998, 2008; Gelo et al., 2008; Patton, 2002), utilising a qualitative methodology for this research provided opportunity for older adults to explain their experiences from within their own personal contexts (Chwalisz et al., 2008; Corbin & Strauss, 2008; Creswell, 2007; Janesick, 2000). Consulting with older adults about their experiences of ageing, allowed for insight into processes of meaning making about ageing. An added benefit of this approach was that information was imparted about factors that both mediated and influenced how individuals constructed understanding about their personal experience of ageing. Moreover, this type of consultation allowed for in-depth information to be collected about the unique experiences of participants that perhaps would not have been identified through the quantification of personal experiences, or relying on secondary sources of information (Creswell, 2007). Consequently, any actions resulting from this shared information concerning participants lived experiences of ageing are more likely to be responsive to their needs.

7.5 Limitations of the research

The primary aim of qualitative research is to return findings that are authentic and beneficial to the context where the findings were gathered, which means limitations exist as to applicability of the current findings to other populations. For this reason, further research could be conducted to assess the utility of these findings amongst other population groups and across different socio-cultural contexts and settings. In addition, given that participation in this research was based on voluntary involvement and self-nomination, it is possible that some participants were representative of a more motivated sample or representative of individuals that had a more vested interest in ageing as a social issue and/or had access to resources (e.g., knowledge, education, mobility) enabling them to become involved in this research. Therefore, further research into marginalised and/or oppressed groups of older people, different cultural perspectives (e.g., non-Western) as well as research looking not only at the differences among specific population groups but also investigating different aspects within population groups would provide a more extensive account of the lived experience of ageing. Furthermore, while not a limitation as such, as the findings from this research reflect the specific aims of the research, it is acknowledged that employing a longitudinal design looking at the ageing experience over a length of time to see if attitudes, views and understandings change significantly would value add to the current research.
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7.6 Directions for future research

Findings from the current research emphasise the importance of shifting from an individualistic focus when exploring the ageing experience to consideration of social, political and economic structures and relationships in mediating the experience (Bernard & Scharf, 2007; Estes et al., 2009; Holstein & Minkler, 2007; Townsend, 2007). This involves continuing to challenge the unreflective acceptance of established and dominant views, as well as “taken-for-granted” and substantive value assumptions, theories, and perspectives in ageing (Estes et al., 2009; Holstein & Minkler, 2007). With findings from this research supporting the tenants of a wellness perspective on health, that is a holistic approach which acknowledges that experiences are affected by power, capacity and opportunity (Goodman, 2001; Prilleltensky & Fox, 2007), it is suggested that such an approach be considered when researching issues associated with the ageing experience. For example, acknowledgment through policy and practice that the personal need for physical and psychological health is influenced by the opportunity and capacity to obtain adequate health care just as a need for equality is influenced and affected by fair and equitable distribution of resources (Prilleltensky & Fox, 2007).

While descriptions and research on healthy ageing espouses a holistic approach to ageing, both prior research and the current research suggest that understandings are still dominated by biomedical and physical understandings of health (i.e., exercise, diet) despite the lived experience emphasising the importance of relational and social factors in facilitating connectedness and as sense of personal control, value and self-worth as people age (i.e., the value of groups, supportive relationships, religion and spirituality, meaningful and respectful social interactions). Therefore, to effectively promote healthy ageing and a more holistic health message to the wider society, critical consideration needs to be given to how knowledge about the lived experience of ageing is better translated into social policy and practice, particularly the social and psychological aspects. Furthermore, with the current findings supporting recent research that highlights the use of pragmatic strengths to negotiate and compensate for perceived weakened abilities, experiences and losses in ageing (M. M. Baltes & Carstensen, 1996, 1999; M. M. Baltes & Lang, 1997; P. B. Baltes & Smith, 1999; Birren & Schaeie, 2001; Birren & Schroots, 2001; Papalia et al., 2007; Schroots, 1996), suggests the necessity for future ageing perspectives that encourage and promote “strengths-based” approaches to understanding health and wellbeing during later adulthood and for this to also be explicitly incorporated into research, policy, and practice to counter dominant discourses associated predominantly with a loss and decline view.
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Findings from this research similarly indicated that the concept of connectedness in relation to the ageing experience would benefit from further research. It is suggested that the definition might be expanded to include aspects identified in the current research such as spirituality, the value of group membership, shared history and emotionally meaningful relationships and investigation into how aspects of culture mediate these factors. Furthermore, with evidence emerging from the data that making social comparisons with family, peers and friends influenced how older adults constructed meaning, and in turn related to their own personal experience of ageing, the present research suggests that social networks provide a powerful medium to promote alternative perspectives on ageing. Hence, utilising such readily accessible and available social networks seemingly presents both a powerful and meaningful point of intervention to encourage older adults to engage in healthy ageing activities and programs considered important for facilitating a positive ageing experience. The ageing field would benefit from future research investigating how social networks may be used to generate and sustain positive social change and how social networks can be effectively used to translate knowledge about ageing into the delivery and implementation of healthy ageing research agendas, policy and services.

