Living at home after 95 years.

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ABSTRACT

Globally the number of older people is increasing with the largest increases occurring in those aged over 85 years. Historically little has been written about this group and because of increasing numbers more information is needed to inform the development of future services. The question was how people live in their own home independently after 95 years? This work was informed by narrative gerontology overlaid with a critical gerontological lens to give voice to this group. Through a purposive sampling strategy ten narrators were identified and were interviewed using a semi-structured format.

Data analysis was undertaken using thematic analysis with three themes; staying socially connected, managing the physical environment and keeping and ageing well emerging. Further to this, there were associated subthemes, which support and further illuminate the detail of the theme itself. These findings also unsettled the ageist, biomedical view of the oldest-old and what we think we know about them. In this study the narrators gave voice to their lives and what contributed to them living at home independently. Not everyone will live to 95^{+} years and how this was achieved by this group was the result of their entire lives and showed itself in the resilient characters of these narrators. All of whom considered the benefits of social connectedness, hard work and keeping well as reasons for living independently at home. As well as this, the need to stay mobile and the current contribution of help and support from both family were contributing factors. This research provides considerations for changes in not only the way we view those over 95 years but also the way we consult and provide services to them. There is an urgent need to promote achieving resilience, eliminate ageism and promote a more balanced view of the oldest-old.

ACKNOWLEDGEMENTS

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1. INTRODUCTION TO THESIS

1.0 INTRODUCTION

It is an ever present consideration for policy makers, service planners and the general public that there is an increasing number of older people living longer lives. In order to develop and provide services we must consider what it means for those who are already old. Whilst it may seem obvious that we would listen to older people and give voice to their thoughts, feelings and opinions, the paucity of literature suggests that this is not the case.

Dewey (2008) writes about deconstruction and its use to construct new knowledge and understanding. In giving the oldest-old voice this work de-constructs older peoples' experience of living at home after 95 years and consequently reconstructs this by allowing the voices of older people to be heard and thereby contribute to what is known internationally about this group. This thesis presents an opportunity to gain an understanding of the experience of ten narrators who are 95$^+$ years in the Southern District Health Board (SDHB) region who are living independently in their home. The material for this qualitative study was gathered from ten semi-structured interviews informed by narrative gerontology with a critical gerontological lens. From these interviews themes and subthemes emerged utilising the process of thematic analysis. The findings from this study contribute to the increasing body of knowledge about the lives of the oldest-old.

The purpose of this chapter is to outline the various elements that have contributed to the development of this research project. I have presented my interest in the topic and the reflexive position taken with respect to this study. This chapter also introduces; the rationale for the project, a presentation of the research question, operationalising key definitions, including ageing and how it is or should be defined as well as demographics of older people both at a local and national level.

1.1 MY POSITION

In order to complete a Masters in Philosophy I am required to undertake a piece of research and write a thesis in an area of my choice. I chose to undertake a qualitative project and talk to a group of the oldest-old. This has given me the opportunity to attune current research findings alongside the local communities' knowledge and thoughts about older people who are living independently at home.

In 1984, I completed my education as a registered nurse at the Southland Community College. Neither I, nor my classmates, considered working in what Reed and Clarke (1999) described as the 'Cinderella service', long term care, perhaps as a consequence of Clendon (2011) and Schumacher's (2003) moot that working with older people is not seen as an attractive career option for nurses. Describing this area of work as a Cinderella service suggests that nursing as a profession gives little value to this speciality and this contributes to what Reed and Clark (1999) identify as a lack of knowledge and understanding of older people by nurses. In spite of this, I began my working life in a general hospital surrounded by elderly patients.

Twenty-eight years later in my current role, I am responsible for the residential and community services provided to older people by a large social service provider in Southland. This role is not strictly a nursing role but is involved across the services in all aspects of operation including on-going strategic development. Accordingly, I meet with older people and their family or whanāu about the services they may require. These discussions include services such as home help or respite care that will help people maintain living in their own home longer. Ironically, soon after this study began the District Health Board reduced the available funding for home based support services in the region. Many of the narrators required no other services but home help. This reduction in service was a discussion point at some interviews.

Undoubtedly, the interest in hearing the voices of people over 95 years describe what enables them to live independently in their home is related to my experience as a nurse. I am interested in this not only because of my profession, but whilst growing up it was clearly instilled in me to listen and consider the older people in our family and neighbourhood's thoughts and feelings. I realise that my own mother who will be 81 years in 2013, has clear ideas about how and where she wants to live. I am aware that it is necessary for me, as a daughter, nurse and researcher to ensure that I not only listen to, but respect her 'voice' and the voices of other older people as they age.

I was born in 1964, consequently I am the very last of the 'baby boom' generation; I will turn 65 years in 2029 and will be 95 in 2059. 2011 was a significant year for the baby boom generation as it is the first year that baby boomers begin to turn 65 years. This significant

group of people will be the largest number to become the oldest-old (Easley & Schaller, 2003). With these burgeoning population numbers, it is a pertinent time to consider how people are living in their own home after 95 years.

1.2 REFLEXIVITY

As Tolich and Davidson (2003) state the nature of qualitative research is inductive, generating theory from observations rather than deductive which is best described as testing a theory by hypothesis. The essence of qualitative research is both the researcher's immersion in their data, which creates the connection with the participant(s) and the process of enquiry and ascertaining meaning from the information gathered, in this case through interview.

A reflexive approach was adopted in this work as it was anticipated that it would contribute positively. The trend toward reflexivity is a conscious move away from conceptualizing old age as a problem (Carr & Manning, 2010). Reflexivity requires researchers to disclose their own interests, motivations, biases and through the research process take time to reflect on these. In an examination of reflexivity, it appears it is impossible to minimise the impact of self on the data gathered and the subsequent findings, Bishop and Shepherd (2011). They add that adopting a reflexive stance allows researchers to examine their own stories and this contributes to maintaining reflexivity and consequently better outcomes. This is due to reflexivity contributing to better understanding of both intrinsic and extrinsic factors that may affect the entire process from selection of excerpts from the narratives through to the interpretation of results.

Nightingale and Cromby (1999) describe two types of reflexivity; personal and epistemological. Personal reflexivity is where the researcher is aware of their own personal contribution to the construction of meanings throughout the research process. It involves reflecting upon the ways both known and unknown values, experiences, interests, political commitments, beliefs, wider aims in life and social identities may affect or contribute to the research. Thus how we, as researchers affect the research and in turn how it may affect and possibly change us, as individuals and the wider research community. It acknowledges that it is impossible for the researcher to remain outside the subject matter, in this case the material generated from the ten narrators. Reflexivity then, urges us "to explore the ways in

which a researcher's involvement with a particular study influences, acts upon and informs such research" (Nightingale & Cromby, 1999, p. 228). They add research that is initiated by the self as researcher generates data that will benefit the wider community. This means that this study will contribute to the community that I, as the researcher, live in.

Willig (2001) posits that epistemological reflexivity encourages the researcher to reflect upon assumptions made in the course of the research. Subsequently it becomes necessary to consider the implications of such assumptions both for the research and its findings. As such, epistemological reflexivity gives both readers and researchers the opportunity to engage with such questions as;

- How has the research question been defined and limited?
- What can be found? How has the design of the study and the method of analysis 'constructed' the data and the findings?
- Could the research question have been approached differently and if it had been, would this have given rise to a different understanding(s) of the phenomena?

By utilising personal and epistemological reflexivity, this study arises from the writer's experience and perspective. The question is - how people live in their own home independently after 95 years? This is situated in the current political and social assumption that being at home - ageing in place is best (Hinck, 2004; NZPAS, 2001). As the researcher, my experience with older people could heighten my awareness, but while this pre-existing knowledge was a useful point of departure every effort has been made to develop an inductive approach to the understanding of the themes.

To reduce personal bias whilst undertaking narrative research a useful tool is to keep a reflective journal (Jootun, McGhee, & Marland, 2009; Ortlipp, 2008). This is wholly consistent with contemporary nursing practice (Cutliffe, Butterworth, & Proctor, 2001). Keeping a journal provides an opportunity to raise issues relating to the narrators, data collection or analysis as well as the possibility of influences during the interview that may contribute to the Hawthorne effect which is when the researcher unwittingly affects the participants and their reaction to questions (Parahoo, 2006). This reflective process is an efficacious process in qualitative research as it provides the opportunity for the researchers to see themselves and assist with stimulating self-reflection and promoting analytical reflection (Hogan, 1995).There are other methods this study could have utilised, such as a

quantitative survey or a literature review. However, the opportunity to take the time and listen to the stories of those currently over 95 years and living independently at home was deemed far more challenging and interesting. One of the aims of this study is to affect local services for the oldest-old. This study will best reflect the realities of ageing as the most appropriate people to ask are older people themselves (Bartlett & Peel, 2005).

1.3   RESEARCH QUESTION

The central focus of this thesis is to explore the question - what do people aged over 95 years believe has contributed to them being able to live independently in their own home? With this question there are four associated aims. The first is to increase an understanding of what contributes to people over 95 years of age being able to stay in their own home. In my current role working with increasing numbers of oldest-old, this work will influence the thoughts and understandings of both myself and the organisation I work for. The second aim is to enable the narratives of people over 95 years to be heard, with the third being to unsettle what is currently known about ageing and ageing in place. The fourth aim of the question is associated with the first and this is to influence the provision of appropriate support services that enabling people over 95 years to continue to age in place/stay at home.

1.4   OVERVIEW OF THESIS CHAPTERS.

The chapters:

Chapter one is an introduction to the various elements that contributed to the development of this research project; this includes both my position as the researcher and how I became interested in this topic. The research question and associated aims are presented here and in considering these the concept of reflexivity is introduced whilst contemplating the position taken.

Chapter two delivers both national and international demographic information about the most rapidly increasing section of our society - the oldest-old. Also introduced are the New Zealand (NZ) ageing strategies with a brief comment on the 2011 review and the success or otherwise of these strategies. As well as this the concepts and terminology utilised throughout the study are presented along with a brief consideration of some theories of ageing.

Chapter three imparts a critical review of the associated national and international literature associated with the health and social issues of the oldest-old. This literature provides the background and context for this study as well as the ensuing discussion and recommendations.

Chapter four presents the methodology utilised in this qualitative study; narrative gerontology informed by critical gerontology. Through this, the voices of the oldest-old narrators are heard and what they say challenges society's traditional discourse of the frail, dementing oldest-old. The remaining part of the chapter details the research processes employed in completing this study.

Chapter five introduces each individual narrator. All narrators were over 95 years, with two centenarians living independently in their own home. It is not possible or practical to reproduce the entire transcript therefore a brief excerpt which represents the essential material gathered from them is included.

Chapter six presents the findings from the ten narratives with a set of themes and subthemes emerging from a process of thematic analysis. These are presented as three themes; *social connectedness, managing the physical environment and keeping/ageing well* along with their associated subthemes. Excerpts from the interviews are included to describe, understand and certainly unsettle the traditional biomedical view of this group of people.

Chapter seven is the discussion of the findings in relation to the literature. Having heard the voices of the narrators there is the opportunity to consider both the strengths and limitations of this study. Further to this is the consideration of what this study can offer to both nursing education and research and the possibilities of future services for the oldest-old.

1.5   CONCLUSION

The purpose of this introductory chapter was threefold. Firstly, my personal background and interest in the oldest-old was presented along with the reflexive approach chosen for this research. Secondly, the research question - "what do people over 95 years believe has contributed to them being able to live independently?" and the associated aims were

presented. Finally, there is a brief overview of the seven chapters to set the context for the research. The next chapter provides key definitions and concepts and identifies NZ's particular demography, theories of ageing and the framework that the NZ government has set for older people.

2. KEY DEFINITIONS AND CONCEPTS

2.0 INTRODUCTION

In order to achieve the aims and objectives of this study it is necessary to set the scene. Included here is the national and international demographic information, definitions of the key concepts and the NZ policy background for older people. Concepts such as ageing, what is old, independence and the legitimacy of gerontology as an endeavour are explored. This assists in providing context for the literature gathered and critiqued in chapter three, consequently situating the research findings and discussion in the NZ framework whilst maintaining an appreciation for the global perspective.

2.1 KEY CONCEPTS

It is intended to introduce and provide the various concepts and definitions that are used in this study. Some of these are the subject of my personal interpretations and understanding of the concepts and definitions which are informed by the evidence base used by the researcher.

2.1.1 AGEING

As suggested by Blaikie (1999); Settersen (2006) old age is best understood as a summation of the factors that have influenced an individual's whole life. Fontaine (1999) proposed there is not one old-age, but many. The various theories of ageing all opine their specific views however, there remains "no single commonly accepted definition theory/model or even pattern of criteria" (Baltes & Cartensen, 1996, p. 402). Kolb (2004) advocates that the experience of ageing has many facets, inferring it is different amongst us all. Calendar age is frequently used as a mark of the beginning of old-age; however, it appears this is a flawed measure as it presumes uniformity with biological age. Armstrong (2002) states calendar and biological ages are in fact not aligned. Others concur with this suggesting calendar age is an ineffective way of considering ageing and the various aspects of it (WHO, 2002). However, utilising chronological age remains a useful tool to collect demographic data which researchers and the public utilise to monitor ageing.

As this is NZ research a local definition should be provided, with the simplest coming from within NZ Society itself. In line with other western societies, the receipt of superannuation

and the ability to access services for older people occurs at a time Erikson (1982) described as late adulthood (65 years). In contrast to this, Joseph and Cloutier-Fisher (2005) suggest that 65 years is elderly while Clifton (2011) identifies 75 years as the new 65 signifying the transition through old age is starting later.

Different societies and cultures endeavour to define the time and process of ageing with various adjectives. These include "active, successful, healthy and good aging" (Nygren, 2006, p.2). Many of these terms demonstrate an implicitly negative view of ageing. The description of active or successful ageing implies if individuals do not meet the criterion set they have been somewhat remiss in their responsibility to themselves, the wider community and society as a whole.

Many writers describe ageing in terms such as successful or active. These terms describe the physiological aspects of getting older - decreased hearing, eyesight and mobility. These are the elements society observes and describes someone as ageing. However, researchers who subscribe to a critical gerontological view see ageing as much more than this. Vaillant (2002) describes healthy ageing as a state of contentment and vigour. He adds it is dependent on various other factors including; "disease prevention, screening for illnesses, healthy lifestyle, independence and quality of life (QoL)" (p. 187). Hansen-Kyle (2005) proposed a model for healthy ageing. Contingent to this model are the antecedents of adaptation, compensation, and resilience. These antecedents are described as the events necessary for healthy ageing to occur as well as the consequences of it. From this work comes a new comprehensive definition of healthy ageing: "the process of slowing down, physically and cognitively, while resiliently adapting and compensating in order to optimally function and participate in all areas of one's life (physical, cognitive, social and spiritual)" (p. 52).

It is necessary in this study to consider all aspects of ageing when contemplating how those over 95 years live independently. It is most likely to be a combination of factors contributing to their ability to live at home. This research is important as "relatively little is known about how individuals currently strategise about how to remain successfully living in the community despite differences in personal characteristics and levels of support" (Ministry of Social Development, 2009, p.3).

The boundaries between middle age and old age are contentious, with old age having a variety of meanings amongst different societies (Vaillant, 2002). Daatland and Biggs (2006) describe the attempt to subdivide life stages as a socially constructed concept. Smith, Braunack-Mayer, Wittert, and Warin (2007) note society's definition of old age is changing with the transition through old age redefined with the development of new subgroups amongst older people. The contemporary meaning of ageing is changing with the young-old who have become increasingly fit and healthy. There is an exponential increase in those who are the oldest-old, those living to the third age and beyond into the fourth age. We now must listen by giving voice to this group of people to understand what they have experienced and how it has been for them as they have aged.

The concept of multiple ages existing, within what has been defined broadly as old age, was first suggested by Neugarten (1974) and Laslett (1989) who noted it could be a life stage of possibly twenty or thirty years duration. Further to this has emerged the notion that the third age/post retirement/young-old (Baltes & Smith, 2003, WHO, 2002) is no longer considered as the time preceding death (Carr & Manning, 2010). The third age has been described as a new life phase emerging in response to demographic and societal changes during the course of the 20th century. These changes, including those related to public health advances and overall improvements in standards of living, and the institutionalization of retirement, resulted in a larger, healthier older population (Carr 2009). These are the young-old, those who are retired but have good health and remain socially engaged. The third age is often understood to be the period following retirement but prior to the point where health problems interfere with one's independence (Weiss & Bass, 2002). Gilleard and Higgs (2010) describe a proliferation in third age studies with the third age taking shape as an important new life phase in later life during which the positive aspects of ageing are particularly visible. The time of the third age can be arbitrarily defined as 70-85 years with Laslett (1998) describing it as a time for personal achievement and fulfilment. In this she concurs with Erikson's eighth stage of life which he describes as existentialism (Carr & Manning, 2010).

First used in 1984 in the United States, the term oldest-old refers to the group of individuals 85 years or older (Suzman, 1995). Baltes and Smith (2003) describe this fourth age as the

time before death and it is those of the fourth age who are the oldest-old, 85-100^{+} years. From the Berlin Aging Study, Baltes (1998) demonstrates that the fourth age involves a period of heightened health risks which are difficult to overcome. Laslett (1989) also describes a fourth age, as a time when disability, dysfunction and ageing both cognitively and functionally become real for the oldest-old. Adding that despite this these older people are still connected, active and despite a variety of limitations do not see themselves as imminently dying. This is confirmed by Holmes (2006) and Kauffman (2000) who confirm that the oldest-old do not always identify with their age and concurrent disability. Gilleard and Higgs (2010) propose the fourth age is a new life period from 85 years-100^{+} some five to seven years before death. They state this is not just the end of the third age but a time when functioning is no longer primarily age focussed but is more death-related. One of the goals of medical technology is to maximise the third age and compress the fourth, compressing senility, illness and consequently death into the shortest possible time frame. Which is of course positive for older people. With older people living healthier lives longer this compression of morbidity should positively affect the state of ageing as well as the countries where this occurs.