In order to influence positive social change in regard to the experience of ageing, findings from the current research revealed that the issue of ageism is an existing problem warranting extra attention. Negotiating the impact of ageism was a significant finding of the current research, pervasive in all contexts of relevance to this research (i.e., WA community, Welsh community). The impact of the different levels of ageism experienced by participants included heightening feelings of worthlessness, invisibility, and a general experience of feeling that they were the most socially and politically devalued segment of the population. These issues were recognised as being mediated through the media, in workforce practices, as a product of culture (i.e., represented as “Western ways”), through generational interactions and through the healthcare system. Therefore, further investigation into the role that these mediums play in the construction of meaning in ageing is of particular importance to addressing ageism. In addition, findings from the current research suggests that there is benefit in further examining gender difference in how older women and older men socially construct themselves in society with a strong emphasis on the ageing body and the disjunction of image and reality. While this did not present as a salient issue for male participants in this study, future research investigating social constructions and experiences of image in older adulthood from a male perspective would complement current understandings.
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In conclusion, although beyond the scope of this present research, an important consideration for future research based on these findings would be to explore further the role that specific systemic factors play in health systems and health care services, in promoting and influencing social constructions of ageing. This would assist in making visible those processes that maintain the dominance of decline and loss discourses and help social policy to move beyond uni-dimensional understandings of the ageing process. Taking into account the multifaceted and dynamic nature of the ageing process rather than a continuation of the status quo that predominantly locates health outcomes solely within the control of the individual, would also assist in a more expedient facilitation of a holistic perspective on health in ageing, that is, a perspective that takes into account the role of systemic influences rather than just individual factors.

7.7 Final conclusions

An important goal of this research was to add knowledge to current ageing ideology through consultation with older adults about their ageing experience. A related goal was to highlight how this knowledge can be used to develop policy and practice that more closely reflects the lived experience of ageing. In particular, this research aimed to understand the systemic influences on constructed meaning in ageing with a particular interest in the disjunction between policy constructions and lived experiences. Although the current research has identified the importance of social, political and psychological factors to participants’ experiences of ageing, findings suggest that participants’ understandings of ageing were influenced by medically orientated health discourses mediated through systemic influences and social interactions, which consequently were found to undermine the existing efforts of positive ageing policy. While it is important that these findings are used to inform existing and future policy decision making and models of best practice towards promoting healthy ageing, it is argued that it is equally, if not more important that this knowledge is translated into practice if policy is to more closely align with older adults’ lived experiences and therefore a critical review on how to more effectively translate policy into practice is required.

In conclusion, findings from the current research encourages further thinking about how society defines and promotes healthy ageing. Findings from the current research also provide evidence that ageing is a socially constructed and therefore modifiable experience. With evidence that health messages and dominant discourses have an influence on peoples’ thinking, positive aspects about ageing indentified through participants’ experiences,
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particularly the psychological and social aspects need to be more effectively communicated, promoted and facilitated in future ageing policy and research. Moreover, these aspects need to be reviewed as to how they can be more effectively translated into practice, especially in healthy ageing directives. Specifically, healthy ageing initiatives implemented in the wider community need to embrace awareness of the lived experiences of ageing and put into practice actions that account for all factors contributing to a healthy ageing experience. Shifting the focus in this direction has the potential to significantly modify peoples’ constructions and understandings about ageing and therefore has the potential to influence the ageing experience more positively.
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Participant Interview Schedule - All Four Participant Groups

To participant: Today we are here to discuss ageing but what is important is that I get a sense of your experiences of ageing. I would also like to hear about the meaning you assign to the ageing process and what is important to you about this topic. You do not have to tell me anything you do not want to and it is okay to stop at any time – just let me know.

With your consent - I am going to audio record our conversation so that I can listen carefully to it later but I may also take notes while we are talking. Do you have any questions?

All the information will be very helpful for my research and I thank you for helping me with it. If you would like to stop for a break at any time, just let me know.

1. What does ageing mean to you?
2. What has been your experience of ageing?
3. How do you understand the ageing process?
4. Describe a moment you have experienced that typifies ageing to you?
5. What in your life has had the most influence on your thinking and experience of ageing (OR What life experiences have affected the way you think about ageing)?
6. How do you think the media (give examples - TV shows, news, documentaries, newspapers, magazines etc) portray people in your age group?
7. What does ageism mean to you?/What is your experience of ageism (definition: generalisations and stereotypes that appear negative in regard to particular groups because of their age)? Has there been a time that this was apparent for you?
8. How do you think younger generations view people in your age group?
9. What has been the most concerning aspect of ageing for you?
10. What has been the most appealing aspects of ageing for you?
11. Tell me about a positive experience related to the ageing process for you?
12. Tell me about a negative experience related to the ageing process for you?
13. Describe how your view of ageing has changed (if it has) from when you were younger?
14. What do you anticipate your needs to be as you get older?
15. What do you understand by the term Healthy Ageing? What does Healthy Ageing mean to you?
16. Is there anything else you would like to add about your experience of ageing?

Verbal prompts:
Tell me more about that experience...
Can you give me an example...

At the end of the interview process:
Is there anything you would like to ask me about our conversation today?
Do you think there is anything we have missed talking about today?

To participant: I really appreciate the time we have spent together and the things you have shared with me about yourself and your experiences. This information will be very useful for my research. Thank you.
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Appendix B - Participant Interview Schedule – LLLS Program Component

(‘LLLS group’ and ‘Discontinuing group’)

To participant: I would like to listen to your experiences of being involved in the Living Longer Living Stronger (LLLS) program. You do not have to tell me anything you do not want to and it is okay to stop talking at any time – just let me know.

I am going to audio tape record our conversation so that I can listen carefully to it later but I may also take some notes while we are talking. All the information will be very helpful for my research and I thank you for helping me with it. If you would like to stop for a break, just let me know.

1. Tell me how you first became involved in the LLLS program? What led you to becoming involved in the program?
2. Tell me about your experience of being involved with the program?
3. Tell me about your main motivations for being involved in the program?
4. Tell me about any challenges you have had/or had during your involvement with the program?
5. Describe to me how your experience of being involved in the program has influenced your experience of ageing and/or understanding of the ageing process?
6. Do you think there is anything we have missed talking about today? Is there anything else you would like to tell me about the LLLS program?
7. Is there anything you would like to ask me concerning our conversation?

Verbal prompt questions:

Tell me more about that experience...
Can you give me an example...

At the end of the interview process:

To participant: I really appreciate our time together and the things you have shared with about yourself and your experiences. This information will be very useful for my research. Thank you.
Dear Participant.

My name is Sasha Stumpers and I am a psychology PhD student at Edith Cowan University. As part of my studies I am required to complete a research project. I am interested in the area of ageing and my research is titled: ‘Exploring the experience and construction of ageing: A wellness perspective’.

Why do I need your help?

Our population is ageing and in the near future there are expected to be less people at younger ages and more people at older ages. As part of this research I would like to learn about how people over the age of 50 years experience and understand the process of ageing. This information is likely to be useful for future interventions and models of service delivery designed for an ageing population.

What would you have to do?

In order to get to know about your experiences and ideas about ageing I would like to organise a time to sit down and talk with you. I will have some set questions to ask to help guide our conversation. What we talk about will be audio recorded (sound recorded) so that I can listen carefully to our conversation later. Written notes may also be made during the interview to help me remember information later. There are no right or wrong answers as I am interested in your experiences about ageing. To check how the information provided by you during our conversation has been interpreted, it may be necessary for me to contact you on one more occasion just to make sure I accurately reflect what it is you have spoken to me about.

What happens with the information you give me?

All information that you provide during our discussion will remain ‘strictly confidential’. This means that only my supervisors and I will have access to your information. I will not play the audio recording to anybody else, or talk about you to anybody. No names or identifying information will be collected. The collected information will be written into a final thesis document and the research data gathered may be published however, the data will not be identifiable.

What do you do if you would like to participate?

Participating in this research is voluntary and if you feel uncomfortable at any time you can stop the interview at any stage with no questions asked. You do not have to answer any questions that you do not want to. It is anticipated that there will be no risk, discomfort or distress associated with being interviewed however, if you do experience any distress you will be provided with contact details of services you can access to assist in working through these feelings. If you have any questions or concerns about this research you can contact me or my supervisors (contact details below).

(Please turn page over)
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If you would like to participate in this research, please carefully read the consent form provided and then sign and return it to me at the School of Psychology and Social Science (address given below) using the reply paid envelope provided.

Thank you for your time in considering this research and I look forward to meeting you in the near future.

Yours sincerely,

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Hello, my name is Sasha,

I am a psychology PhD student at Edith Cowan University. As a part of my studies, I am conducting research titled ‘Exploring the experiences and construction of ageing: A wellness perspective’. What this means is that I would like to talk with you about your experiences of ageing. If you are interested in participating in this research, please carefully read, or listen to being read the information below before signing and dating your name. Thank you for agreeing to be a part of this research.

I …………………………………….. (print name) hereby consent to participate in the research and understand;

- The information provided outlining and explaining the research.
- I have been given the opportunity to ask questions and have had these questions answered to my satisfaction.
- I have been given the opportunity to talk to alternative people who have knowledge of the research and have been provided with their contact details.
- Participation in the research project will involve; participation in an audio-recorded interview and written notes may also be taken during the interview.
- Participation in the research project will also involve completing a short demographics information sheet.
- Information provided by me will be kept confidential, and that no personal information (i.e., name, address) will be linked with information I provide.
- Information provided will only be used for the purposes of this research.
- Collected information will be written into a final thesis document and the research data gathered may be published however, the data will not be identifiable.
- Participation in this research is voluntary and that I do not have to answer any questions that I do not want to.
- I am free to stop or withdraw from participating in the research at any time, without explanation, questioning or penalty.
- I freely agree to participate in this research and understand what I am being asked.
- It is not anticipated that there will be any risk, discomfort or distress associated with being interviewed.
- If I do experience any distress, I will be provided with contact details of services I can access to assist in working through these feelings.
- I give permission for the researcher to contact me again (with the information I provide below) if necessary after the interview to check how information provided by me was interpreted.

(Please turn page over)
Exploring the Lived Experience of Ageing

**Participant contact details:**

Name: ________________________________________________________________

Most convenient interview time - (please circle the best time(s) for you below):

<table>
<thead>
<tr>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning</td>
<td>Morning</td>
<td>Morning</td>
<td>Morning</td>
<td>Morning</td>
</tr>
<tr>
<td>Afternoon</td>
<td>Afternoon</td>
<td>Afternoon</td>
<td>Afternoon</td>
<td>Afternoon</td>
</tr>
</tbody>
</table>

Day time contact phone number(s): ______________________________________

________________________________________

Participant signature: .........................    Date: ..........................
Appendix E - Participant Demographics Information

Please provide the following information about yourself.

1. What is your gender?
   - Female
   - Male

2. What is your age? (Tick one only)
   - 50 – 55
   - 56 – 60
   - 61 – 65
   - 66 - 70
   - 71 – 75
   - 76 – 80
   - 80 +

3. What is your Ethnicity? ____________________________

4. Would you describe your current health as: (Tick one only)
   - Very poor
   - Somewhat poor
   - Neither poor nor good
   - Somewhat good
   - Very good

5. For your age would you describe your current health as: (Tick one only)
   - Very poor
   - Somewhat poor
   - Neither poor nor good
   - Somewhat good
   - Very good

6. Do you have any chronic illness (e.g., diabetes, heart condition)?
   - Yes, please describe ________________________________
   - No

7. Which term best describes your current relationship status? (Tick one only)
   - Single
   - Married
   - Re-Married
   - Widowed
   - Divorced
   - De facto