The current view of the fourth age has been negative (Gerstorf, Smith, & Baltes, 2006; Kirkwood, 2001), with descriptions of it including frailty, decrepitude and lingering death. Suggestions include describing it as the age of Alzheimer's, characterised by high levels of frailty, dysfunction and multimorbidity with maintenance and management of losses the central task for daily survival. Contrary to this view, data from the New England Centenarian Study, Okinawa Centenarian and Georgian Centenarian Projects indicate a significant proportion of the oldest-old those living in the fourth age are healthy. This supports Perls (1995) who proposed a rethink of ageing, considering that the oldest-old may constitute a special – and long misunderstood –-population. In this study the term oldest-old is used to refer to those over 95 years.

2.1.2 THE STUDY OF AGEING

Ageing has always been part of human existence. However, the impact of ageing on people, their wider community and society has only been examined over the past 60 years as their numbers have dramatically increased. Today the study of ageing is a multidisciplinary field

that combines and integrates information from various areas of study including biology, sociology and psychology as well as the humanities and economics. Often the terms gerontology and geriatrics are used interchangeably however, it is important to note they are two different endeavours.

In 1961, R.J. Havighurst proposed the function of gerontology was to provide guidance to society and individuals regarding issues of old age such as retirement, social security, housing, how to relate to one's family and what to do in retirement. As Carr and Manning (2010) observe the past forty years has seen a shift in focus for gerontologists. There has been a growing interest in examining the positive aspects of ageing. This has broadened the scope of what we know about the process of ageing and the lived experience of elders. More recent definitions concur with this, describing gerontology as the study of ageing processes and individuals, investigation of societal changes resulting from ageing populations and the application of this knowledge to policies and programs (Arai et al., 2012). This includes not only the study of the physical and mental aspects of ageing but also the social changes that occur as people move through maturity to old age (Erber, 2005). Gerontology utilises numerous frameworks, two of which are utilised within this study; narrative and critical gerontology (see chapter four).

Another aspect associated with the study of ageing is the study of geriatrics. It involves the study of health and disease and as such represents the biomedical view of ageing. More recently, it includes the provision of comprehensive health care for older people as well as promoting the well-being of informal caregivers, those that support them. Arai et al. (2012) advocate for a reform of medical-care services in order to cope with the coming aged society. They suggest that in today's increasingly aged society gerontology and geriatrics are critical aspects of both health care and research. McCormack (2005) suggest that nursing must promote care of older people as a specialty that requires significant skill and training. Wadenston and Carlsson (2003) opine this would be assisted by ensuring that nursing considers the relevance of the ageing process.

2.1.3 Independence or interdependence?

Independence is seen in most western societies as a major ingredient in the maintenance of self-identity and self-respect. It is frequently associated with control over one's own life with

adequate income being important ingredient in determining levels of independence. There are a large number of factors identified in the literature contributing to a sense of independence and well-being for older people. These include the various aspects of housing and home as well as keeping the house and garden in good order. Other aspects of community and neighbourhood are important; being close to friends, shops and other amenities, in safe, well designed towns and streets, close to social activities and social networks. The role of aids to assist with mobility for example walkers and scooters, the availability of transport, such as taxis are other essential elements for older people to maintain their independence. The benefits of newer technologies will become increasingly relevant. There are also the things that younger people take for granted: learning, leisure and fun; means and income. Notably independence (like age) has been identified as a cultural value, therefore something which may not be seen as important in ageing in non-western cultures (Hansen-Kyle, 2005). Secker, Bowers, Webb, & Llanes, (2005) propose independence amongst older people encompasses self-reliance, self-determination, self-esteem, purpose in life, personal growth and continuity of the self. Older peoples' sense of independence and well-being incorporates their capacity to make choices and exercise control over their lives (United Kingdom Audit Commission, 2004). This concurs with the WHO (2002) definition of independence as having the "capacity of living in the community with no or little help from others" (p.13). Often the key to maintaining independence for older people is remaining in their home (Ministry of Social Development, 2002). Scholfield, Keeling, Davey, and Parsons (2006) identify good emotional and mental health as requisite components for independent living. Further to this Dwyer, Gray, and Renwick (2000) identify other critical factors; personal health, income adequacy, safety and security, access to community-based support or social services, and mobility. Independence is seen by society to have both positive and negative connotations. Davey, de Joux, Nana, and Arcus (2004) purport a positive view of living independently where older people have easy access to services and resources so they can enjoy a good QoL, despite the presence of age-related illnesses or disabilities. An example of the negative aspects of independence is when an older person refuses a service that others such as family or health professionals perceive as necessary to maintain independence. Of course the question here is, who determines what a necessary service is and who has the right to determine this for older people?

As in their previous studies, Bowling and Dieppe (2005) uncovered a perspective amongst older men that closely aligned successful ageing to their ability to maintain their independence. This was consistent with sustained personal autonomy being perceived as a measure of successful ageing. Independence is highly valued by older people as the loss of it leads to a decline in status, choice and dignity. It is often mediated by gender, ethnicity and social position and it appears independence is as important an influence on the well-being of older people as are the concepts of health and disease/illness (Gabriel & Bowling, 2004). Older people themselves tend to have more flexible interpretations of independence that changes over time. Ball et al. (2004) conducted research with 54 residents in assisted living units in Georgia, United States of America. They concluded that older people understood independence in terms of self-reliance and avoiding dependency, as well as retaining functional ability, reciprocity, autonomy, meaningful activity, valued roles of friend, community member and continuity of personal identity. Study participants expectations of independence were reduced over time so that these matched their decreasing functional capacities.

However, independence is not only about being able to do everything without support; it includes accepting assistance in areas of a person's life which allows them to remain independent (United Kingdom Audit Commission, 2004). Interdependence with others is a reality for many older people and it is exhibited in belonging to supportive networks of family, friends and the wider community. It appears there is a level of interdependence, a reciprocity within supportive relationships, which incorporates the notion that being able to give, also allows one to accept help (Fine & Glendinning, 2005; Godfrey et al., 2004). Interdependence in old age is often obtained in association with medical or other health professionals' assistance. McCloughlin (1991; 1992) suggests that independence enhances the QoL almost always implies interdependencies of various types. Interdependence is connected with the social context based on the norm of mutual reliance and connectedness with others thus stressing the relational aspects of self. Of interest, Bowling and Dieppe (2005) suggest that reliance on others should not be seen as unsuccessful ageing, antithetically it is perhaps the ultimate in ageing.

2.2 SOCIO-DEMOGRAPHIC CHARACTERISTICS

One of the major drivers in research about older people is the increasing numbers of older people. A significant focus has been placed on the effects of the baby boomers and their needs whilst neglecting the parents and grandparents of these who are already old and becoming amongst the oldest-old.

2.2.1 INTERNATIONAL TRENDS

In 1950, there were less than 15 million people aged over 80, by 2009 this number had risen to 102 million people and by 2050, it is projected to quadruple and reach 395 million

Figure 1 *Global population aged 80⁺ years 1950-2050*

Figure 1 *Global population aged 80^+ years 1950-2050*
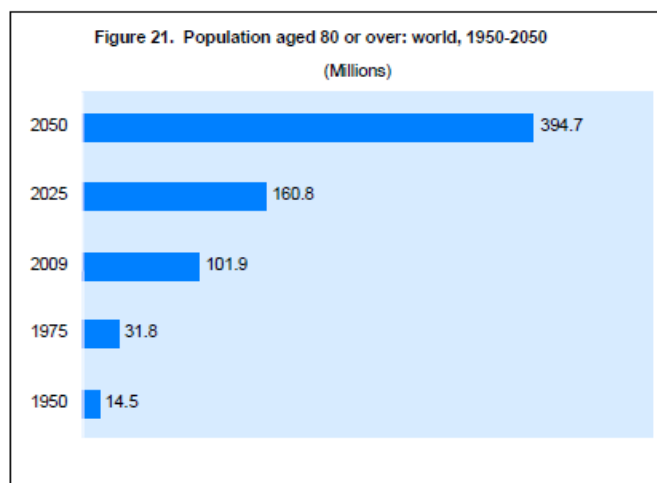
Source: World population ageing 2009

The United Nations, (2010) identifies both regional and international age-distribution numbers are changing. Over the past 50 years, the percentage of older people has increased fourfold from 5.7 per cent in 1960 to 23 per cent in 2010. In France, the percentage of older people has increased just twofold in the past 100 years, whilst Japanese society is ageing at an unprecedented rate with those aged 75 years and over exceeding 10 per cent of the population in 2008. The number of older people particularly those over 80 years is also accelerating. Not only are more people surviving to 65 years but once there they are living longer. In developed countries, those who survive to age 80 can anticipate nine more years of life, compared to seven years for those in less developed regions and six years for those living in the least developed countries. The age that societies consider as old and who is old

is different as well as how different societies treat their older people varies. There are also new groups of older people emerging such as those born with health conditions that would previously not have survived. This will contribute to an increasing heterogeneity of the older population which will place increasing pressure for the needs of the new aged to be understood.

2.2.2 NEW ZEALAND

NZ is experiencing the same global trend of increasing numbers of older people. The reasons for this relates to decreased fertility rates, increased life expectancy and baby-boomers are now at retirement age (Khawaja, 2000). New Zealand's fertility rate is lower when compared to the numbers of historical total births however; it is still higher than many other developed nations. This means we are ageing at a slower rate than other developed countries (Dyson, 2002) which will assist in alleviating the impact of the baby boomers who began to retire in 2011 (Statistics New Zealand, 2010). Figure two shows the rapidly increasing number of those over 80 year in NZ from 1992 to the present. This age group will continue to be the fastest growing population group growing at about twice the rate of those over 65, and as such they are high users of the NZ health system (Scholfield et al., 2006; Statistics New Zealand, 2011).

Figure 2 *Population aged over 80 years in New Zealand*
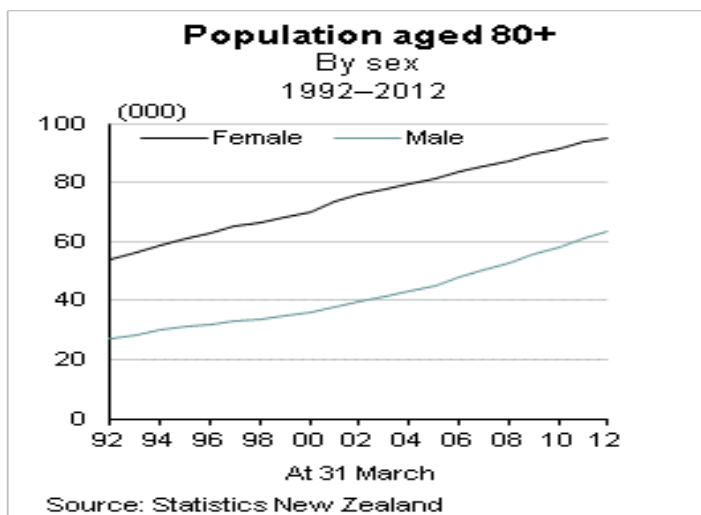
Figure 3 *Ageing of the aged in New Zealand*

Ageing of the Aged, New Zealand

Age group (years)	2006	2051	Increase (percent)	2006	2051	2006 Sex ratio
	Population			Age group as a % of 65+ Pop		Number of females per 100 males
65-69	155,500	291,200	87	30.4	21.5	106
70-74	120,200	257,300	114	23.5	19.0	109
75-79	103,600	245,400	137	20.2	18.1	118
80-84	74,200	223,900	201	14.5	16.6	146
85+	58,200	335,100	476	11.3	24.8	219
Total 65+ Population	511,600	1,352,800	164	100.0	100.0	124

- There were 531 Centenarians recorded at the 2006 Census (up from 399 in 2001).

Source: Statistics New Zealand

Figures 2 and 3 demonstrate the increased numbers of all those over 65 years and as a percentage of the entire over 65 group. Statistics New Zealand (2011) state those aged over 80 years represent 26 per cent of those over 65, they project this will more than triple from 158 600 in 2012 to 531 700 in 2052. Figure 2 also shows that females are and will continue to be the larger population group in the over 65s and in particular the over 80 age group. These numbers will also increase. Statistics New Zealand (2009) projections indicated the numbers of those over 90 years are likely to more than double between 2010 and 2030 to reach 49 000. In 2051, Statistics New Zealand (2011) projects there will be 62 men for every 100 women.

As in other countries, older NZ women greatly outnumber older men. Figure 2 demonstrates the difference in numbers of older women and men and this gap continues to widen as women continue to live longer and experience lower mortality rates (Statistics New Zealand, 2007). The United Nations (2010) suggests that as the gender differences are so large, the concerns of the older population should in fact be viewed primarily as the concerns of older women. Despite this Statistics New Zealand (2012) identify NZ men are living longer. Demographic changes such as the increasing longevity of men will have an effect on many areas of the lives of older people. With more men surviving into their old age there will be an increased number of couples. Mirowsky and Ross (2003) state that the loss of a spouse is an indicator signifying a time that older people move into residential care. With increased numbers of couples, there will be a potential decrease the number of older people that need to leave their family home.

2.2.2 Māori and other ethnic groups

Due to ethnic differences in fertility, mortality and migration Māori, Pacific and Asian populations have aged less quickly than the European population (Khawaja, Boddington, & Didham, 2007) leading to less ethnic diversity in NZ's older population. Pasifika Peoples' life expectancy is similar to NZ Māori. Dyson (2002) expects that this will change dramatically over the next 50 years, with a 270 per cent increase in Māori people aged 65^+ and a 400 per cent increase in Pasifika Peoples' in the same age group.

The 2002 break-down of population numbers by ethnicity was 92 per cent European and 8 per cent Non-European - this includes all other ethnic groups; Māori, Pacific Island, Asian (Statistics New Zealand, 2006). By 2026, the number of non-European older people will have increased to 14 per cent. This will include numbers of older Māori, due to both improved health and management of associated conditions. With this increasing number of the oldest-old from differing ethnicities it will be important to not only hear their voices but also understand what it is they are saying about living as older people and what services and support are required.

2.2.3 The Southern District Health Board (SDHB) and older people

The SDHB has an estimated resident population of 304 260. The population is older than the NZ population profile. This means SDHB has more elderly and less young people than the average community and the population is spread across many communities with a 40 per cent rural population.

This study has been located in the recently created Southern District Health Board (SDHB). The total numbers of the oldest-old in these regions are shown in the tables on page 28. Unfortunately, the most current information from the planned 2011 census was not available as the census was postponed due to the February 2011 Christchurch earthquake. Tables 3, 4, and 5 compare the number of people over 95 years in Otago and Southland in the years 1996, 2001 and 2006. These tables confirm both increases in numbers of older people and identify there is an increase in numbers in rural as well as urban areas.