(Please turn page over)
Exploring the Lived Experience of Ageing

8. Which best describes your current living arrangements (primary place of residence)?
   (Tick one only)
   □ In own home (renting or owner)
   □ With a family member (please describe): _______________________
   □ With a friend
   □ Retirement facility
   □ Other, please describe_______________________________________

9. What is the highest level of education that you have achieved? (Tick one only)
   □ Lower secondary or primary school
   □ Upper secondary school
   □ Post secondary school but not tertiary (e.g. trade school, TAFE)
   □ Tertiary non-degree (certificate/diploma)
   □ Undergraduate degree
   □ Postgraduate

10. Are you currently working? (Tick as many as necessary)
    □ Yes, I am in full time paid employment
    □ Yes, I am in part-time paid employment
    □ Yes, I am in casual paid employment
    □ Yes, I am involved in volunteer work
    □ No
    Occupation (if applicable): ________________________________________

11. In what age bracket did you or do you intend to retire from work altogether? (Tick one only)
    □ 50 – 55
    □ 56 – 60
    □ 60 – 65
    □ 66 – 70
    □ 71 – 75
    □ 76 – 80
    □ 80+
    □ Never

End of form.
### Table E1

#### LLLS group

<table>
<thead>
<tr>
<th>Participant No.</th>
<th>Gender</th>
<th>Age</th>
<th>Nationality</th>
<th>Health status (self-assessed)</th>
<th>Health status for age (self-assessed)</th>
<th>Chronic illness (Y/N &amp; list of conditions)</th>
<th>Relationship status</th>
<th>Living arrangement</th>
<th>Education level</th>
<th>Working status &amp; Occupation (former or current) if stated</th>
<th>Age at Retirement (or planned)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>M</td>
<td>65-70</td>
<td>Australian</td>
<td>VG</td>
<td>VG</td>
<td>N</td>
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<td>None (Forced leave)</td>
<td>59</td>
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<tr>
<td>2</td>
<td>M</td>
<td>66-70</td>
<td>Scottish</td>
<td>VG</td>
<td>VG</td>
<td>Y (Diabetes, CVD, stroke, &amp; high blood pressure/cholesterol)</td>
<td>Married</td>
<td>Retirement facility (own home)</td>
<td>Upper secondary</td>
<td>Volunteer work</td>
<td>50-55 (NB: due to disability)</td>
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<tr>
<td>3</td>
<td>F</td>
<td>66-70</td>
<td>English</td>
<td>VG</td>
<td>SG</td>
<td>Y (Cancer, asthma, heart attack)</td>
<td>Married</td>
<td>Retirement facility (own home)</td>
<td>Upper secondary</td>
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<td>N/A</td>
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<td>4</td>
<td>M</td>
<td>80+</td>
<td>English</td>
<td>SG</td>
<td>Neither P nor G</td>
<td>Y (Diabetes &amp; heart attack)</td>
<td>Married</td>
<td>Own home</td>
<td>Upper secondary</td>
<td>None</td>
<td>60-65</td>
</tr>
<tr>
<td>5</td>
<td>F</td>
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<td>Neither P nor G</td>
<td>SG</td>
<td>N (Arthritis)</td>
<td>Divorced &amp; widowed</td>
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<td>Upper secondary</td>
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<td>71-75</td>
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<td>German</td>
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<td>Upper secondary</td>
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<td>66-70</td>
</tr>
<tr>
<td>7</td>
<td>M</td>
<td>71-75</td>
<td>English/Australian</td>
<td>SG</td>
<td>SG</td>
<td>Y (Open heart surgery)</td>
<td>Married</td>
<td>Own home</td>
<td>Lower secondary</td>
<td>None (Storeman)</td>
<td>71-75</td>
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<td>F</td>
<td>71-75</td>
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<td>VG</td>
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<td>9</td>
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<td>VG</td>
<td>VG</td>
<td>Y</td>
<td>Married</td>
<td>Own home</td>
<td>Tertiary non-degree (Cert.dip.)</td>
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<tr>
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<td>M</td>
<td>76-80 (78)</td>
<td>English</td>
<td>SG</td>
<td>SG</td>
<td>Y (Type 2 diabetes, &amp; high blood pressure)</td>
<td>Married</td>
<td>Own home</td>
<td>Upper secondary</td>
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<td>56-60 (Forced retirement)</td>
</tr>
<tr>
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<td>M</td>
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<td>English/Australian</td>
<td>SG</td>
<td>SG</td>
<td>Y (Cancer, glaucoma &amp; Hypertension)</td>
<td>Widowed</td>
<td>Own home</td>
<td>Upper secondary</td>
<td>None</td>
<td>60-65</td>
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<tr>
<td>12</td>
<td>F</td>
<td>56-60</td>
<td>Australian</td>
<td>VG</td>
<td>VG</td>
<td>N</td>
<td>Married</td>
<td>Own home</td>
<td>Undergraduate degree</td>
<td>Casual – paid (Teacher)</td>
<td>50-55 – Went PT</td>
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<td>80+ (89)</td>
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<td>VG</td>
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<td>Upper secondary</td>
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<tr>
<td>14</td>
<td>F</td>
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<td>VG</td>
<td>VG</td>
<td>N (Arterial fibrillation)</td>
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<td>Y (Arthritis)</td>
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<td>45 (NB: disability pension with RSI)</td>
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<td>M</td>
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<td>British</td>
<td>VG</td>
<td>VG</td>
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<td>Own home</td>
<td>Tertiary – non-degree (Cert.dip.)</td>
<td>PT – paid (Analyst water corp.)</td>
<td>65 (Planned)</td>
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</table>
Exploring the Lived Experience of Ageing

Table E2

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<thead>
<tr>
<th>Participant No.</th>
<th>Gender</th>
<th>Age</th>
<th>Nationality</th>
<th>Health status (self-assessed)</th>
<th>Health status for age (self-assessed)</th>
<th>Chronic illness (Y/N &amp; list of conditions)</th>
<th>Relationship status</th>
<th>Living arrangement</th>
<th>Education level</th>
<th>Working status &amp; Occupation (former or current) if stated</th>
<th>Age at Retirement (or planned)</th>
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</thead>
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<td>Australian</td>
<td>VG</td>
<td>VG</td>
<td>N</td>
<td>Married</td>
<td>Own home</td>
<td>Undergraduate degree</td>
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<td>F</td>
<td>66-70</td>
<td>Australian</td>
<td>VG</td>
<td>VG</td>
<td>N</td>
<td>Married</td>
<td>Own home</td>
<td>Lower secondary</td>
<td>None</td>
<td>50-55</td>
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<tr>
<td>3</td>
<td>F</td>
<td>66-70</td>
<td>Australian</td>
<td>SG</td>
<td>SG</td>
<td>-</td>
<td>Married</td>
<td>Own home</td>
<td>Lower secondary</td>
<td>PT – paid (Travel Advisor)</td>
<td>71-75</td>
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<td>71-75</td>
<td>Australian</td>
<td>SG</td>
<td>SG</td>
<td>Y (Post MI - 14 years &amp; osteoarthritis)</td>
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<td>Own home (Renting daughters house)</td>
<td>Undergraduate degree</td>
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<td>71-75</td>
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<td>5</td>
<td>F</td>
<td>56-60</td>
<td>Australian/New Zealander/Australian</td>
<td>SP</td>
<td>SP</td>
<td>Y (Rheumatoid arthritis, COPD &amp; asthma)</td>
<td>Single</td>
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<td>Upper secondary</td>
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<td>50-55</td>
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<td>6</td>
<td>F</td>
<td>71-75 (73)</td>
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<td>SG</td>
<td>SG</td>
<td>N</td>
<td>Married</td>
<td>Own home</td>
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<td>7</td>
<td>M</td>
<td>80+</td>
<td>Australian</td>
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<td>Neither P nor G</td>
<td>Y (Diabetes, Ischemic heart disease &amp; Arthritis)</td>
<td>Married</td>
<td>Own home</td>
<td>Tertiary non-degree (Cert./dip.)</td>
<td>None</td>
<td>50-55</td>
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<td><strong>M</strong></td>
<td>76-80</td>
<td>-</td>
<td>SG</td>
<td>SG</td>
<td>Y (High blood pressure)</td>
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<td>Own home</td>
<td>Lower secondary</td>
<td>None</td>
<td>60-65</td>
</tr>
<tr>
<td><strong>9</strong></td>
<td><strong>F</strong></td>
<td>71-75</td>
<td>Australian</td>
<td>SG</td>
<td>SG</td>
<td>Y (Arthritis, hypertension &amp; kidney disease)</td>
<td>Married</td>
<td>Own home</td>
<td>Upper secondary</td>
<td>None</td>
<td>56-60</td>
</tr>
<tr>
<td><strong>10</strong></td>
<td><strong>F</strong></td>
<td>66-70</td>
<td>Australian</td>
<td>VG</td>
<td>VG</td>
<td>N (2 hip replacements)</td>
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<td>Own home</td>
<td>Lower secondary</td>
<td>Casual – paid (Retirement village assistant)</td>
<td>71-75 (Planned)</td>
</tr>
<tr>
<td><strong>11</strong></td>
<td><strong>F</strong></td>
<td>66-70</td>
<td>Australian/Italian</td>
<td>SG</td>
<td>SG</td>
<td>N (Arthritis)</td>
<td>Married</td>
<td>Own home (owner)</td>
<td>Upper secondary</td>
<td>Volunteer (Assists with Music @ nursing homes)</td>
<td>56-60</td>
</tr>
<tr>
<td><strong>12</strong></td>
<td><strong>F</strong></td>
<td>61-65</td>
<td>Australian</td>
<td>SG</td>
<td>VG</td>
<td>N</td>
<td>Widowed</td>
<td>Own home</td>
<td>Upper secondary</td>
<td>None</td>
<td>56-60</td>
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<tr>
<td>Participant No.</td>
<td>Gender</td>
<td>Age</td>
<td>Nationality</td>
<td>Health status (self-assessed)</td>
<td>Health status for age (self-assessed)</td>
<td>Chronic illness (Y/N &amp; list of conditions)</td>
<td>Relationship status</td>
<td>Living arrangement</td>
<td>Education level</td>
<td>Working status &amp; Occupation (former or current) if stated</td>
<td>Age at Retirement (or planned)</td>
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<td>1</td>
<td>F</td>
<td>56-60</td>
<td>Australian</td>
<td>VG</td>
<td>VG</td>
<td>N</td>
<td>Divorced</td>
<td>Own home</td>
<td>Lower secondary</td>
<td>PT - paid</td>
<td>66-70</td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>56-60</td>
<td>Australian</td>
<td>SG</td>
<td>VG</td>
<td>N</td>
<td>Divorced</td>
<td>Own home</td>
<td>Lower secondary</td>
<td>FT - paid</td>
<td>60-65</td>
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<td>F</td>
<td>56-60</td>
<td>English</td>
<td>VG</td>
<td>SG</td>
<td>N</td>
<td>De Facto - same sex relationship</td>
<td>-</td>
<td>Undergraduate degree</td>
<td>Retired (PT gardener)</td>
<td>49</td>
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<td>56-60</td>
<td>Anglo-Indian</td>
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<td>SG</td>
<td>Y (Type 2 Diabetes)</td>
<td>Married</td>
<td>Own home</td>
<td>Postgraduate</td>
<td>FT - paid</td>
<td>66-70</td>
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<td>5</td>
<td>F</td>
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<td>Australian</td>
<td>VG</td>
<td>VG</td>
<td>N</td>
<td>Single</td>
<td>With family member (son and daughter in law)</td>
<td>Upper secondary</td>
<td>PT - non-paid</td>
<td>Never – ‘I like to tailor my work to suit my lifestyle’</td>
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<td>6</td>
<td>M</td>
<td>66-70</td>
<td>Australian</td>
<td>SG</td>
<td>SG</td>
<td>Y (Minor heart condition)</td>
<td>Married</td>
<td>Own home</td>
<td>Lower secondary</td>
<td>None</td>
<td>66-70</td>
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<td>F</td>
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<td>VG</td>
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<td>Married</td>
<td>Own home</td>
<td>Lower secondary</td>
<td>Volunteer work</td>
<td>60-65</td>
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### Exploring the Lived Experience of Ageing