Table 1 *Spread of oldest-old across the SDHB*

Number of 95 - 99 and 100+ years in local authority areas
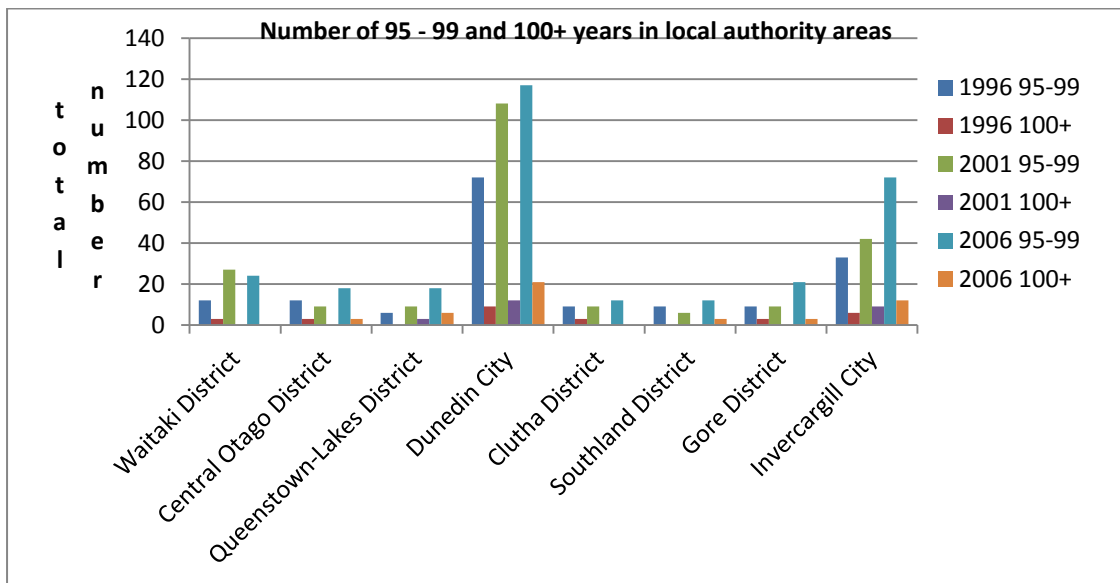
Source: Statistics New Zealand

Table 2 *Increase in number of 95-99 year olds and the 100+ year olds 1995 - 1999*

SDHB older people

	1996	1996	2001	2001	2006	2006
	95-99	100+	95-99	100+	95-99	100+
■ Otago/Sland	162	37	219	24	294	48
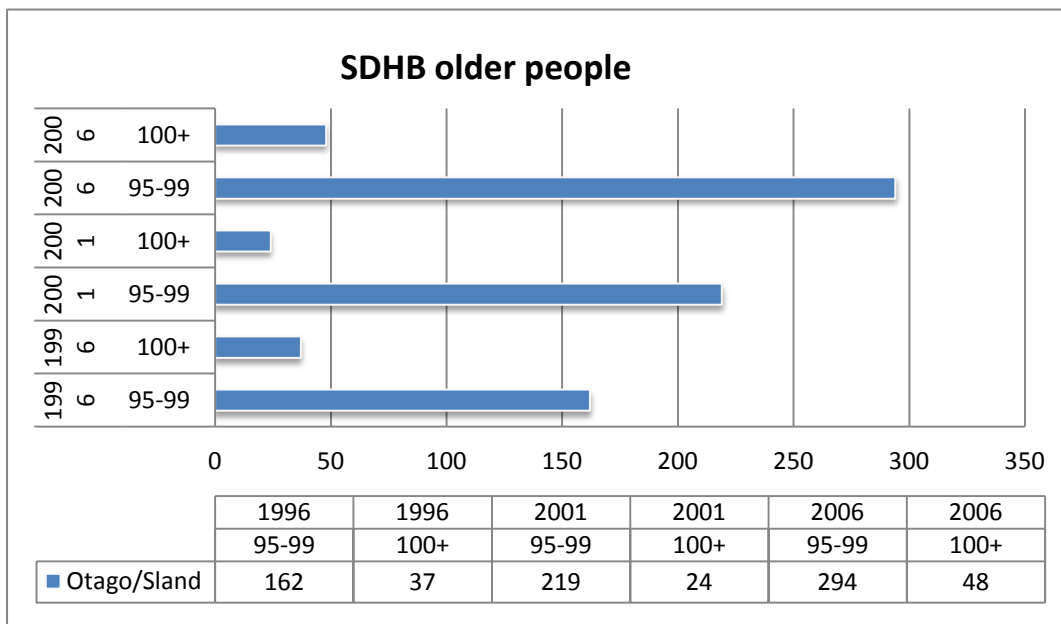
Source: Statistics New Zealand

Table 3 *Increase in total numbers of older people in the combined regions 1995-2006*

SDHB over 95 year olds

	1996	2001	2006
	95-100+	95-100+	95-100+
■ Otago/Sland	199	243	342
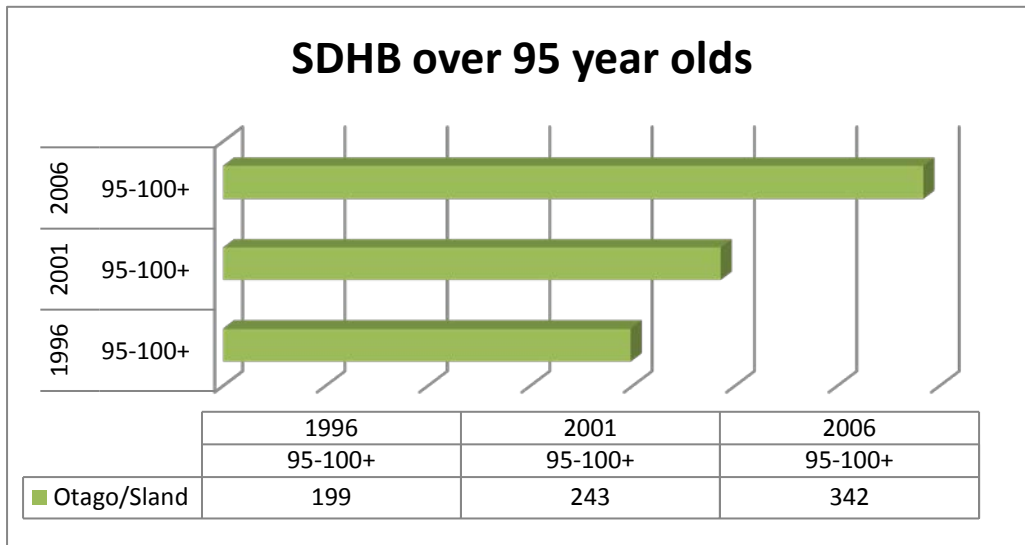
Source: Statistics New Zealand

There is a projected increase for the overall SDHB population with some areas anticipated to experience a decline. The elderly in particular the oldest-old group is expected to increase. It is therefore necessary for the region to be closely looking at the needs of these age groups as the population ages and as older people are choosing to be supported in their rural communities.

2.3   THEORIES OF AGEING

What is the purpose of a theory and should theory be considered as part of this study? Alausuutari (1996) proposes that being theoretically informed when undertaking qualitative research (in this case narrative) is a means of being aware of the different ways to consider the topic. Further to this it contributes positively to the reflexive position of the researcher. Bengston, Gans, Putney, and Silverstein (2009) suggest ageing theories are an attempt to hypothesise and simply explain how the specific changes we see as part of the ageing process can be understood. They add that humans seek explanations and want to find meaning in their experiences. This leads to questions about the what, why and how beyond their immediate observations which is theorising and search for explanations (Putney & Bengston, 2008). As a nurse, I consider it essential for nursing to utilise theories of ageing for the same reasons as other health workers, so that it is possible to know and engage with older people (Moody, 1998; Kolb, 2004).

Wadeston and Carlsson (2003) recognise that there are no nursing theories which articulate an effective understanding of ageing and that a specific theory is required. Is it possible to have just one theory of ageing? Moody (1988) suggests the development of an overarching theory is not possible as no single theory of ageing is likely to include all the areas relevant to understanding the convoluted nature of older age. Despite this, many of these theories presume homogeneity - that all older people are the same. Findlay and McLaughlin (2005) posit that many theories of ageing are based on observations of five to six per cent of the older people in long term care. They further opine this number is a small minority of the population and therefore not a representative group from which to draw conclusions from. Bengston, Gans, Putney, and Silverstein (2009) construe that it might be most useful to consider several theories given the complexity and diversity of the ageing process.

The predominant discourse of older people, particularly the oldest-old is the biomedical theories of ageing. These assist in defining successful ageing in terms of optimising life expectancy while minimising mental and physical deterioration and disability. Apart from the biomedical theories there are other ways of viewing ageing including the psychosocial approaches. These emphasise life satisfaction, functioning and social participation, and psychological resources. Presented here are four frequently offered theories, three of which embody the life course and life span perspectives.

2.3.1 LIFE COURSE PERSPECTIVE

This study is grounded in narrative gerontology which is consistent with a life course view as researcher listen to the narrators' stories which have evolved over a life time. In this study, the particular focus was how older people came to be living independently at over 95 years. This stresses the lifelong interactions of narrators within their own social context and the roles undertaken throughout their life (Vincent, 1999).

The life course and life span approaches collectively provide a more complete understanding of ageing, addressing patterns of change over time. These assist in understanding the process of ageing. Both perspectives take a long term, dynamic view of ageing, with life course focussing particularly on the social pathways that define the sequence of events, transition, roles and experiences in the lives of individuals (Fuller-Iglesias, Smith, & Antonucci, 2010). They add to this stating there are fundamental

differences between the two approaches, including the effects of age, the cohort that people belong to, the time they live in and the impact of that on people as they age.

Erikson's (1982, 1986) work particularly resonates with me because it reflects the fluid nature of determining what ageing is (Smith et al., 2007). As well as this Erikson's seminal work began in the 1930s which was the same time that the narrators in this study were reaching the third stage of Erikson's now nine period lifespan. Erikson and Erikson (1998) expanded the previous eight stages of life to include a ninth; despair versus hope and faith, to this was ascribed a calendar age of 80$^+$. In this ninth stage, with continued loss of autonomy, control, family, and friends this is a time when older people reflect on their life with satisfaction, if they have lived well or are in a state of despair over their losses. It is here that the final stage called gerotranscendence is reached.

Gerotranscendence is described as a state where a person moves from a materialistic and rational vision to a condition characterised by peace of mind and increased life satisfaction (Tornstram, 1996; Wadensten, 2005). During this stage, there may be a re-definition of space, time, death, and self. Transcendence need not be limited solely to experiences of withdrawal from life it may include regaining lost skills or activities. It provides an opening forward into the unknown with a trusting leap above and beyond the fear of death. Further to this the theory proposes older people can develop to a point that takes full account of the obligations that old age leaves behind. As Erikson states, "this final stage speaks to soul and body and challenges it to rise above the dystonic, clinging aspects of our worldly existence that burden and distract us from true growth and aspiration" (p. 127).

2.3.2 DISENGAGEMENT THEORY

Initially proposed by Cumming, Dean, Newell and McCaffery in 1961 the disengagement theory is one of three major psychosocial theories which describe how people mature in old age (Ebersole, 2005). It opposes the other two psychosocial theories of activity and continuity. The fundamental premise is the "mutual withdrawal or disengagement resulting in decreased interaction between the ageing person and others in the social system he belongs to" (Bengston, Gans, Putney, & Silverstein, 2009, p.31). They add that in 1960 disengagement theory was seen as an over simplification of ageing that older people were willing to be automatically disengaged from their social networks. Since then with decades

of research and public interest focussed on the young-old (the baby boomers) it is not surprising this theory has been largely ignored. However, for this study disengagement theory may be helpful in contemplating why those 85^{+} are more likely to disengage from their active lifestyles (Bengston, Gans, Putney, & Silverstein, 2009) and as such is worthy of consideration.

2.3.3 ACTIVITY THEORY

The World Health Organisation (WHO) policies for older people are based on Activity Theory, initially developed by Havighurst in 1963. Havighurst believed ageing could be both lively and creative. In the event of the usual happenings of old age such as widowhood, activity theory reasons that both activity and social interaction are the keys to the maintenance of high morale, satisfaction and QoL. Activity theory takes a positive attitude to older people, and suggests a middle aged person's level of activity can be achieved in old age through participation in life rather than withdrawal from it and suggests they can maintain this by keeping active. Critics of activity theory are concerned that it does not address the numerous barriers in remaining active. Barriers to active ageing are not only physical disability, chronic disease, declining motivation and energy, but also include social, economic and environmental factors. Therefore, older people may be seen to fail to meet the tenets of this theory despite their best endeavours. Havighurst (1961) warns "as long as there is disagreement as to what constitutes successful ageing, caution must be used in selecting measures of successful ageing" (p. 12).

2.3.4 CONTINUITY THEORY

First written about in 1989, continuity theory proposes behaviour is consistent across the life span and is a way of considering how adults adapt to their life throughout old age. Further to this Atchley (1999) explicates the concepts of internal and external continuity. External continuity refers to consistency over time with individuals choosing their activities, social roles, relationships and living arrangements whilst internal continuity represents personal values, temperament, preferences and ideas about self and the world. It is the interplay of both of these that contribute to individuals life-long continuous adaptations.

Much of the critique of Continuity Theory is based on its inability to be tested. However, Atchely (1999) believed it made an invaluable contribution to explain the successful

relationships and activities of older people. In 1989, he declared it could provide a blueprint for the "general adaptive principles that people who are normally ageing could be expected to follow" (Atchley, 1989, p. 183). Given this view there is the potential for this to be of benefit in this study but perhaps only if it can be agreed on as to what is normal ageing?

2.3.5 SUCCESSFUL AGEING

In 1987, Rowe and Kahn argued research had failed to delineate successful and healthy ageing, rather its focus was on differentiating pathology from normal ageing. As well, they proposed that successful ageing was at the other end of the continuum from pathological ageing and as a multidimensional and operationalisable construct, successful ageing should itself be thoroughly studied.

Proposed by Rowe and Kahn (1998) successful ageing is one of the most well-known theories. It proposes individual responsibility for our relative success or otherwise in ageing. To succeed in something requires a determined interest - a considered effort requiring planning and on-going work. They suggest the ability to successfully age is the result of making wise lifestyle choices and therefore avoiding the associated disability of illness. Similar to the theories of active ageing it focuses on western measurements of success; education, health and finances, which will assist older people to delay the onset of age related disease and ill health. This view is contrary to what is being well described in the literature; despite the effects of multimorbidity and chronic illnesses, older people see themselves as healthy (Bartlett & Peel, 2005; Butcher, 2003). Despite living in this era of human genetics, successful ageing is still seen as largely under the control of the individual.

2.3.6 THE FREE RADICAL THEORY

A physiological theory of ageing such as the Free Radical Theory is important to consider as the suggestion that ageing is a disease itself and can be fixed. There is a multi-billion dollar international industry that supports the on-going medicalisation of older age, with the hope that a capsule will fix the maladies of ageing and ideally cure the problem of ageing. This is despite a general lack of evidence and some potential health risks (Perls, Reisman, & Olshansky, 2005) of some of these products. Perls (2004) warns that even if these problems are harmless they have the potential to divert society and particularly older adults'

attention away from lifestyle and other activities, which do have an evidence base supporting their use.

The Free Radical Theory was developed in 1956 at the University of Nebraska by Dr Denham Harman. A free radical is a molecule that has a free electron, and it is this property that makes it react negatively with healthy molecules and subsequently destroys or alters them thus causing disease and ageing. Free radicals are created in various ways through diet and lifestyle including the use of drugs such as tobacco, alcohol and radiation. There is also a natural production of free-radicals within the body created by the simple process of eating, drinking and breathing which forms free-radicals from energy production cycles. Since first proposing this theory there has been on-going modifications and extensions to his original theory. In 1972, Harman modified his original theory which became known as the Mitochondrial Theory of Aging (Harman, 1972). This theory has been more widely accepted in the belief it could play a major role in contributing to the ageing process and work in this area is on-going.

2.4   NEW ZEALAND POLICY FOR OLDER PEOPLE

As the 20th century progressed old age was transformed from a residual social category into a more complex cultural field (Jones & Higgs, 2010). Recent literature promotes the view that older people are no longer seen as a homogenous group but a dynamic and heterogeneous one. Consequently as the ageing population increases there are complex community and governmental responses required (Bartlett & Peel, 2005; Laslett, 1989).

In 1997, a Prime Ministerial Task Force on Positive Ageing in NZ suggested that the effects of ageing and illness are often confused and if the illnesses are correctly identified and treated then they do not need to become irreversible. This Taskforce foregrounded the work known as the Health of Older Person Strategy (HOPS) (2002). The NZ strategies demonstrate what Biggs, Phillipson, Money, and Leach (2006) identify as a change in thinking, a move away from concern about social hazards to a new focus on ageing well. These new policies look at shaping a "new sort of ageing citizen" (p. 239). They also highlight the importance of considering how older people think about themselves, as well as their intergenerational relationships.

In the early 21st century there were numerous strategic documents developed with the intention of politically impacting on the health of New Zealanders. Dyson (2005) states the Health of Older Persons Strategy (HOPS) (2001) and the NZ Positive Ageing Strategy (NZPAS) (2001) are the primary government strategies influencing the health and well-being of older people. There are other strategies of interest which despite influencing the lives of older people are not covered here, these include; the Primary Health Care Strategy, Mental Health Strategy and the Palliative Care Strategy.

2.4.1 NEW ZEALAND POSITIVE AGEING STRATEGY

In 2001, United Nations Vienna International Plan of Action on Ageing sought to address international concerns regarding ageing. Following this there were international responses including the WHO (2002) which identified strategies based on other concepts of ageing, primarily defining active ageing as "the process of optimising opportunities for health, participation and security in order to enhance the QoL as people age" (p. 12). According to Stenner, McFarquhar, and Bowling (2011), this appears to be mostly concerned with both physical health and functioning.

The NZ response included consultation with older people which resulted in the positive ageing concept being established within New Zealand policy. This concept is similar to active and successful ageing, promoting; independence, productivity and personal decision making. The NZ focus of positive ageing promotes the role of all society to the contribution of the lives of older people. The subsequent development of the NZPAS (2001) was an articulation of ageing in a positive view which includes attitudes and expectations across the life span regarding ageing and older people. This strategy proposed the development of policies to support older people rather than leave the whole responsibility of ageing to older people. It provided a framework to ensure polices affecting older people are able to be easily understood and identified the barriers which older people face when attempting to participate in the community. The focus of the NZPAS (2001) was for society to improve the life of older people in the areas of income, housing, health, ageing in place, transport, cultural diversity, rural communities, social attitudes, employment and. This strategy has ten goals which reflect what Dalziel (2001) opines are the desire for all New Zealanders to create a society where people are able to age positively. Dyson (2005) added to this by

suggesting all New Zealanders have positive attitudes to both older people and ageing. Amongst the goals, number five specifically advocated for ageing in place by helping older people to feel safe and secure in their homes (Dalziel, 2001).

The NZ Government's emphasis as stated in HOPS (2002) and the associated action plan was to support positive ageing. Ageing in place is another key concept defined in the HOPS (2002), it is a term used when discussing services for older people, in conjunction with the phrase continuum of care. Living in their own home, moving to a retirement village and then moving into a resthome or hospital is an example of moving through the continuum of care and getting the support required;

> The ability to make choices in later life about where to live and to receive the support needed to do so. A key component of implementing ageing in place is developing services that support older people to continue to live safely in the community. (p. 78).

2.4.2 Health of Older Person Strategy (HOPS)

The HOPS (2002) strategy was part of the NZPAS (2001) and was established to provide an integrated service for older people in NZ District Health Boards by 2010. This was necessary to address the escalating needs of increasing numbers of older people. It focussed on ensuring the population aged in the best health and for the future it recognised that most older New Zealanders were healthy and independent with few needing extensive care. HOPS (2002) was composed of eight objectives which affect all New Zealanders. These covered diverse goals including: health, income, housing, transport, and cultural diversity, opportunities for older people in rural areas, accessibility to services, perceptions and attitudes towards ageing and older people and ageism. Dyson (2002) rightly contended that unless all of the strategies, eight objectives are implemented the goals of HOPS would not be achieved.

2.4.3 Effectiveness of the Strategies on the lives of older New Zealanders

The intention was that the HOPS (2002) would be implemented by 2010. In 2009, the Hope Foundation commissioned a report to review its effectiveness. Indications from this independent analysis by Hood (2010) which included Ministry of Health, District Health

Boards (DHB) reporting and planning and funding manager interviews indicate that its outcomes had not yet been achieved. Despite considerable work to support developing services for older people Hood (2010) states not one of the interviewees felt the objectives of the HOPS had been fulfilled. There were various reasons for this, the primary one being it was introduced at a time when DHBs had a number of competing priorities. Further to this Hood (2010) contends it was the view of most participants that it was necessary to keep the health of older people a priority and it remains a work in progress. Of particular importance for the future is that many interviewees included in Hood's (2010) work indicated their DHBs are now close to achieving the integrated continuum of care required to support ageing populations. Further monitoring of the HOPS strategy and other associated strategies occurs on the Ministry of Economic Development website (2012), this provides an on-going reporting function which monitors, what is happening in this area. The impact of the NZPAS (2001) and the HOPS (2002) may not have been seen in the immediate lives of the oldest-old. However, this website provides information about a monitored action which means there is an on-going focus on what is happening for older people and what outcomes are occurring.

2.4.4 AGEING IN PLACE

This concept has several meanings with a general understanding that it is an aspirational ideal where older people are able to remain in their home as they age. It is expected that over time there will be a change in their needs and requirements (Cutchin, 2003). Ageing in place suggests maintenance of independence and especially on-going competence and control over their environment (Lawton, 1982). In their study Oswald et al. (2007) demonstrated a pivotal relationship between well-being and place. Government strategies and policies in NZ promote ageing in place. Dwyer, Gray and Renwick (2000) undertook a government funded research project which resulted in the NZPAS (Dalziel, 2001) and HOPS (MOH, 2002). These identified that most older people wished to remain in their homes for as long as possible which Frank (2002) confirms is an international phenomenon. Dahlin-Ivanoff, Haak, Fänge and Iwarrson (2007) describes home as the most important locus of the lives of older people. Ageing in place – growing old in one's dwelling and neighbourhood – is a major consideration within the national policies on older people, housing and care countries such as the United Kingdom and the Netherlands (Sixsmith & Sixsmith, 2008).

Government and service providers both internationally and in NZ have embraced the notion of ageing in place. No doubt this is because it has the potential to more effectively meet the care and support needs of an ageing population whilst avoiding the costly options of institutional care. However, ageing in place is not just about staying at home. It should also be about staying in their community (Peace, Holland, & Kelleher, 2006). As such housing developments intended for older people should be situated not only close to relevant community supports but also social networks. Davey (2006) indicates services such as; meal deliveries, home help, health care, gardening and home maintenance are services which will contribute to ensuring ageing in place is accessible for older people. Statistics New Zealand (2006) revealed that 93 per cent of those over 65 years live in the community, suggesting ageing in place is entrenched. Historical statistical information suggests the percentage is largely unchanged which challenges the comments regarding ageing on place and older people.

A 2006 NZ pilot scheme, Assessment of Services Promoting Independence and Recovery Services (ASPIRE) evaluated three ageing in place support services (Ministry of Health, 2006). In comparison to the usual services these were found to have reduced the risk of mortality and risk of entry into residential care. Schofield et al. (2006) in their NZ review of ageing in place confirm the relationship between the location and personal characteristics such as gender and health of an older person and their ability to age in place. There is no doubt that 'ageing in place' is seen as the way people should live. However, it necessitates the question about where and how 'ageing in place' should occur.

2.5 CONCLUSION

Chapter two has explicated the key concepts relevant to the ageing, national and international strategies and demographic information for review and consideration. Despite a global pre-occupation with baby boomers, it is the oldest-old, this silent generation who have experienced phenomenal changes throughout their life and have limited visibility within society. Society needs to hear their experience of living after 95 years, not only for ourselves but also for our siblings, spouses, parents and grandparents. This chapter demonstrates the work NZ has completed in relation to the lives of older people and

provides the context for this study. In the next chapter there will be a critical review of the literature regarding older people in particular the oldest-old.

3.   LITERATURE REVIEW

3.0   INTRODUCTION

The objective of this chapter is to present both international and national literature critiqued in this study. This will focus on literature which discusses the various factors that may contribute to people over 95 years being able to live independently in their own home. A literature review is an integral part of the research process (Oermann, 2002) providing the researcher the opportunity to; look widely at a topic, define a research field, and identify where there is a potential gap in the body of knowledge (De Poy & Gitlin, 1998). The literature review evaluates how others have researched the topic, their methodology, findings, interpretation of findings and conclusions. Consequently, it provides opportunities to understand the broad range of theories, main ideas and research that exists in a field of study. In reading this literature review there may be aspects of the oldest-old literature that are not covered specifically or where the literature included refers to the younger old due to the deficit in the literature on the oldest-old. However, in bringing disparate information together, this literature review is the researcher's opportunity to compare and critique the research and identify what are the elements that contribute to and enable those over 95 years to be able to live independently at home.

3.1   SEARCH STRATEGY

In February, 2010 a cursory search of journals available at the Southern Institute of Technology (SIT) library including *Nursing Praxis in New Zealand, Kai Tiaki, Advanced Journal of Nursing* and *The Gerontologist* was undertaken. Consistent with the nature of qualitative research the search continued through the research process as an iterative process with on-going searching and collecting of information (Wilson, 2007). A number of key terms surfaced, these were related to the research question and also other possible authors and subjects that assisted in undertaking a broader electronic scan. Combining a visual search with an electronic scan proved beneficial as I was able to cross reference more fully. Key terms used included; age, aging/ageing well, older people, old-old/oldest-old, nonagenarian, successful ageing, active ageing, interdependence, independence, qualitative, narrative, critical gerontology, community, home, staying at home, family, family support, healthy aging/ageing, successful aging/ageing, qualitative, social gerontology, activities of daily

living, health status indicators, aging/ageing in place and staying at home. Databases searched included; CINAHL, PUBMED, Scopus, Web of Science and Google Scholar.

Many of the publications searched in this literature review predated the initial research parameter of ten years with a number of older seminal articles being included; these have been accessed through secondary data sources. In order to gather relevant material and data it was necessary to review a wide variety of sources which included; qualitative and quantitative studies, review articles, abstracts, books and book chapters. To further reduce gaps in automated searches manual searches of reference lists were scanned for additional publications as well as the NZ Ministry of Health website. Abstracts of articles were not included as they provided insufficient information. However, other materials such as unpublished theses were included.

3.2   WHAT DOES THE LITERATURE SAY?

No doubt the increased volume of research on the lives and experiences of older people is attributable to the greying of international populations, with a variety of terms such as the 'ticking time bomb', 'grey tsunami' and 'grey wave' referring to the increasing numbers of older people. These terms permeate academic literature, the popular press and reflect society's view of the imminent disaster that awaits as the numbers of older people exponentially increases. As Marengoni et al. (2011) opine the numbers and associated costs of individuals with chronic multiple diseases have overtaken infectious diseases that were previously the major health and societal issues facing older people. They amplify this by highlighting the potential relationship between acute and chronic conditions and the impact of these on the health of older people is more important than a mere tally of their chronic illnesses. However, there are predictions that the gains made in lifespan may be relinquished owing to current health issues including obesity and diseases such as the diabetes (Olshansky, Grant, Brody, & Carnes, 2005). These remarkable and rapidly evolving changes to the age distribution of our species and the emergence of age-related diseases support Cutler and Mattson's (2006) claim that ageing is the number one public health issue faced by the western world.

The literature contains little evidence of older people's, particularly the oldest-olds personal voice about what they say about their lives and ageing (Holmes, 2006; Reed, 2008) in particular with reference to qualitative narrative research (Foster & Neville, 2010). Much of the current literature takes the traditional and negative view of the oldest-old which suggests policy, government and society sees them as problematic and passive (Reed, 2008). These writers observe this is consistent with the traditional biomedical western view of ageing; where illness, degeneration and decline are inevitable. Ray (1998) encourages researchers to value older peoples' participation in research practices and considers that this will contribute to better understanding their lives.

Over recent years there has been an increased interest in research projects about ageing. Within the literature there are increasing mixed method studies utilising both qualitative and quantitative methods. These are generally described as methods to expand the scope or breadth of research to offset the weaknesses of either approach alone (Minichello, Sullivan, Greenwood, & Axford, 2004). This maximises the validity and robustness of qualitative data whilst providing a greater depth of information. Northern hemisphere research seems to have led the way with a number of mixed methods studies, major long term research programmes which have incorporated the multiple dimensions of well-being. They have also emphasised the wider socioeconomic constructs matrix within which people develop and age (King & Waldegrave, 2009).

Davey (2006) identified a number of NZ research priorities in particular giving voice to older people. The NZ Longitudinal Study in Ageing (NZLSA, 2008) is looking biannually at the lives of 4000 older people in NZ. The potential contribution of research projects such as NZLSA (2007) and The Irish Longitudinal Study of Ageing (TILDA, 2011) to the lives of older people cannot be over emphasised. However, they utilise research populations 50[+] years with the upper age limit 84 years. This is ten years short of the group of oldest-old that this research project worked with and highlights the dilemma presented with reviewing literature across a span of up to 40[+] of years. The more recent LiLAC Study, Te Puawaitanga o Ngā Tapuwae Kia Ora Tonu (2010) looks at the oldest-old Māori and follows them for ten years. It is this group of the oldest-old, the fastest growing group of people, who will have increased healthcare requirements, which will include not only medicine and nursing but also wider community and social services. If meaningful and appropriate policy for these people is to

be developed then service providers and health professionals must know this group of people and implement new courses of action to respond to their needs. Alongside this, in order to become the "architects of a definition of themselves" (Reed & Clarke, 1999, p. 213) older people can, by telling their own stories, influence both the policies and strategies written about and for them. Amongst the wider multi-disciplinary team nursing must listen to the voices of older people to embrace and understand their diversity. Nursing must also understand that working with this diverse group is a specialist and skilled activity (Easley & Schaller, 2003; Leahy, Thurber, & Calvert, 2005).

To assist with better identification of the true diversity of older people, utilisation of narrow age band cohort studies are useful to reflect what could otherwise be confounded by the differential aspects of ageing (Jagger et al., 2011). Research projects such as the Umea 85[+] Study (1988), northern Swedish study researched the health and outlook on life of the oldest-old. The Umea 85[+] study used a salutogenetic perspective with a focus on the oldest-old persons' experience of life (Nygren et al., 2005) where it identifies various specific, cohorts of 90, 95 and 100 year olds utilising both qualitative and quantitative methodologies.

Jagger et al. (2011) acknowledge the difficulties in working with the oldest-old such as maintaining reliability and the internal validity of self-reported data. Further, they caution that external validity may not apply amongst varying geographical groups suggesting reasons for this include both the small total population numbers and the heterogeneous nature of varying groups. This is why studies such as this are important and contribute to the wider body of knowledge.

The literature reviewed here includes the impact of various chronic diseases including depression, pain and disability on the oldest-old. Unfortunately within the literature illnesses are frequently looked at in isolation to one another rather than presenting the reality which is most of the oldest-old having at least one but often two or three long term illnesses. It is essential to consider the various elements that affect, contribute and define how the oldest-old, those over 95 years, are able to live at home. The literature demonstrates that illness, either the presence or absence impacts on a person's ability to live independently. However, there are other constructs essential to the oldest-old to be

able to live at home. these include; safety, home support, social support, transport and meals, as well as the socio-cultural aspects of support, family and QoL.

3.2.1. HOW SOCIETY VIEWS OLDER PEOPLE

When studying the lives of the oldest-old it is necessary to consider the reasons they are viewed as they are. No doubt, ageist views are associated with the historical fact that older people were a minority of the population, therefore not well known and understood by wider society. The opportunity and need for western societies to treat their elders well is often only aspired to (Stone & McMinn, 2012) unlike other cultures such as Māori and Chinese. They suggest that our attitudes are shaped not only by our culture but by language. As the 20th century progressed, the numbers of older people increased. Therefore, it might have been assumed that older people's issues would have been better known to the community, resulting in diminished ageism. However, it appears quite the reverse has occurred. As the number of older people increase ageism appears rife within society. Neville (2007) opines that the use of chronological age to categorise people is itself ageist as it fails to consider the variety in both psychological and physical function of those over 65 years.

In 1968 Robert Butler defined ageism as "allowing the younger generations to see older people as different than themselves; thus they subtly cease to identify with their elders as human beings" (p.139). Butler added to this in 1995 by stating "ageism is a process of systematic stereotyping and discrimination against people because they are old" (p. 41). Ageism discriminates against older people depriving them of their social status, power and authority as a result of their age (Duncan & Loretto, 2004). It is when the characteristics of a few members of a group are generalised to the entire group such as; all people with dementia exhibit violent behaviours. Other forms of ageism include; cultural ageism which is a "prejudice against our feared older self" (Nelson, 2005, p. 213-214), institutionalised ageism which explains the role of the State in the distribution of resources and retirement benefits to older people (Hagested & Uhlenberg, 2006) and positive ageism. Positive ageism (also known as compassionate ageism) includes activities such as reducing costs of medicine, medical visits, script costs, as well as encouraging wider society to be kind to old people.

In a 2012 review of literature on ageism and elder abuse van den Heuvel found that in scientific literature and official documents there was scarce information available. This is contrary to Teaster, Wangmo, and Anetzberger's (2010) findings, who concluded that the existence of elder abuse especially of the very dependent is well documented. However, van den Heuvel and van Santvoort (2011) proposed while they could not provide exact figures about 25 per cent of the older population experiences discrimination based solely on age. Older people themselves may contribute to ageism by a focussed endeavour not to see themselves as ageing and actively work against this (Scholfield et al., 2006). Sneed and Whitbourne (2005) encourage us to reconsider society's views of older people. With the increasing numbers of older people, there are opportunities to move away from the focus of loss and declines associated with ageing to a view of older people which embraces the view of ongoing growth and development in old age. Holstein and Minkler (2007) suggested that ageism could be eliminated by focussing on the positive aspects of old age which would mean understanding the real bodies of older people" (p.16) thus eliminating unrealistic and "oppressive standards" (p.16) which may negatively affect the identity and self-worth of older people.

3.2.2 OLDER PEOPLE AS FAMILY AND COMMUNITY MEMBERS

It is clear from the literature social support is an essential aspect of ageing (De Jong Gierveld, De Valk, & Blommesteijn, 2001). Social support is provided by social networks, which are defined as "all those people involved with an elderly person in a significant way; as a member of the household, in providing companionship, emotional support, instrumental help, advice or personal care or receiving any of these from the older person" (Wenger, 1994, p. 2). Wenger's definition situates the older person as a participant and central to their network not just as a passive receiver of support.

Family is identified as a key form of support for older people. McPherson (1993) suggests family support especially from adult daughters is the main source of social, emotional support and physical care for older people both in NZ and internationally. She identifies that this support may be lacking for some groups of older New Zealanders in particular older women born 1897-1916. This particular group experienced World War Two and often delayed having children or have outlived their children who would have provided that

support for them. Holt-Lunsdat, Smith, and Layton (2010) undertook a meta-analysis of some 308 849 individuals with a range of ages of 42-85 years, whose average age were 63.9 years, these people were followed for an average of 7.5 years. The results indicate that individuals with adequate social relationships have a 50 per cent greater likelihood of survival compared to those with poor or insufficient social relationships. Despite these people not being part of the oldest-old age group it is known that what contributes to them being able to live independently occurs over a lifetime as does the nature and quality of social relationships.

Lyyra and Heikkinen (2006) identified a strong association between the mortality of older women and social support but no such relationship for men. Statistics New Zealand (2007) note that men under 84 years have less contact with others however, this reverses at age 85 as those living alone have increased contact. Alpass and Neville (2003) discovered an association between loneliness and depression in older men, concurrently they suggest loneliness may mediate a relationship between depression and social support. There is an assumption the oldest-old are lonely and have limited company. Whilst it is obvious that the cohort decreases with the death of spouses and friends it is evident there are new people to replace the roles of these people (Bould et al., 1988). Waldegrave (2009) suggests family members will feel satisfied with the obligations to be involved with older family members, despite these relationships appearing to be quite prescribed about what is required by the older person such as assistance to shop, visiting daily or weekly to assist with specific tasks.