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<th>No.</th>
<th>Gender</th>
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<th>Ethnicity/Origin</th>
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<th>Housing Type</th>
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<th>Income Type</th>
<th>Other Health Conditions</th>
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<td>South African</td>
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<td>(Silver chain – home help)</td>
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<td>Australian</td>
<td>VP</td>
<td>-</td>
<td>Single</td>
<td>Own home</td>
<td>Lower secondary</td>
<td>None</td>
<td>60-65</td>
</tr>
<tr>
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<td>M</td>
<td>76-80</td>
<td>Australian</td>
<td>VG</td>
<td>Y</td>
<td>Married</td>
<td>Own home</td>
<td>Undergraduate degree</td>
<td>None</td>
<td>60-65</td>
</tr>
<tr>
<td>11</td>
<td>F</td>
<td>61-65</td>
<td>English/Scottish/Australian</td>
<td>SP</td>
<td>Neither P nor G</td>
<td>Married</td>
<td>Own home</td>
<td>Tertiary non-degree (Certif./dip.)</td>
<td>None</td>
<td>56-60</td>
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<td>12</td>
<td>M</td>
<td>61-65</td>
<td>Aboriginal/Torres Strait Islander</td>
<td>VG</td>
<td>Y (Diabetes-diet controlled)</td>
<td>Married</td>
<td>Own home</td>
<td>Lower secondary</td>
<td>FT – paid (Consultant)</td>
<td>Never</td>
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<tr>
<td>13</td>
<td>F</td>
<td>50-55</td>
<td>English/Australian</td>
<td>SG</td>
<td>N</td>
<td>Married</td>
<td>Own home</td>
<td>Postgraduate</td>
<td>FT - paid</td>
<td>60-65</td>
</tr>
<tr>
<td>14</td>
<td>M</td>
<td>71-75</td>
<td>Irish</td>
<td>SG</td>
<td>N</td>
<td>Divorced</td>
<td>Own home</td>
<td>Postgraduate</td>
<td>Retired/Volunteer</td>
<td>66-70</td>
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<tr>
<td>15</td>
<td>M</td>
<td>66-70(69)</td>
<td>English/Australian (moved 1970)</td>
<td>VG</td>
<td>N (High Blood pressure/cholesterol)</td>
<td>Single</td>
<td>Own home</td>
<td>Post secondary (TAFE/trade sch.)</td>
<td>Casual - paid</td>
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<td>Age</td>
<td>Nationality</td>
<td>Health status (self-assessed)</td>
<td>Health status for age (self-assessed)</td>
<td>Relationship status</td>
<td>Living arrangement</td>
<td>Education level</td>
<td>Working status &amp; Occupation (former or current) if stated</td>
<td>Age at Retirement (or planned)</td>
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<td>-------------------------------</td>
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<tr>
<td>1</td>
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<td>76-80</td>
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<td>SG</td>
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<td>Own home</td>
<td>Post secondary (TAFE)</td>
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<td>Tertiary non-degree</td>
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<td>Own home</td>
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<td>Upper secondary</td>
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<td>5</td>
<td>F</td>
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<td>VG</td>
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<td>Widowed</td>
<td>Own home</td>
<td>Lower secondary</td>
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<td>VG</td>
<td>VG</td>
<td>Married</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
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<td>VG</td>
<td>VG</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>None</td>
<td>-</td>
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<td>Welsh</td>
<td>VG</td>
<td>VG</td>
<td>Married</td>
<td>-</td>
<td>-</td>
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## Exploring the Lived Experience of Ageing

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<th>Housing</th>
<th>Occupation</th>
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<td>75-80</td>
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<td>VG</td>
<td>N</td>
<td>Widowed</td>
<td>Own home</td>
<td>Lower secondary</td>
<td>Volunteer (Charity work) 74 (stopped paid work)</td>
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<td>British</td>
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<td>Own home</td>
<td>Upper secondary</td>
<td>FT - paid 66-70</td>
</tr>
<tr>
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<td>F</td>
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<td>British</td>
<td>VP</td>
<td>Y</td>
<td>Married</td>
<td>Own home</td>
<td>Lower secondary</td>
<td>None 50-55</td>
</tr>
<tr>
<td>12</td>
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<td>British</td>
<td>VG</td>
<td>N</td>
<td>Married</td>
<td>Own home</td>
<td>Upper secondary</td>
<td>Volunteer (Salvation Army) 56-60</td>
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<tr>
<td>13</td>
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<td>76-80</td>
<td>British</td>
<td>SG</td>
<td>Y</td>
<td>Married</td>
<td>Own home</td>
<td>Upper secondary</td>
<td>Volunteer (Salvation Army) 50-55</td>
</tr>
<tr>
<td>14</td>
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<td>80</td>
<td>Welsh</td>
<td>Neither P nor G</td>
<td>Y (Diabetes)</td>
<td>Single/Divorced</td>
<td>Own home</td>
<td>Lower secondary</td>
<td>None 40 (couldn't get job due to health issues)</td>
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<td>F</td>
<td>79</td>
<td>Welsh</td>
<td>VG</td>
<td>N</td>
<td>Widowed</td>
<td>Own home</td>
<td>Upper secondary</td>
<td>None Never</td>
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Appendix F - Participant Information Letter
(‘LLLS group’ and ‘Discontinuing group’)