Fiori, Smith, and Antonucci (2007) note there is a similarity between the concepts of social networks and social support for older people (Litwin, 2001; Fiori, Antonucci, & Cortina, 2006; Cheng, Lee, Leung, & Lee, 2009). Social networks can be defined as friend-focused, family focused or restricted; each providing social support in a unique way. Within the restricted network two further groups were identified, these include non-friend and non-family and may be specific to western cultures (Fiori et al., 2006). The non-friend and non-family type of network reports high levels of depressive symptoms which suggests that friendship is an important aspect of subjective well-being and increasing social participation. This is in contrast to Eastern cultures, which tend to utilise the family network group for social support (Litwin, 2001). Cheng, Lee, Leung, and Lee, (2009) also describes a network type specific to studies on older Chinese adults. This network is composed of single people

who rely on distant relatives when there is no close family and this appears to impact positively on their subjective well-being. Cheng, Lee, Leung, and Lee (2009) did not find any differences between families or friend focused network times on subjective well-being. These findings confirm Litwin's (2001) findings that there were no gender or ethnic differences in the types of network support. In a cross-cultural study where Antonucci et al. (2001) researched the structural characteristics of older people aged 70-90 years they found the social networks of older people in France, Germany and the United States decrease in size as they age.

Results from the New Zealand Longitudinal Study of Ageing (2007) identified that older people had a high level of satisfaction with their social contacts. Ninety six per cent of the respondents expressed satisfaction with their family contacts and 97 per cent expressing satisfaction with their contacts with other people (Waldegrave 2009). This gives a picture of happy families and friendships among the older age group. Of interest, those who lived with others conveyed a higher level of satisfaction with their social contacts than those living alone. Baron-Epel, Shemy, and Carmel (2004) reported that older adults who live alone identified their social networks as not highly supportive. Exceptions to this were widowed people who despite living alone expressed a high level of satisfaction with their social contacts. This perhaps indicates that those who are single and live alone experience difficulty in maintaining social contacts whilst widowers find it easier to maintain their previous social contacts or find it easier to make new social contacts (Baron-Epel et al., 2004). Boyden and Van der Pas (2009) research supports the assertion that there is an association between the respondent's satisfaction with their social contacts and well-being. These NZ findings suggest social contacts and the quality of those relationships had a bearing on the well-being of older people which means both the number of social contacts and satisfaction with these contacts is important.

3.2.3 MARRIAGE

The positive effect of marriage on older people is well established in the literature and validates that being married is positively related to physical health and longevity (You & Lee, 2006). There seems to be a clear pattern where older people who live with a partner have a higher level of well-being than older people living alone (divorced or widowed) or with

others, who in turn have greater well-being than older people who are single and living alone. An explanation for the benefit of living with a partner might be that this relationship not only fulfils basic and universal human needs (Rook, 1984) but also provides companionship and freedom from loneliness (Peters & Liefbroer, 1997). De Jong, Gierveld, Dykstra, and Schenk (2011) advocate for more attention being paid to the impact of gender differences on the living arrangements of older people within the 65-84 year age group, and in particular to the differential impact of marital status for men and women. It is also clear that older people who live with a spouse/partner participate in more leisure activities, especially men (NZLSA, 2007). Men with a partner have the highest rate of participation of any group; single women living alone have the lowest, a situation which highlights the importance of having a companion to support an older person's leisure and recreational interest. Organisations for older people and those interested in encouraging them into leisure activities might more diligently seek out those who live alone.

Moreover, the NZLSA (2007) findings concur with international research that there is a positive impact of living with a partner in later life and well-being of older New Zealanders. Married adults show evidence of better health outcomes than the unmarried across a variety of acute and chronic conditions ranging from colds to cancer and heart attacks. Those that are married are less likely to die in any given period than the unmarried; there is evidence that the longevity benefits of marriage are more substantial for men than women. The mental health of married men and women appears to be better than those who are unmarried (Mirowsky & Ross 2003; Williams, 2003). However, it appears that second marriages do not appear to enhance mental health as do first marriages (Williams, 2003). Marital status is widely used as a measure of social integration. However, growing literature documents its divergent effects based on level of marital quality (Coyne & Benazon, 2001; Eaker, Sullivan, Kelly-Hayes, D'Agostino Sr, & Benjamin, 2007). Mirowsky and Ross (2003) reported the married group in their large multicultural study experienced higher levels of social integration and support, whilst Baron-Epel et al., (2004) suggest that there may be a link between marriage and lower mortality rates.

Bereavement is a common experience for older people that increases as people age and become the oldest-old. Statistics New Zealand (2007) identify that most un-partnered older adults are widowed. The loss of a family member is perhaps the most stressful situation

older people face. Whether this bereavement is a child or spouse, the effects of this may lead to negative health outcomes. In the case of the death of a spouse the older person has to deal with acquiring new skills of living alone, loneliness, reduced morale and social engagement (Bennett, 2005) and depression (Bennett, Hughes & Smith, 2003); with mental and physical illness being linked to bereavement. Loss of a spouse affects men more than women (Stroebe, Stroebe & Schut, 2001). Supporting this Bennett, Smith, and Hughes (2005) opine that women receive less support in widowhood than men. Social and physical health issues such as alcoholism and depression may be related or exacerbated by bereavement. Men are at greater risk of an increase in both the frequency and the amount of alcohol consumed. There have been reported episodes of depression prior to and post bereavement, these may also be related to a change in relationships with others (Djernes, 2006).

3.2.4 ENVIRONMENT

Environment is a broader concept than home while encompassing home, environment includes the wider community older people live in; with amenities such as transport, and neighbourhood being important (Wiles, Leiburg, Guberman, Reeve, & Allen, 2011). The inability to stay within their environment of choice - their home, requires support from others in the community. This may not be provided by family but by other means such as the State and is invaluable in assisting older people to manage their environment(s). Unfortunately, a time may come when despite assistance they may no longer be able to live independently and need to change where they live.

3.2.4.1 HOUSING FOR OLDER PEOPLE IN NEW ZEALAND

Housing is not only a matter for older people; all people need housing. Currently 25 per cent of those 85^+ years live in a residential care facility (Statistics New Zealand, 2007). This means 75 per cent own their own home or rent and of that number, 33 per cent live alone. Literature suggests that housing is a critical issue for older people, more than just physical shelter, meaning other things such as attachment to place and a sense of identity (Andrews & Phillips, 2005; Wiles et al., 2009). They add that these are influenced by a variety of factors such as age, environment and physical capacity. Many of the family homes of the oldest-old are amongst the more than 35 per cent of NZ houses built before 1935 meaning

they are often in need of major repair and refurbishment and require updating with the modern conveniences such as inside toilets and electric washing machines.

Using Rowles (2006) view of home the notion of housing and home are separated. He contends home is more than a persons' physical location, while housing is generally about the structures that are lived in, where they are, how they are built. The nature of housing, which I have viewed as home is described as a "positive experiential state" (Rowles, 2006, p. 27) or a sense of belonging (Keeling, 1999), and is discussed later in this chapter. It is vital to discuss each of these as the literature suggests that both affect the outcomes for vulnerable groups of which the elderly is one (Grimes, Kerr & Aitken, 2004).

Older people state staying in their own home is important to them (Hinck, 2004). However, where home is may be influenced by various elements. These include living alone because of illness or death of a spouse, partner issues or the effects of a decline in health. In these situations, older people find themselves alone in a large house and often with minimal support from neighbours, family or friends. On these occasions, maintenance may become onerous and become one the factors that lead older people to change their housing (Davey, 2006).

Housing and the suitability of it affects a person's ability to continue living at home, in particular the housing needs to meet the requirements of people as they age, such as having accessible entrances and bathrooms (Davey, 2006). Of increasing significance as the numbers of older people increase and are living alone, is the quality of housing they are living in. Howden-Chapman, Signal and Crane (1999) state that one-person superannuitant's are amongst the poorest households in NZ and the quality of the housing often reflects this. They add that the effects of such housing may have a detrimental influence on older people's health. Davey et al. (2004) build on this view of one-person superannuitant's being amongst the poorest households in NZ and suggest there are a further set of determinants which enable people to stay at home including access to maintenance, renovation and adaptation that keeps homes in good condition as well as having suitable heating and ventilation. Of particular concern especially in the southern part of NZ where this research took place is that NZ experiences greater seasonal mortality than other countries which

have more extreme climates (Davey et al., 2004). This is related to housing and highlights the relationship health has to the housing needs of older people.

3.2.4.2 Home

"Home" as a place is a constant process involving ongoing negotiation of meanings. Peace, Holland, and Kellaher, 2006; Wiles et al., 2011; add that home is not only about the house but includes the setting - neighbourhood and wider community. Chalmers and Joseph (1998) in their study of older people's experiences in rural NZ demonstrated the strong attachment older people had to their town and the unavailability of alternative housing as influential motivators for people to remain in a community. This attachment older people had for their town was confirmed by Keeling (1999) in another NZ study on older people's experiences of home and community. Keeling (1999) suggests ageing in place is more than the ability to stay in their home; it entails the ability to make independent decisions regarding change and adaptation to changing needs.

Wiles et al. (2009) concluded that attachment to place is developed through the relationship between a number of social and physical features such as location, convenience of the house, involvement in neighbourhood activities and proximity to family. It is this changing balance between the social, emotional and practical aspects of living in a certain place which influences the well-being of older people. Many elderly people do not want to make their home with close relatives or friends, fearing they might become, or be felt to be, a burden. Both informal and formal care providers, when entering the homes of older people must carefully negotiate their way and recognise the potential loss of control that may occur for the older person. There is the possibility that home is not always a positive experience for older people. This may occur when care cannot be provided in their home or if they wish to move but cannot (Aneshensel et al., 2007). Perkins, Thorns, and Winstanley (2008) posit that home is often imagined in ideal terms far exceeding the lived reality.

New Zealand's high level of post-war homeownership has allowed most older people to live in mortgage free houses (Waldegrave, 2006). Given the long periods of time that many older people live in their home and neighbourhood it is no surprise that many researchers note the strong attachments people experience in respect to their home. This experience is about practicality and comfort (Davey, 2006; Wiles et al., 2009). These experiences include the

physical aspects of home that positively influences older peoples' well-being (Lawton, 1982). Hidalgo and Hernandez (2001) state that attachment to place has been definitely demonstrated to be higher amongst older people.

The needs of older people in respect to housing will change as the demographics continue to change. The ability of older people to continue to own their own homes is unlikely and therefore new policy initiatives are imperative. Whether or not retirement villages in their current form will meet the needs of older people is unlikely. The term retirement village is identified in the Retirement Villages Act (2003) and includes a variety of legal forms of residence allowing residents the right to live in a dwelling; these include a unit title; licence to occupy; or life time lease or tenancy. The policy decisions required to support the frailty and disability of the oldest-old are not only about housing but include wider health and social service issues (Wiles, 2005).

3.2.4.3 WHO DO THE OLDEST-OLD LIVE WITH?

As is identified earlier the changing composition of society with a greater number of older people living alone with minimal family support will impact on the formal structures required to support people (Lazonby, 2007). International research has shown that co-residence between adult children and parents is affected by: a shortage of affordable housing for first home buyers, parental need for care in old age, job insecurity among young adults and few institutional care facilities for older adults (Fokkema, Bekke, & Dykstra, 2008). They suggest future research is needed to explain the motives for co-residence of older New Zealanders with their adult children.

The living arrangements amongst older age groups are diverse as they are different from the general population (Statistics New Zealand, 2006). Not surprisingly, the living arrangements of older people change as they age. From the NZLSA, King (2008) identified older people are less likely to be living with a partner and that this is much more noticeable in women and they (women) are more likely than men to live in a one person household. This is due to the differences in mortality rates between the genders and whilst the age gap will decrease in up-coming years a difference will remain. Statistics New Zealand (2008) identify a small percentage of older New Zealanders living in shared households, with older men more likely to be living with a partner or spouse than older women. King (2008) asserts that older New

Zealanders who shared their household with others did primarily with their adult children with some identifying the challenges of living in busy households with young children or teenagers. Dunster (1986) suggested that older people loved seeing their families and being involved in aspects of their lives and would want to live with them. This is an interesting finding considering that NZ research suggested that older people generally prefer not to live with their adult children (Davey et al., 2004).

In a systematic review undertaken by Gaugler, Duval, Keith, Anderson and Kane (2007) the predicative factors which may lead to long term care admissions were identified. This review covered more than 170 000 American 65$^+$ year olds. The strongest predictive factors included functional and cognitive indicators as well as three or more activities of daily living dependencies which include such things as incontinence, bathing and eating. Other factors such as previous admission to a care facility, being non-Caucasian and social support/caregiving requirements are other indicators. These are the issues that society must consider in order to support those over 95 years to live independently in their own home.

Findings from a variety of international literature including the NZLSA (2007) identify older people as perceiving health to be the most important factor enabling them to continue to live independently in their own home. Subsequently older New Zealanders identified having family and friends and living in a desirable neighbourhood as key factors in staying in their homes. Associated with these factors was the need for affordable housing costs and the importance of mobility so that older people could continue to not only be able to get to but also access places that were important to them. Resnick (2003) identified older adults in retirement communities as being more interested in health promotion and had higher levels of health promotion activities such as influenza immunisations provided on-site than those living in other settings. Thus, retirement communities represent a different environment than living in the wider community. It is evident from this research that having social networks such as neighbours, the support of families and regular care givers as well as good health appears to have an impact on people feeling able to stay on in their own home and be involved within the community.

3.2.5 FINANCES

Dwyer, Gray, and Renwick (2000) purport that adequate financial resources increases options regarding house and home for older people. They add, assets accumulated over a life time can be utilised in old age to supplement lower incomes. It is clear from the literature that adequate income is a key contributor to health status and is linked to security and the ability to meet needs and maintain social contacts (King & Waldegrave, 2009). This means those with greater financial resources are more able to stay at home with support. Support includes the physical aspects of ADLs as well as house and garden maintenance. The NZ passion for home ownership means many older people in NZ are asset rich and cash poor (Morgan, 2012). As older NZers are increasingly healthy through the young-old period there will remain opportunities to continue accruing assets with changes in work force patterns. The result of this will be older people working later in their lives which may impact positively on matters such as health and management of other resources.

Statistics New Zealand (2007) identify that it is increasingly common for New Zealanders 70^{+} to have NZ/state superannuation as their only income. Hughes and Waite (2002) acknowledge those living with a partner have more economic resources than other households. Superannuation as the sole source of income is more likely to be an issue for those who live alone, which is the reality for many of the oldest-old, particularly women. It is generally recognised that women's financial situation is less comfortable; this is because fewer of this cohort have worked outside the home.

It is evident that socio-economic status and health share a close relationship. A re-analysis of the data from the Fergusson, Hong, Horwood, Jensen and Travers (2001) NZ survey found there was a higher prevalence of frailty among older people who lived on low incomes and who had minimal savings. These people had less secure housing, mobility constraints and less frequent social contact (Barrett, Twitchin, Kletcho, & Ryan, 2006). The concurrent associations of socio-economic status with health and well-being are well established in the international literature on ageing (Emmerson & Muriel, 2008; Hodes & Suzman, 2007; Woods et al., 2005). The relationships between socio-economic status, living standards, and well-being (each broadly defined) are confirmed in the global research, specifically for older people but also the general population. In a synthesis of findings from empirical studies, Pinquart and Sorensen (2000) identified socio-economic status, social network and

competence to be positively associated with subjective well-being. Income has been shown to be significantly related to reported well-being and QoL. In the 2004 Survey of Health, Ageing and Retirement Study (SHARE) from across ten European countries it is evident that income, net worth and car ownership were consistently associated with perceived QoL.

In a significant British study which researched the association between QoL in old age with socio-economic position the results obtained were largely congruent with those of international studies where personal income and wealth (excluding the family home) were both significantly associated with gender, age, and education (Breeze et al., 2004). Waldegrave and Cameron (2008) identify men as having more income and wealth than women with the younger-old having more income and wealth than older cohorts. As has been identified in other literature QoL is related to higher educational levels which are associated with greater income and wealth than less education. In the same research there was a significant association with marital status, with income being highest for those married or living in a partnership.

In a Danish study, low income was found to be correlated with poorer functional capability, poorer psychological well-being and lower physical activity among older people (Arendt, 2005). More retired women rented their accommodation than men. Breeze et al. (2004) identified that living independently and those who owned their own home had increased QoL. Inferentially the NZLSA (2007) identified that owning a home throughout most of one's adult life was associated with a better QoL.

3.2.6 Well-being and quality of life

Well-being and QoL are perhaps the most complex of constructs relevant to the lives of older people (Ziegler & Schwanen, 2011) because they are studied in disciplines as diverse as gerontology, economics, psychology, health studies, and sociology within the social gerontological literature. Ziegler and Schwanen (2011) build on this further discussing the amplification of the conceptual complexity of well-being by the use of the closely related term QoL. Gabriel and Bowling (2004) and Nettenet et al. (2002) suggest that QoL is multifaceted and based on combinations of domains affecting daily life, such as social supports, health and role in society, as well as the need for socio-economic security.

Fleuret and Atkinson (2007) identify clear distinctions between well-being and QoL while others tend to see them more or less interchangeably. In 1948, the WHO established a well-known definition of health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (p. 28). The inclusion of (social) well-being contained within this definition no doubt contributes to the on-going ability to easily define these constructs. Alongside this has been the development of many QoL measurement tools in quantitative research such as CASP 19 and SF 36. For the purposes of this research, the terms are seen as interchangeable as both concern the 'good life' emphasising healthy or successful ageing as more than the absence of disease, illness or impairment and what makes life worth living. For instance, having both positive relationships with others and a role in society have been identified as components and constituents of well-being and QoL (Bowling & Gabriel, 2007; Bryant, Corbett, & Kutner, 2001).

Older people identify common characteristics about what contributes to QoL and this view changes as individuals' mature and age. There are various measures of QoL including; life satisfaction, functional capacity, health, meaning of life, well-being, inner strength, self-acceptance and happiness to name a few. Sarvimaki and Stenbock-Hult (2000) suggest there are three aspects identified as contributing to QoL; a sense of well-being and meaning, a sense of value and a sense of self-worth. Well-being involves the inter-related components of mental, physical and social well-being (Majeed & Brown, 2006). They add that well-being is determined by the activities impacting on our everyday activities. From, Johansson and Athlin (2007) undertook qualitative research aimed at obtaining a deeper understanding of older peoples' own views about their health and well-being. Interviews were carried out on two occasions with 19 older people living in homes and in sheltered accommodation to identify the views of what contributed to well-being. Their results demonstrated that older people worked to balance their lives to maximise their life experiences which contributes to well-being.

In their meta-analysis Pinquart and Sorenesen (2000) reviewed gender differences in self-concept and psychological well-being reporting the quality of social relationships are positively correlated to well-being. They further describe that when a social network does not provide the older person with what they expect then the social relationship may

negatively impact on their well-being. Participants in community organisations usually share a common interest, and it infers that the continued involvement of people as they age allows for a greater sense of well-being and belonging. The encouragement of current participation as well as participation into and beyond their early 80s may help ensure their continued overall well-being, and integration in society.

There is contention over the extent to which QoL is maintained as people age. Bowling, Seetai, Morris and Ebrahim (2007) identify that over 80 per cent of over 65 year olds reported a good QoL. However, Netuveli, Wiggins, Hildon, Montgomery and Blanes' (2006) research suggests that QoL peaks at 68 years and progressively declines reaching the same as 50 year olds by the time the participants were 86 years. Bowling and Dieppe (2005) propose that older people themselves refer to health and functioning as integral elements of QoL and poorly perceived health is associated with lower QoL (Bowling et al., 2007). However, 62 per cent of participants reported a good QoL despite fairly severe or severe restrictions on their daily life. Along with other literature, they identify that despite physical decline older people remain satisfied with their life (Bowling et al., 2007; Stanford, 2006). This suggests older people expect and accept that physical decline is a part of ageing (Steverink, Westerhof, Bode, & Dittmann-Kohli, 2001).

Research has been undertaken on self-perception in ageing and what influence it has on well-being and health. In a prospective study by Levy and Myers (2004) individuals that had more positive self-perception of ageing, showed an increased likelihood of practising preventive health behaviours, such as eating a balanced diet, exercising, and following directions for taking prescribed medication. These preventative behaviours persisted over a 20 year follow-up. This finding is particularly important as it remained statistically significant after adjusting for age, education, race, and both functional health and self-rated health at baseline. Other prospective studies have demonstrated that positive self-perceptions of ageing are associated with increased longevity, improved functional health and better physical health (Wurm, Tesch-Romer, & Tomasik, 2007). Self-acceptance is critical for older people as they accept the "potential negative aspects of ageing" (Wurm, et al., 2007, p. 291). This is consistent with Reed (2008a) who conjectures that a "positive outlook contributes to well-being in spite of the losses and declines" (p. 66). Caprara, Caprara, and Steca (2003) discuss self-acceptance where there are no differences in self-acceptance

across the life span. Inferentially as people age they may be more accepting and comfortable with themselves; this finding is similar to the concept of inner strength proposed by Nygren, Norberg, and Lundman (2007).

Well-being not only changes over time but also varies with age. Westerhof et al. (2001) found that older people were equally or even more satisfied with their life than younger persons. The researchers attributed these similar outcomes across the ages to the tendency of people to move from specific judgements to general judgements as they grew older. Consequently, the increasing causes of dissatisfaction associated with ageing were compensated for by older people's increasing use of general criteria that are more likely to produce positive judgements. Overall well-being appeared to be closely associated with the older people's satisfaction with their economic standard of living, and this was further associated with income, wealth, subjective assessments of living standards, and housing tenure. The relationship between overall well-being and these indicators was less strong, with the exception of their assessment of adequate income.

3.2.7 RESILIENCE

Becoming one of the oldest-old is an achievement in itself and there is increasing consideration given to how this occurs. There are a variety of concepts that have been considered as to how older people achieve this which include; inner strength (Moloney, 1995), sense of coherence (Nesbitt & Heidrich, 2000); purpose in life (Sarvamäki, Stenbock, & Hult, 2000), self-transcendence and resilience (Wagnild & Young, 1990; Nygren, 2006; Staudinger & Fleeson, 1996).

Windle (2012) advocates 'resilience' is the new buzz word in relation to older people. The earliest work in considering this as a concept was undertaken with children and young people. As with other concepts and the lives of the oldest-old Windle (2012) reminds us that far less is known about resilience in later life but there is a need to have a greater understanding of it and how it affects all aspects of life. Despite being faced with prolonged and significant exposure to adversities, such as chronic illnesses, resilience is evident in the lives of older people. The notion of resilience as a personality characteristic can moderate the negative effects of stress and as a result promotes adaptation (Wagnild & Young, 1993). Wells (2012) concurs suggesting high levels of resilience may be a contributing factor to

helping older adults adjust to the hardships associated with ageing. Gatz, Kasl-Godley, and Karel (1996) suggest that whilst older people become more affected by physical ailments as they age their psychological resilience increases. They encourage the telling of stories (narratives) in order to share and learn how resiliency is part of ageing. Richardson, Neiger, Jensen, and Kumpfer (1990) developed a Resiliency model which suggests individuals who experience disruption to their lives when a stressor is encountered rely on internal protective factors, including self-reliance, as well as external protective factors such as social networks to restore balance in their lives. They describe this process as resilience reintegration. This model could lead to screening to determine the level of resilience in older people with the potential to develop ways in identifying older adults who may experience difficulties in adjusting to life stressors. Another potential is using this information in developing interventions to encourage and support individuals to adjust to hardships in a resilient manner.

In a range of Swedish studies involving more than 150 oldest-old who ranged in ages from 85-103 years, resilience was identified as a move from looking at individuals' weaknesses to looking at their strengths (von Heideken et al., 2006). Further to this they state that resilience can "moderate the negative effects of stress when meeting adversity and that resilience enables one to bounce back from adversity" (p.8). Resilience is further described as a driving force, affected by an individual's life circumstances. Greene (2002) adds that those who are resilient draw on other internal resources such as hope and external supports such as family who support them.

The Georgia Centenarian Study data was further examined for aspects of personality traits including resources for resiliency and maintaining autonomy (Poon et al., 2007). This research identified low levels of neuroticism as key personality characteristics of centenarians. As evidenced by studies such as Martin et al. (2006) and Givens et al. (2009) there has been a flurry of interest in studying centenarians with the results uncovering of higher levels of extroversion and conscientiousness relative to cultural and social norms. From this, it could be presumed extroverted individuals may obtain more social support and conscientious persons may take better care of daily tasks necessary to survive (Martin et al., 2006).

In a quantitative study of older people aged between 65 and 94 years, Wells (2009) identified rural community-dwelling older adults as having high levels of resilience. The sample size of 106 was small, with an overall return rate of 30 per cent and the majority of participants were as follows; female (54 per cent), married (63 per cent), and not employed (80 per cent). Wells (2009) suggested resilience levels did not appear to decrease with age, it may actually increase. Similar to findings in the other literature they uncovered a weak relationship between resilience and social networks and postulated this may be due in part to the belief that those who live rurally tend to be self-reliant. Within the Resilience Scale, self-reliance is a measure of resilience and those with high resilience levels demonstrated high levels of self-reliance. This study found perceived physical and mental health status was correlated with resilience, and this is well supported in the literature (Adams, Sanders, & Auth, 2004; Hardy, Concato, & Gill, 2004; Hinck, 2004; Wagnild, 2003). Wells (2009) identifies a weak correlation between resilience and physical health, indicating that declining health status may not reduce resilience levels. This is inconsistent with European studies reviewed where only one study, which included a sample of 125 Swedish adults age 85 years or older, did not find a relationship between physical health status and resilience (Nygren et al., 2005). For the future, Wells (2009) suggests research should include identifying recent losses or stressors experienced by participants. This would assist in ascertaining the potential effect of loss and stress on resilience levels; this may also assist in understanding the process of resilience.

A positive relationship between life satisfaction, morale and resilience was identified by Wagnild (2003). Other studies uncovered an inverse relationship between mental health disorders, such as depression, and resilience (Hardy et al., 2004; Wagnild & Young, 1990). Mehta et al. (2007) found that age influences the relationship of apathy, resilience, and disability with depression. Mental health status had the strongest association with resilience, and multiple studies support this relationship. However, they discerned that with increasing age, resilience seems to lose importance with regard to late life depression (Mehta et al., 2007). Research by Lee, Brown, Mitchell, and Schiraldi (2008) indicated that optimism and self-esteem were significant predictors of resilience in both Korean mothers and daughters who immigrated to the United States. Nygren and colleagues (2005) identified that mental health was correlated with resilience in women, but not men.

Lamond et al. (2008) realised that emotional health, self-rated cognitive function, optimism, days spent with family and friends, and self-rated successful ageing were most likely to predict resilience levels in a sample of community-dwelling older women. Many qualitative studies of older adults found relationships between positive attitudes, such as optimism, and fewer feelings of depression, and well-being (Easley & Schaller, 2003; Hinck, 2004; Wagnild & Young, 1990). In Stanford's (2006) study of 13 women aged 75-91 years there was an exploration using multiple interviews of how they thrived in community. In this study six patterns of resilience were identified; (1) vital involvement and service, (2) desire to learn, (3) appreciation of basic life components such as family, friends, health, home, and financial security, (4) valuing honesty and responsibility, (5) positive attitude, and (6) reliance on faith. It is of interest that this study demonstrated older women who live alone were relatively happy and independence surpassed the negative aspect of dealing with loneliness.

Wagnild (2009) compared income and resilience in three different samples and observed lower income was associated with lower resilience in two samples, but not the third. Hardy and colleagues (2004) identified associations between higher incomes and higher resilience levels. Resilience has been studied in community-dwelling older adults and strong physical and mental health, as well as strong social networks are associated with higher resilience levels. There were no studies accessed that addressed differences in resilience levels among those living in rural, suburban, or urban locations. Additionally, studies have not addressed whether the relationship of resilience and protective factors, specifically the level of physical and mental health, strength of social networks, and socio-demographic factors, vary according to location.

3.2.8 FUNCTIONAL IMPAIRMENT AND TRANSPORTATION FOR OLDEST-OLD

Independence in activities of daily living are major contributors to older peoples' ability to live in their own home. Activities of Daily Living (ADLs) include the basic activities of bathing, dressing, using the toilet and eating. Further to this there are Instrumental Activities of Daily Living (IADLs) that are those necessary for independent living - these are; shopping, food preparation, housekeeping, transportation and handling finances.

Davey (2004) undertook a study of how older New Zealanders cope without their own transport. In this study food shopping was highlighted as one of the various activities where people required transport. Griffith (2003) opines that for older people, shopping is more than just gathering food and that shopping practices change over time. Adding that the way shopping is undertaken by older people is a reflection of their life and experience. Shopping may be about other things such as a means of addressing social isolation. Whilst respondents reported they were able to access transport from other people they reported feeling that their request may have been an imposition. The ability for older people to use public transport was a limited option and whilst taxis were an option, they were expensive.

Other things contributing to independence include capability and dependence. In their 2012 study Jagger et al. (2012) aimed to estimate capability and dependency in a cohort of 85 year olds and to project future demand for care. They undertook structured interviews at age 85 with 841 people born in 1921 who lived in Newcastle and North Tyneside, United Kingdom, 62 per cent were women, 77 per cent lived in standard housing, 13 per cent in sheltered housing and 10 per cent in a care home. They measured capability of the older adults by self-reported ADL, Timed Up and Go test (TUG), Standardised Mini-Mental State Examination (SMMSE), and assessment of urinary continence in order to classify interval-need dependency. Overall, 20 per cent of participants reported no difficulty with any of the elements. Notably men were both more capable in performing ADLs and more independent than women which highlights the diversity of capability and levels of dependency in this cohort.

3.2.9 SPIRITUALITY

Contemplating the meaning of spirituality for older people and the potential for it to influence a person's ability to be able to live at home is yet another complex construct, as it means different things to different people. Spirituality is related to well-being, QoL life, health and the oldest-old. It may include a search for; one's ultimate beliefs and values; a sense of meaning and purpose in life; a sense of connectedness; identity and awareness; and for some people, religion (Egan et al., 2011). Pargament (2007) describes spirituality as to do with the thoughts, feelings, and behaviours experienced through a person's search for the sacred.

Sinnott (2009) contends spirituality is vital to understanding the meaning making process for older people suggesting it provides a framework to experience our self in the larger context - this is of increasing importance as people live longer. McFadden (2005) quantifies this by saying these aspects are important for some but not all. Given this and the changing experience of what it means to be old in today's society requires researchers and practitioners to continue to engage in discussions about meaning and purpose in later life (Butler, 2009).

There are earlier studies linking higher religious attendance and increased longevity. Helm, Hays, Flint, Koenig, and Blazer, (2000) examined the relationship between survival and private religious activity by using a probability sample of elderly community-dwelling adults in North Carolina, United States of America. The level of participation in private religious activities such as prayer, meditation, or Bible study was assessed by self-report at baseline, along with a wide variety of socio-demographic and health variables. The results were that older adults who participate in private religious activity before the onset of ADL impairment appeared to have a survival advantage over those who do not.

In a study exploring the protective effects of attachment security researchers found older adults have had longer to develop a consolidated sense of spiritual meaning, purpose and faith (Dalby, 2006; Wink & Dillon, 2008). The findings indicated that spiritual well-being and attachment security mediate an inverse relationship between age and depression. These results support the view that ageing is associated with increasing vulnerabilities and pathologies but also with the development of new, adaptive capacities (Lo et al., 2010). Despite what may be thought by the wider community, older individuals tend to under-estimate both their ability to adapt and their needs for support. Wink and Dillon (2008) suggest older people are more likely to respond to negative life events with a growth in their spirituality. Despite suggesting older people experience less distress than younger people, it does not infer older people require less psychosocial care (Bouchard, Beliaeff, Dionne, & Brochu, 2007).

3.2.10 NUTRITION AND THE OLDEST-OLD

It may appear obvious that nutritional well-being is essential to living well (Wham, Carr, & Heller, 2011a). Wahlquist and Savage (2000) note living alone/independently decreases the

level of the social participation involved with food and may affect the quality of food that older people eat. The role of food and meals is not just about intake of energy and nutrients, Sydner and Fjellstrom (2005) state eating is a social occasion thus potentially adding other important aspects to people's lives. Amarantos, Martinez, and Dwyer (2001) suggest meals provide a sense of order and structure to the day and as a result provide a feeling of independence and "mastery over the environment" (p. 55). The ability to be able to provide and produce food is an integral part of being able to stay at home.

In a small NZ study of 108 community living 80-85 year olds Wham, Teh, Robinson, and Kerse (2011b) evaluated the nutritional status of the participants and identified key health social factors which could potentially put their health at risk. The screening tool used in this study focussed on eating alone and confirmed that there are numbers of older people living alone and therefore eating alone. Despite the small sample size this study endorsed results from other research; that eating with another person(s) increases the amount and variety of food eaten (de Castro & Stroebele, 2002). Other things such as bereavement also impact on nutrition and associated weight loss with a greater loss experienced by widows. It is evident that transport issues, lack of support to shop and assistance in making choices, can lead to food inadequacy for older people (Locher, Robinson, Roth, Ritchie, & Burgio, 2005; Sidenvall, Nyadahl, & Fjelstrom, 2002).

Whilst there are various factors including the ability to shop and cook affecting what is eaten, it is the non-physiological factors; psychological depression and cognition that have a greater impact on nutrition and social factors. Notably weight loss is not a natural consequence of ageing however, by the time people become the oldest-old weight loss is usually evident. Hickson (2006) states that food intake declines with age which in itself is a potential cause of weight loss. This corresponding decline in energy intake is directly related to decreased energy expenditure. Malnutrition exists at any age however, it is known to be more prevalent in the oldest-old where Margetts et al. (2003) identify 14 per cent of community dwelling people over the age of 65 years were at a medium to high risk of malnutrition. This is significantly less than the 33 per cent of older people that Wham et al. (2011b) identify as malnourished in their New Zealand study. Possible reasons for the differences in research results are the different screening tools used in the data collection processes.

3.2.11 Multimorbidity, Geriatric syndromes and the oldest-old

In a qualitative study, utilising critical gerontology it may appear antithetical to include a discussion of what may be considered biomedical matters of multimorbidity and geriatric syndromes. However, these are the issues that contribute to older people losing independence and moving to residential home or hospital. QoL improvements for older adults require addressing geriatric syndromes in addition to managing chronic disease.

Geriatric conditions or syndromes are similar in prevalence to chronic diseases amongst older adults and include conditions such as; functional and cognitive impairment, frailty, depression, hearing impairment, visual impairment, and urinary incontinence (Chen, Yen, Wang, Dai, & Huang, 2011). In some cases, particularly when more than one condition is apparent, they are strongly associated with disability. These things impact negatively on the ability of the oldest-old to live at home without significant support. From the literature, it can be inferred that although not a target of current models of health care, these are central to the health and function of older adults and should be addressed in their overall care. Many older adults with geriatric conditions live in the general community and are not under the primary care of geriatric specialists. In order to meet the increasingly complex needs and numbers of older people what is currently the traditional medical model should move from a disease-centred perspective to a functioning-centred view (Landi et al., 2010). The development and utilisation of different models of care such as nurse led guided care is an example of a functioning centred view (Boult et al., 2009). This is where identification and assessment of these clinically important geriatric conditions such as visual impairment, managed cognitive impairment, falls, incontinence, hearing impairment, low body mass index (BMI) can be prevented or at least delayed with resulting improvement in symptoms, decrease in disability and an improvement of QoL. This results in supporting those with these conditions in living at home. The geriatric conditions named above are significant contributors to moving into long term care.