Dear Participant,

My name is Sasha Stumpers and I am a psychology PhD student at Edith Cowan University. As part of my studies I am required to complete a research project. I am interested in the area of ageing and my research is titled: ‘Exploring the experience and construction of ageing: A wellness perspective’.

Why do I need your help?

Our population is ageing and in the near future there are expected to be less people at younger ages and more people at older ages. As part of this research I would like to learn about how people over the age of 50 years experience and understand the process of ageing. I would also like to explore the experiences of being involved in the Living Longer Living Stronger (LLLS) program. This information is likely to be useful for future interventions and models of service delivery designed for an ageing population.

What would you have to do?

In order to get to know about your experiences and ideas about ageing and your experiences of being involved with the LLLS program, I would like to organise a time to sit down and talk with you. I will have some set questions to ask to help guide our conversation which is likely to take about 30-45 minutes. What we talk about will be audio recorded (sound recorded) so that I can listen carefully to our conversation later. Written notes may also be made during the interview to help me remember important information later. There are no right or wrong answers as I am interested in your experiences about ageing. To check how the information provided by you during our conversation has been interpreted it may be necessary for me to contact you on one more occasion just to make sure I accurately reflect what it is you have spoken to me about.

What happens with the information you give me?

All information that you provide during our discussion will remain ‘strictly confidential’. This means that only my supervisors and I will have access to your information. I will not play the tape recording to anybody else, or talk about you to anybody. No names or identifying information will be collected. The collected information will be written into a final thesis document and the research data gathered may be published however, the data will not be identifiable.

What do you do if you would like to participate?

Participating in this research is voluntary and if you feel uncomfortable at any time you can stop the interview at any stage with no questions asked. You do not have to answer any questions that you do not want to. It is anticipated that there will be no risk, discomfort or distress associated with being interviewed however, if you do experience any distress you will be provided with contact details of services you can access to assist in working through these
Exploring the Lived Experience of Ageing

feelings. If you have any questions or concerns about this research you can contact me or my supervisors (contact details below).

If you would like to participate in this research, please carefully read the consent form provided and then sign and return it to me at the School of Psychology and Social Science (address given below) using the reply paid envelope provided or simply return to the reception desk at Vario wellness clinic.

Thank you for your time in considering this research and I look forward to meeting you in the near future.

Yours sincerely,

Ms Sasha Stumpers
PhD candidate
School of Psychology and Social Science
Edith Cowan University
100 Joondalup Drive
Joondalup Western Australia 6027
Tel: (08) 6304 3841
Mobile: 0400 768 156
Email: sstumper@student.ecu.edu.au

Principal supervisor:
Associate Professor Lynne Cohen
School of Psychology and Social Science
Edith Cowan University
100 Joondalup Drive
Joondalup, Western Australia 6027
Tel: (08) 6304 5575
Fax: (08) 6304 5834
Mobile: 0417 956 607
Email: l.cohen@ecu.edu.au

Associate supervisor:
Dr Julie Ann Pooley
Senior Lecturer
School of Psychology and Social Science
Edith Cowan University
100 Joondalup Dve
Joondalup, Western Australia 6027
Tel: (08) 6304 5591
Fax: (08) 6304 5834
Email: j.pooley@ecu.edu.au
Hello, my name is Sasha,

I am a psychology PhD student at Edith Cowan University. As a part of my studies I am conducting research titled ‘Exploring the experiences and construction of ageing: A wellness perspective’. What this means is that I would like to talk with you about your experiences of ageing. I would also like to talk to you about your experiences of being involved in the Living Longer Stronger (LLLS) program. If you are interested in participating in this research, please carefully read, or listen to being read the information below before signing and dating your name. Thank you for agreeing to be a part of this research.

I …………………………………….. (print name) hereby consent to participate in the research and understand;

- The information provided outlining and explaining the research.
- I have been given the opportunity to ask questions and have had these questions answered to my satisfaction.
- I have been given the opportunity to talk to alternative people who have knowledge of the research and have been provided with their contact details.
- Participation in the research project will involve; participation in an audio-recorded interview and written notes may also be taken during the interview.
- Participation in the research project will also involve completing a short demographics information sheet.
- Information provided by me will be kept confidential, and that no personal information (i.e., name, address) will be linked with information I provide.
- Information provided will only be used for the purposes of this research.
- Collected information will be written into a final thesis document and the research data gathered may be published however, the data will not be identifiable.
- Participation in this research is voluntary and that I do not have to answer any questions that I do not want to.
- I am free to stop or withdraw from participating in the research at any time, without explanation, questioning or penalty.
- I freely agree to participate in this research and understand what I am being asked.
- It is not anticipated that there will be any risk, discomfort or distress associated with being interviewed.
- If I do experience any distress, I will be provided with contact details of services I can access to assist in working through these feelings.
- I give permission for the researcher to contact me again (with the information I provide below) if necessary after the interview to check how information provided by me was interpreted.
Exploring the Lived Experience of Ageing

**Participant contact details:**

Name: __________________________________________

Most convenient interview time - (please circle the best time(s) for you below):

<table>
<thead>
<tr>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning</td>
<td>Morning</td>
<td>Morning</td>
<td>Morning</td>
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</tr>
<tr>
<td>Afternoon</td>
<td>Afternoon</td>
<td>Afternoon</td>
<td>Afternoon</td>
<td>Afternoon</td>
</tr>
</tbody>
</table>

Day time contact phone number(s): ________________________________

________________________________________

Participant signature: ………………………..    Date: ……………………………..