In considering older people particularly the oldest-old, terms such as multimorbidity and frailty are used. Multimorbidity is defined as any co-occurrence of diseases in the same person indicating a shift of interest from a given index condition to individuals who suffer from multiple diseases (Batstra, Bos, & Neeleman, 2002). Fried et al. (2005) defines frailty as having three or more of the following traits – shrinking (in size-height), weakness, poor

endurance or exhaustion, slowness and low activity levels. Further to this, they add that having one or two of these characteristics identifies a person as 'pre-frail'. In research by Woods et al. (2005) women between 65-79 were identified as frail by having risk factors of; being old, living with a chronic disease, smoking and depressive symptoms. Fried et al. (2004) concluded those with multimorbidity, disability as well as frailty identified a vulnerable subset of the older population. Yancik et al. (2007) propose that diseases, signs and symptoms displayed may be the interface between basic pathophysiological processes, such as inflammation with the possible final health outcome being functional disability. Prevalence of multimorbidity increases in very old persons as well as younger women and those from lower social classes (Mangeroni et al., 2011). As well as this older men seemed to have less likelihood of experiencing multimorbidity, this apparent good health of the oldest-old men are confirmed in other studies.

Cigolle, Langa, Kabeto, Tian and Blaum (2007) completed a cross sectional analysis of American adults, 65-92 years to investigate the prevalence of geriatric conditions and their association with dependency in ADLS by using nationally representative data. They found in adults 65[+], 49.9 per cent had one or more geriatric conditions. Some conditions were as prevalent as common chronic diseases, such as heart disease and diabetes. Significantly, the association between geriatric conditions and dependency in activities of daily living was strong even after adjustment for demographic characteristics and chronic diseases. There were limitations in this work as it was cross-sectional and based on self-reported data where other common aspects of old age; delirium and frailty were not able to be assessed. In their systematic review, Marengoni et al. (2011) summarised 20 years of research regarding the occurrence, causes and consequences of multimorbidity in older people. They identified in the various study participants a range from 55 to 98 per cent of those who experienced multimorbidity which had a significant effect on disability, QoL and health care utilisation.

Little is known about risk factors for multimorbidity but they include genetic background, biological causes, life styles, or environmental factors. Gijsen et al. (2001) noted few studies had investigated how diseases are distributed or co-occur in the same individual, and that most utilised different approaches to address this research They were unable to identify data that provided a scientific basis for evidence-based care of patients that has affected functional impairment, poor QoL and health care utilisation. However, Baltes and colleagues

(1999), studying those between 70 and 100 years in a Berlin population, reported multi dysfunctionality and multimorbidity to be five times higher in the oldest-old (Baltes & Mayer, 2001). Baltes and Smith (2003) conclude that oldest-old persons are more fragile, with a lower level of functioning, and suffer from depression and dementia more often than the younger-old do.

Much of the current literature demonstrates older people in many countries are more independent than previous generations. This reflects the shifting of the burden of chronic illness and disability to later chronological ages, – described as the compression of morbidity. Christensen, McGue, Petersen, Jeune, and Vaupel (2008) suggest this provides an improved outlook for those 85[+] and challenges the idea and perceived threat to the rest of society, inferring that increased longevity and life expectancy should not always be treated with alarm.

3.2.11.2 INCONTINENCE

Tseng, Chen, Chen, Kou and Tseng (2000) identify that urinary (UI) and faecal (FI) incontinence are common, distressing, and often disabling conditions in the elderly, they are significant factors contributing to people moving to institutionalised care. In their Taiwanese study they randomly sampled and surveyed 504 subjects aged 65 and older in face-to-face interviews. They found about 22 per cent of respondents reported that they had experienced involuntary loss of urine Tseng et al. (2000) and also reported that women, people who were overweight, and those aged 70 years or older were at higher risk of UI. Women were more likely to suffer from stress incontinence while men were at higher risk of urge incontinence. As is evident in other geriatric conditions, those most at risk are women and those with low education as well as those perceived UI as a normal part of the ageing process.

3.2.11.3 VISUAL IMPAIRMENT

Having an understanding that their age-related peers are all experiencing diminished activity and independence may help other older people to adjust their expectations of themselves and of rehabilitation, which may enhance their self-esteem, satisfaction and rehabilitation. The findings of this study support the findings of Levasseur, Desrosiers, and St.-Cyr Tribble (2008) that age might be considered as an important contributor to the decrease in activity,

just as visual impairment is. In 2008 a NZ study of 560 community dwelling older adults aged between 65-100 years was undertaken with people who were visually impaired or sighted and placed into two groups (Good, La Grow, & Alpass, 2008). The groups underwent analysis as to whether they experienced different levels of activity, independence, and life satisfaction. The degree to which activity and independence contribute to the prediction of life satisfaction independence and frequency of activity were found to be lower for the older age cohorts and those with visual impairments.

Although essential for survival, adaptive independent living skills do not appear to have a great influence on life satisfaction. Good, La Grow, and Alpass (2008) established that satisfaction with life was rated as lower overall for the visually impaired. The unusual finding was the oldest age cohort with visual impairments had a higher score on life satisfaction than did the younger age cohorts. This may be the result of resilience, accumulated flexibility and skills for coping. In other studies of the 85[+] the functionally impaired group performed more like those with sight. It may be that the oldest group with visual impairments have compared themselves positively in terms of daily functioning with others and this may have explained their higher levels of life satisfaction. Having sight, being more independent, and active were the three factors that were uncovered as being significant predictors of higher life satisfaction. Although each factor made a significant and unique contribution to life satisfaction, more than 93 per cent of the variance in overall life satisfaction remained unexplained. It is clear that activity and independence, although frequently emphasised in rehabilitation programs for those who are blind or have low vision, may not be key to improving or maintaining life satisfaction.

3.2.11.4   DUAL SENSORY IMPAIRMENT (DSI)

For those who experience either hearing or visual impairments the capacity to extract information from the environment can isolate people, jeopardise independence and influence well-being (Heine & Browning, 2002). Therefore, those who experience a dual sensory impairment (DSI) show greater risk of negative outcomes such as depression, morbidity, and functional limitations (Campbell, Crews, Moriarty, Zack, & Blackman, 1999; Capella and McDonnall, 2005; Crews & Campbell, 2004). Visual impairment limits independence, increases use of care services, reduces QoL, and increases risk of death (Chia

et al., 2006; Tay et al., 2007). Age-related hearing loss is more frequent and a burden of disability (Begg, Vos, Barker, Stanley, & Lopez 2008; Chia et al., 2007) as it impairs QoL, relationships and increases reliance on community and informal supports (Schneider et al., 2010).

Individuals with combined hearing and vision loss, termed dual sensory impairment (DSI), are thought to experience more than the sum of each impairment alone (Chia et al., 2006; Saunders & Echt, 2007). Prevalence of DSI in population-based samples was recorded between 1.6 per cent to 22.5 per cent (Brennan, Su, & Horowitz, 2006). Quantitative research (Campbell et al., 1999; Crews & Campbell, 2004) supported the proposition DSI leads to reduced social participation. In Crews and Campbells' (2004) United States study of 9 447 participants aged 70[+] years, used self-report methods and noted those with DSI were least likely to get together with friends, go out to restaurants, attend church or go to movies, followed by those with a visual impairment, hearing impairment or no sensory impairment. Approximately one in three persons with DSI desired more social activity, compared to one in five of their non-sensory impaired peers (Crews & Campbell, 2004). Self-reported depressive symptoms occurred more often among older people with DSI compared to their non–sensory-impaired peers (Capella & McDonnall, 2005; Harada et al., 2008). Studies that utilised self-reported impairment (Capella & McDonnall, 2005; Chou, 2008) and those using functional or objective measures of hearing (Crews & Campbell, 2004) showed that both dual and single sensory impairments increased the likelihood of difficulty in ADL. These include walking, getting around outside, getting in and out of a bed or chair and instrumental activities of daily living IADL; preparing meals and managing medications.

In their systematic review, Schneider et al. (2011) concluded that even though it might be expected that those with DSI have more negative impacts over and above single sensory impairment; the research results are mixed and evidence remains inconclusive. Studies frequently demonstrate that vision loss dominated the negative effects of DSI, with concurrent hearing loss not significantly increasing effects from vision loss alone (Capella & McDonnall, 2005; Chou, 2008). Thus, the impact of DSI on the lives of older people appears to stem largely from the negative effects of vision loss and fits an additive model of understanding DSI - vision plus hearing effects.

3.2.11.5   MENTAL HEALTH AND DEPRESSION

Dong, Wilson, de Leon and Evans (2009) confirm that cognitive function is one of the corner stones of geriatric medicine with both morbidity and mortality associated with lower levels of cognition. Depression and early dementia appear to be closely linked (Alexopoulos et al., 2002, Stek et al., 2006). It has been demonstrated that cognitive impairment as a baseline can predict an accelerated increase of depressive symptoms in the oldest-old, whereas depression at baseline was not related to increased cognitive decline (Vinkers et al., 2004). It is therefore evident that cognitive impairment preceded depression but depression itself does not proclaim cognitive decline. It is anticipated that cognitive impairment or early-stage dementia may play a significant role in the high incidence of depression as well as the on-going nature of it with the oldest-old. To date the underlying mechanisms of this remain unresolved.

Cognitive function has a significant impact on the ability to stay living at home with safety a further critical aspect for the oldest-old. This is not just the physical safety of the environment but is frequently related to the concept of self-neglect. Dong et al. (2009) undertook a longitudinal study of 7 604 participants with a mean age of 78.5 years; most of whom were women and black. There is no standard definition of self-neglect however, the general consensus is centred about the potential of harm resulting from self-neglect, most likely to be the result of inadequate food, water clothing, shelter, personal hygiene and safety. Those included in the study were referred by social agencies; this was a potential limitation for the study and may be the reason that most participants were black. The results of this study identified that lower cognitive functioning contributes to self-neglect however, further research is required to more fully identify and explain why in contrast to other research there is only a weak link between self-neglect severity and changes in cognitive function. A limitation in many studies of the oldest-old is their focus on a single aspect of competence, such as driving or medication management. Competency assessments are crucial for timely interventions and safe discharge planning for patients with cognitive impairment. In their research, Law, Barnett, Yau, and Gray (2012) identified five available instruments for evaluating everyday problem-solving or everyday competence in a variety of levels of cognitive ability. Most of the instruments identified utilise hypothetical scenarios/problems. The limitations of the review by Law et al. (2012)

demonstrates the need for further research in this area, especially for those with moderate to severe cognitive impairment.

Cognitive impairment contributes to increased hospital use which in turn is related to institutionalisation of the oldest-old (Ferri et al., 2005). In their systematic review, Law et al. (2012) identified the different instruments available for evaluating everyday problem-solving/competence of elderly people with cognitive impairment. The research was undertaken from 1995-2001 and was in a community setting with an established inclusion criteria. Research such as this is important as the traditional psychometric measures of cognitive abilities may not adequately reflect older adults' functioning in a real everyday context. Functional assessments only inform about potential problems in specific functional areas. In undertaking such assessments, it may be necessary to utilise tools whereby older people are able to apply the experience and knowledge they have accumulated over their lifetimes. The need to accurately establish cognitive impairment is essential for individuals, their families and the wider community. Having accurate and useful assessments with improved accuracy in determining the support that people require is essential and is a matter of concern for the public, health professionals and policy makers alike.

A strong tendency for chronic depression has been reported in the young-old (Beekman et al., 2002; Blazer, 2003) and there is a potentially misguided assumption this could be extrapolated to the oldest-old. Djernes (2006) identifies various factors associated with depression; widowhood – particularly for men, cognitive impairment, chronic illness and a lack of close social contacts. Margrett et al. (2010) suggest that 20 per cent of older people experience depression. They add that older people's mental health concerns often present with physical illnesses and therefore may go untreated. Notwithstanding the current lack of knowledge about the origins of depression in the oldest-old, it occurs frequently in the oldest-old and has a poor prognosis. In Canada, the reported prevalence of major depression is 9.5 per cent for seniors with dementia; this is somewhat higher than the average prevalence of late-life depression (Government of Canada, 2006). The clinical features of dementia appear to overlap with the clinical features of depression, these include; apathetic mood, problems with concentration, and anhedonia. Moreover, self-reports of depressive symptoms are unreliable for measuring depression in dementia patients because cognitive impairments in concentration, communication abilities, and

personal insight can distort self-reporting. The Canadian Study of Health and Aging, (1991) is a longitudinal, population-based epidemiological survey that consists of a national sample of 10,263 Canadians aged 65 and older residing in communities and institutions (Wu, Schimmele, & Chappell, 2011). Using prospective data, their main objective was to examine whether age has an independent effect on depression or is a proxy for other risk factors of depression, such as declines in physical health. The study offers several key conclusions about the relationship between age and late-life depression. These included demonstrating the importance of medical comorbidity for the well-being of older people and that an age-related increase of depression symptoms occurs entirely through medical illness, such as dementia, chronic conditions, and functional limitations. Once these risk factors are controlled, the relationship between age and depressive symptoms attenuates to non-significance.

As depression often occurs in the context of multimorbidity, it is necessary to realise that the symptoms of some medical illnesses may mimic depressive symptoms (Alexopoulos et. al., 2002; Schieman & Plickert, 2007) which may lead to such things as mis-diagnosis. Findings from Patten, Williams, Lavorato, and Eliasziw (2009) demonstrate that major depression decreases from age 65 to age 79 however, for those over 80 years it begins to increase, suggesting that old age has two discrete phases (Rothermund & Brandstädter, 2003). Stek et al. (2006) found that the recognition of depression by general practitioners was poor and anti-depressive treatment virtually non-existent. Baltes and Smith (2003) suggest there may be different characteristics for assessment of depression between the young-old and the oldest-old. This may mean that the measures of depression and cognition developed for younger individuals may not be the same when assessing functioning in older groups. The diagnostic items for major depression tend to be endorsed differently between younger and older age groups (Balsis & Cully, 2008). Margrett et al.'s (2010) research emphasises the need for researchers and wider society to ensure that the different ages in older adulthood are considered when treating older adults. For example, we should remember there are differences between 80 and 100 year olds just as there would be 20 and 40 year olds.

The variation in numbers of those who are believed to experience depression takes into consideration the different situations older people find themselves in. It confirms this age

group of people experience life in diverse situations. Writers such as Boyd, McKiernan, and Waller (2000) suggest cognition is frequently a key component in explanatory models of depression, with several studies pointing to a link between cognitive skills, problem-solving ability and mental health in later life. Diminished executive functioning, may particularly contribute to depression in older people and its treatment (Alexopoulos et al., 2002). The relationship between cognition and mental health includes normative cognitive functioning and extends to non-normative cognitive functioning. For instance, a study by Lee, Potter, Wagner, Welsh-Bohmer and Steffens (2007) demonstrated a concomitant relationship between mild cognitive impairment and increased depressive symptoms in a sample of older adults. Anstey, von Sanden, Sargent-Cox, and Usacz (2007) has found evidence between later life mental health illness and indicators of access to services and functioning, such as ethnicity, residential status, ability to perform activities of daily living, and subjective health.

In Formiga et al.'s (2010) three year longitudinal study of 186 Spanish people aged 89^{+} years, 74 per cent lived in their own home. All participants underwent a full assessment of their functional capability. Results uncovered over the three years that there was a decline in functional ability with a substantial amount evident in the first year. However, a significant group maintained a good baseline level of function. Formiga et al. (2010) found despite an acceptable functional status at baseline that new disability appears in a high percentage of nonagenarians. They concluded by saying that research in this area demonstrates that previous functional decline and cognitive impairment in older people is generally related to subsequent functional decline.

There is an increasing understanding of the relationship between physical and mental health and the contribution of both to longevity. Depression is a contingent aspect in the health of older people with poor daily functioning and institutionalisation being strong predictors in the oldest-old. Findings between increased age and decreased satisfaction and worries with life have been previously reported among the oldest-old (Jeon, Dunkle, & Roberts, 2006). Therefore, it is necessary to consider the impact of late-life depression in the lives of the oldest-old.

3.2.12 MOBILITY AND FALLS

The maintenance of mobility is thought to be fundamental to the concept of active ageing, allowing older adults to continue to lead dynamic and independent lives (World Health Organization, 2007). Ziegler and Schwanen (2011) propose that within gerontological literature mobility is identified as the capacity to move or as the actual or potential movement through physical space. Barrett, Hale. and Gould, (2012) and Webber, Porter, and Menec, (2010) suggest that mobility of the older population is considered an essential component of their independent and autonomous life. Other mobility issues such as a walking disability affects autonomy and well-being of older people. The results of the SIZE project ("Life Quality of Senior Citizens in Relation to Mobility Conditions" Groenvall et al., 2006) showed older people ranked the social problems of mobility as most important to them. Mobility is often compromised by a variety of things including limited cognition or the result of a fall. The likelihood of falling is affected by a variety of health measures including the ability to walk, or not, and the likelihood of having impaired balance.