23 June 2008

Dear

Our records indicate that you have previously attended the Vario Wellness Clinic (Formerly Joondalup Rehabilitation Clinic) to participate in the Living Longer Living Strong Program at Edith Cowan University, Joondalup Campus.

As a past participant, we would like to invite you to participate in a Research Study being conducted by Ms Sasha Stumpers in conjunction with the Vario Wellness Clinic.

Please find enclosed an information letter detailing the research, what may be involved if you do decide to participate and what to do if you wish to be part of the research study.

Should you require further information regarding this invitation, please don’t hesitate to contact me on 6304 3444.

With Kind Regards

Chrys Payne
Administration Officer
Mediaportal Report

07/10/2008

Study for the ages
Wanneroo Times, 07/10/08, Regional Changes - Central, Page 2
By: None

PEOPLE aged over 50 are wanted for an Edith Cowan University study on WA's ageing population. Researchers from the School of Psychology and Social Sciences are interested in examining how older generations experience and understand ageing.

Keywords: ecu(2), Edith Cowan(1), University(1)
Exploring the Lived Experience of Ageing

Wanneroo Times
07/10/2008
Page: 2
Regional Changes - Central
Region: Perth
Circulation: 77898
Type: Suburban
Size: 55.19 sq.cms

Study for the ages

PEOPLE aged over 50 are wanted for an Edith Cowan University study on WA’s ageing population.

Researchers from the School of Psychology and Social Sciences are interested in examining how older generations experience and understand ageing.

The study will help improve the delivery of programs and services for the elderly.

Anyone who wants to volunteer, and is not already involved in a ‘healthy ageing’ program, can call Sasha Stumpers on 6304 3611, or email ss-stumpers@student.ecu.edu.au.

Short interviews on participant’s experiences will be conducted at ECU Joondalup during October and November.
## ADULT COMMUNITY MENTAL HEALTH CLINICS

Community based mental health services are spread throughout the metropolitan area and in country locations. These clinics and centres have professional staff including psychiatrists, social workers, mental health nurses, clinical psychologists and occupational therapists to provide assessment, diagnosis, treatment, rehabilitation and ongoing support.

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
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<tr>
<td>Avro Mental Health Clinic</td>
<td>2 Nicholson Road, Subiaco WA 6008</td>
<td>(08) 9381 9055</td>
</tr>
<tr>
<td>Fremantle Adult Mental Health Services</td>
<td>Alma Street Centre, Alma Street, Fremantle WA 6160</td>
<td>(08) 9431 3555 (triage)</td>
</tr>
<tr>
<td>Inner City Mental Health Service</td>
<td>70-74 Murray Street, Perth WA 6000</td>
<td>(08) 9224 1720</td>
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<tr>
<td>Joondalup Community Mental Health</td>
<td>Joondalup Mental Health Centre, Regents Park Road, Joondalup WA 6027</td>
<td>(08) 9400 9599</td>
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<tr>
<td>Mills Street Centre</td>
<td>Mills Street, Bentley WA 6102</td>
<td>(08) 9334 3666</td>
</tr>
<tr>
<td>Mirrabooka Mental Health Services</td>
<td>1/20 Chesterfield Road, Mirrabooka WA 6061</td>
<td>(08) 9344 5400</td>
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<tr>
<td>Osborne Community Mental Health Service</td>
<td>Location: Osborne Place, Stirling, WA, 6021</td>
<td>(08) 9346 8350</td>
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<tr>
<td>Peel Mental Health Services</td>
<td>Peel Health Campus Site, Lakes Road (cnr Murdoch Road), Mandurah WA 6210</td>
<td>(08) 9531 8080</td>
</tr>
<tr>
<td>Swan Adult Mental Health Centre</td>
<td>Eveline Road, Middle Swan WA 6056</td>
<td>(08) 9347 5700</td>
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</table>
Exploring the Lived Experience of Ageing

You can also contact:

**Psychological Services Centre Joondalup House**
8 Davidson Terrace
Joondalup WA 6027
Telephone: 9301 0011
Facsimile: 9301 0014
E-mail: s.morris@ecu.edu.au

The clinic is attended from 8.40am to 4.45pm (last appointment 3.30pm) weekdays and appointments are available Monday to Thursday. The Centre provides counselling, psychotherapeutic services and psychological assessments to members of the community. Clients may be self-referred, or referred by professionals in the health, legal, educational, employment and other sectors. Assessment and treatment is available for individuals, groups and families in areas such as:

- anxiety and depression
- stress and lifestyle management
- family therapy and children’s behaviour management
- adolescent counselling
- sexual assault, accident and trauma counselling
- behaviour and adjustment disorders
- loss and grief
- anger
- relationship difficulties
- chronic pain or illness
- mediation and conflict resolution
- drug and alcohol problems

For more immediate assistance contact:

**Lifeline** (free anonymous 24/7 generalist counselling that does not discriminate).
Phone: 131114

**Mental Health Direct** (24 hour health advice).
Phone: 1800 220 400

**Salvo Care Line** (24/7 - Counselling, information and referral for people experiencing a crisis, enabling them to gain access to a network of community services).
Phone: (08) 9442 5777
Appendix K – Example of Data Analysis: Theme Development and Reviewing Themes