In the Leiden 85-plus study assessments of walking disability were undertaken. As part of this research other common chronic conditions and general impairments were investigated as determinants of walking disability. In the oldest-old general impairments such as dizziness, depressive symptoms and cognitive impairment and not chronic conditions were more highly associated with walking disability. Arthritis, which could be considered as a high risk factor for walking disability in the oldest-old had only a mild effect on it. This may not be the same for the younger older people and indeed this further reinforces the heterogeneity of this population and the need for all practitioners involved in the care and support of all older people to look carefully at wider general impairments not just at the obvious chronic condition.

Whilst it is tempting to fit in with the pervasive medical model of decline and decrepitude for the oldest-old there is research being undertaken that challenging this. In a six month trial with 259 cognitively intact and physically well Berlin women between the ages of 70 and 93 years, Klusmann et al. (2010) demonstrates the beneficial impacts of both cognitive and physical activity on older people. The results were phenomenal, demonstrating that using either stimulating physical or mental activities the naturalistic, episodic memory function increased and both episodic and working memory were maintained. Whether there

would be an additive impact if the women underwent both physical and cognitive training will be the subject for future research. This study demonstrates the need to undertake neuro-protective activities when well rather than waiting until memory deficits occur when the improvements may be more modest as evidenced in other studies (Lautenschlager et al., 2006).

3.3 CONCLUSION

The purpose of this chapter is to provide a review of the literature associated with older people and how that may affect their ability to live independently. It is important to note that researchers discourage assumptions that findings can be generalised across geographic populations. As such the increasing amount of NZ research will better inform local policy and service development. Within the international literature it is evident that there is an international desire to identify the multiple issues that confront the ageing population and it is encouraging to see an increasing number of mixed method studies adding depth and richness to the information collected.

Given that the group of older people involved in this research were part of the oldest-old, over 95 years, being able to access research that is specific to this group is challenging as the time when society defines old age covers some 40^{+} years. In this search it is evident in earlier research that the oldest-old have not been an easily accessible population. Utilisation of narrow band cohort studies challenge earlier assumptions which presumed research findings from younger age groups could be extrapolated to the oldest-old. This supports the heterogeneity of old age. The notion of positive ageing and the associated strategies to promote older people in our society are community initiatives that are not just about older people but also about all of society. However, central to meeting the needs of this diverse group is the need for their individual voices to be heard.

4.   RESEARCH DESIGN

4.0   INTRODUCTION

The intent of this thesis is to explore the life and experiences of a group of the oldest-old and elevates their voices as they tell their story of living at home, independently after 95 years. The experiences shared are personal and unique and as such it is the intention of the researcher to give as much life and voice to these narrators. In order to ensure this takes place a clear explication of the methodologies that have been used is imperative. This is a qualitative piece of research informed by both narrative and critical gerontology. This chapter provides an overview of both narrative and critical gerontology, as well as the choice of methods used to gather and analyse the data collected.

The question is – what is it people over the age of over 95 years believe has contributed to them being able to live independently in their own home? The four associated aims are;

1. To increase an understanding of what contributes to people over 95 years of age staying in their own home
2. To enable the narratives of people over 95 years to be heard
3. To unsettle what is currently known about ageing and ageing in place
4. To influence the provision of appropriate support services that enable people over 95 years to continue to age in place/stay at home

4.1   METHODOLOGY

4.1.1   QUALITATIVE RESEARCH

In order to answer the question posed and address the associated aims it was identified that a qualitative approach be utilised. The research question resulted from identifying a gap in the literature as there is little written both nationally and internationally about what the oldest-old say about living independently after 95 years. It also arose from my own desire to gain a deeper understanding of the oldest-old which as Reed (2008b) states have had little research and information written about them.

Tolich and Davidson (1999) state that qualitative research provides the opportunity to look at a small group in great depth and Minichello et al. (2004), add that the ultimate goal of research is to understand the process, the event or situation in-detail. Further to this

Winchester (2000) adds that qualitative methodologies are "concerned with elucidating human environments and human experiences within a variety of conceptual frameworks" (p. 3-4). Creswell, (2009) suggests that methodology is a strategy used to guide a set of procedures.

4.1.2 NARRATIVE

Fundamental to using the narrative approach is to recognise how identity is formed and how it is created from experiencing life events, composing and telling a narrative/story of these (Bishop & Shepherd, 2011). They suggest that a narrative is a personal myth, which is both situated in the person's own time and space. Hsu and McCormack (2010) add that it "provides an option to explore personal experiences beyond the boundary of a questionnaire" (p. 249). Verifying the facts is less important than understanding their meaning both for individuals and groups add Denzin and Lincoln (2005). Cohen, Greene, Lee, Gonzalez and Evans (2006) confirm that story telling is an integral part of older age. The terms storytelling and narrative are frequently used interchangeably with Overcash (2004) identifying these as being proximal to nursing and a process nurses use in their daily work. Writers such Kenyon, Clark, and De Vries (2001) and Cohen et al. (2006) support this by suggesting narrative (storytelling) is indeed the basis of the health care provision.

A narrative approach was deemed efficacious for a number of other reasons. It provides the opportunity to hear and explore the lives of the oldest-old and to hear what has contributed to their lives both past and present. In addition, it can provide answers to the specific research question about what has enabled them to live independently in their own home. Narratives also provide an opportunity to tell a different story, one that will challenge the traditional western discourse of ageing, which Gullette (2004) describes as the narrative of decline. Further to this there is the opportunity to elucidate issues that were previously hidden and "furnishes us with a framework to get at the inside of aging" (Randall 2001, p. 54). It was with these considerations at the forefront that this research was undertaken.

Randall (2001) identifies the principal strength of narrative as it "opens the inside of life for official consideration but it can provide a common and comparatively non-technical vocabulary with which to forge connections, theoretical and practical, between the various fields that address themselves to ageing" (p.5). Frank (2010) describes narratives as acts of

telling and it is this telling that assists individuals in making sense of their experiences. Through this process both the story teller and the researcher learn and understand the story. Bishop and Glynn (2003) describe this as the researcher being the junior partner where both learn and understand the research process. Ruth and Kenyon (1996) describe narratives as an opportunity to see the similarities in ageing as well as the differences. They further suggest narratives allow the opportunity to see variation occurring over a person's life and in life's wider context; political, social and cultural. A narrative approach is therefore central in enabling a greater understanding of the various aspects, both personal and social aspects of ageing and as such can assist in interpreting how life and ageing occur.

The use of a narrative methodology ensures the participant's own voice is heard and that the analysis can use the participant's voice to ensure that their story is as they told it. As with all methods and processes, there are both advantages and disadvantages. In qualitative research, there is the possibility that the researcher, researched and the reader become clouded by their personal frames of reference (Derrida, 1972). There are a variety of other methods and frameworks that could have been used to address this thesis' question, aims and objectives. If a survey had been used then the response rates as suggested by Leahy, Thurber, and Calvert (2005) would be possibly quite low. However, in order to access this particular population as Overcash (2004) describes the advantage of qualitative research as giving it the additional dimension. Neville, Keeling, and Milligan (2005) state that quantitative approaches minimise the opportunity for the interpretation that qualitative research promotes. They further add that:

> (N)arrative approach elucidates the participants' social networks and provides the opportunity to gain further insight into the ways that older people in later life not only negotiate, but also limit and adapt relationships in a particular way with family (or those considered in the same role).

> (Neville, Keeling, & Milligan, p. 16, 2005)

Neville, Keeling and Milligan (2005) posit that the voice of older people participating in research is different from the health professionals writing gerontological literature. The narrators focus on what is possible whereas the health professionals identify deficiencies. Therefore, utilising the narrative aspect of qualitative research in this project ensures that the story told is situated both in the culture and context of the story-telling. Narrative is

clarified as examining how the story is told by considering a number of elements. These include positioning of the; actor/story-teller, endpoints, supporting case, sequencing and the tension created by the revealing some events in preference to others (Minichello et al. 2004; Riley & Hawe, 2005). Thus, by taking the opportunity to conduct the interviews in the narrators' own home ensured that the primary question of living at home was at the forefront allowing the opportunity to gain a deeper understanding. Being able to see the reality of their lives was instrumental in the development as well as the consideration of the themes that are presented in Chapter Six.

The narratives presented in Chapter 5 will both contribute to the body of knowledge as well as assist shaping the organisation I work for and its' behaviour towards the oldest-old. Kvale and Brinkmann (2008) encourage flexibility of the interviewers and remind them to accept ambiguity, noting that this is a reality of life and despite a natural desire to force clarity on particular aspects, it is important not to do so. The nature of narrative is to involve the interviewee in an almost co-researcher role (Bishop & Glynn, 2003). This challenged me as the interviewer; many of the participants did not wish any involvement beyond the interview most only wishing to see an abridged version of transcripts. This is a particular challenge in working with this population as Jagger et al. (2011) purport it is related to the advanced age of the interviewees.

4.1.3 Critical Gerontology

Critical gerontology has evolved from social gerontology and draws from a variety of approaches including critical and feminist theories. Perhaps the clearest definition is from Cole, Achenbaum, Jacobi, and Kastenbaum (1992). They opine critical gerontology challenges the assumptions underlying all the theories and methods of inquiring related to the ageing experience. This in turn calls attention to the gaps and biases in existing research and this is the business of critical gerontology. Overbo and Minkler (1993) further develop this by stating it not only considers how all the forces that influence ageing for example political, socioeconomic and other related factors, inter-connect but also how these factors "influence the field of gerontology itself " (p. 289).

Minkler (1996) identifies two major aspects within critical gerontology. In one, she confirms Estes (1979) earlier thoughts that the experience of ageing is dependent on how

others/society react to ageing and suggests this is frequently negative. This means that within a group there are differences in relation to the ageing experience. These may include cultural and perhaps even gender differences. The other aspect Minkler (1996) focuses on is the opportunity to look at the meaning of the lives of older people with a critical gerontological lens which provides alternative ways of thinking about how older people live and experience life.

More recent writers, such as Rozanova (2010) confirm Minkler and Estes (1999) earlier thoughts by stating critical gerontology questions the manner in which old age is constructed, seeing it as influenced by society, medicine, politics and the economy. Rozanova (2010) proposes that in western society it appears that the idealisation of good age, is not ageing at all, with many/most media representations of ageing explicated negatively. Further to this she suggests ageing occurs on a continuum and as such is neither successful nor unsuccessful. Subsequently critical gerontology questions the conditions of ageing at both a micro and macro-level. King and Calasanti (2006) add that critical gerontology fundamentally rejects the idea that old age is a social burden and opposes ageism which itself stigmatises the dependency of old age as burdensome. It is evident given the issues covered that the thinking and associated research regarding critical gerontology occurs predominantly in western nations. This thesis and listening to the voices of the older people who were interviewed will contribute to generate a positive view of ageing which emphasises both strength and diversity (Bengston, Burgess , & Parrott 1997).

The combination of a narrative approach with a critical gerontological perspective challenges the traditional western biomedical approach as to the way society defines age and ageing. Reed and Clarke (1999) posit that there is an emerging view of a lay construction of ageing and this may not be consistent with that of health professionals. This view concurs with the critical gerontological view point that the development of meaningful services and strategies for the oldest-old need to be based on what older people themselves have identified. This is consistent with the purpose of this study and as King and Calasanti (2006) suggest critical gerontology assists professionals to not only listen but also to engage with old people, including them in determining what they (oldest-old people) want.

4.2   METHODS

4.2.1   SAMPLING

Selection of the participants is a key factor in qualitative research. Munhall (2012) states the primary vehicle for data collection in the narrative approach is the interview(s). These narratives will contribute to the body of knowledge and as such have the power to shape the behaviour in the organisation that I work for and how we treat older people. Munhall (2012) encourages interviewers to be flexible and reminds them to accept ambiguity from the narrators, noting that this is a reality of life and despite a natural desire for interviewers to force clarity on particular aspects, it is important not to do so. In order to gather a group to interview for this study it was necessary to establish a theoretical sampling methodology and from this was the development of inclusion and exclusion criteria (Minichello et al., 2004). The inclusion criteria included three factors;

1. Being 95 years or older in the year of the interview,
2. Living in Southland or Otago and in their own home which may include a retirement village or with family or other people;
3. Participating in activities both inside and outside of the house.

The only criterion that excluded participation which was living in a resthome, hospital or long-stay hospital.

A data set was created through the interview process. A data set is developed through the sampling of the group or population identified in the research question. The type of sampling that is undertaken is an integral and on-going part of the research. For this research a purposive sampling method was chosen. Purposive sampling starts with a purpose in mind and the sample is selected to include people of potential interest and exclude those who do not suit the purpose, utilising the selection criteria (Suri, 2011).

Narrators for this research were selected according to the inclusion criteria relevant to the question and aims. Sample sizes were not fixed prior to the data collection but depended on resources and time available. Another aspect of purposive sampling which can be useful is snowballing. This is when the social networks of interviewees refer others to the researcher. This technique is often used to find populations that are not necessarily easily accessible,

such as those over 95 years. This occurred with narrators in this study telling me about other older people who may have been interested in being interviewed. Purposive sampling is an ideal process to use with thematic analysis, as the review of data and the development of themes is completed in conjunction with the collection of data, in this case by interview. This type of sampling approach was particularly useful given the specific knowledge about potential narrators and data I have through the organisation I work for therefore, it was possible to handpick some of the narrators. Early in the preparation for this study, it was identified that it would probably be necessary to undertake approximately ten interviews to reach data saturation. Data saturation is when additional data, in this case further interviews no longer brings additional insights to the research (Burns, Grove, & Gray, 2011).

Along with the advantages of purposive sampling Minichello et al. (2004) identify there are also potential disadvantages, one such disadvantage is the possibility of sample bias occurring. In this study, the inclusion of residents at the Retirement Village in the organisation I work for could be seen as bias. However, I believe it facilitated an easy transition for the interviewer-interviewee relationship which benefited/enhanced the interview process. This enhanced relationship with the interviewees enabled me to have what Morse (1994) identifies as a good informant, this is when the participant is willing to participate, has both the knowledge and experience and is willing to spend not only the time for the interview but for the follow up(s).

4.2.2 INFORMED CONSENT

Informed consent is an integral part of all research and in particular that which involves the very personal nature of narrative (Holloway & Freshwater, 2007). All narrators signed a form giving their consent to be interviewed and for their information to be used as part of the research process. A transcript release form was provided at the time of the interview and was signed after the interviewees had received and approved their final proof of the summary and the full transcript. There were also provisions made for any participant that may identify English as not being their first language, with the option of interpreting services being made available. One participant identified she was not born in NZ, however, there were no language issues.

4.3   Recruiting

There is value in knowing an area and the associated needs well before services are planned (Manthorpe, Malin, & Stubbs, 2004). Both the narrators and researcher live in the recently formed Southern District Health Board, which includes both Otago and Southland. Recruiting - contact with potential interviewees occurred in two ways; through third party contact and direct contact with people who met the inclusion criteria. Direct contact was by using my own contacts through organisations involved with older people such as Age Concern and Grey Power. There was an article published in the two regional Grey Power magazines, through this, two contacts were obtained. A poster was developed (Appendix B, p. 199) which was placed in areas older people visit including communal areas at two Retirement Villages, a Senior Citizens Lounge and the offices of Age Concern Invercargill.

There were potential difficulties with the process of third party recruiting as there was for example no ability to control what and how the third party portrays how the research process is conducted. A concern arose when a person I had been in contact with thought this study was being used as part of a resident recruiting process for a residential care facility. The generosity of both the third parties and interviewees to be contacted and available for and assist with follow up was humbling.

4.4   Interviews

The opportunity to interview a number of older people for this study was one that as a nurse working in a management role I relished as it provided opportunities to be working in close contact with people. This study utilises what Minkler (1996) describes as the second path of critical gerontology. This is a focus on the exploration of the meanings of old age which is sought from the oldest-old themselves, in this case by hearing their uninterrupted voices as part of the interview process. Overcash (2004) suggests that the tools of narrative research such as interviewing are familiar to nursing roles. This study utilises both of these methodologies and is therefore likely to be congruent with nursing thinking. Using interviews with narrative methodology is an ideal strategy to assist in developing nursing knowledge related to older people. Throughout the interviews there was the opportunity to get immediate feedback from the narrator. This process required the interviewer to listen analytically to ensure that the research question is addressed (Minichello et al., 2004). The

aim was to make the narrators feel safe and encourage them to speak freely. To this purpose, clarifying questions were asked, such as "How do you feel about…?" and "How is it for you?"

At the interview, I took the time to explain the essential elements of the research process, this included: recording the interview - describing the transcription process, explaining informed consent and the purpose of the participant consent form (Appendix C, p.196). Interviews took between 45 minutes and two and a half hours and in some instances involved time looking at transcripts and summaries generated from the interview with the narrator.

Through the interview process the narrator and the researcher have the potential to learn and understand the older persons' story. Frank (2010) describes narratives (the result of interviews) as acts of telling which assist us in making sense of our experiences. A frequently utilised narrative data collection technique is the semi-structured interview process (Bishop & Glynn, 1999; Overcash, 2004). In this research the interviewing techniques utilised the face to face nature of relatively unstructured interviews these allow the interviewer the opportunity to accurately gauge the feelings and opinions of the narrators. Semi-structured interviews provide the opportunity to guide the interview with a selection of predetermined questions. The interview guide was developed prior to the study and provided a series of questions that address the identified aims of the study. The set of questions were not routinely asked in the course of the interview but were referred to as required, as the interview progressed. As occurs with narrative methodology, as interviews were completed the interview guide was reviewed and further refined with questions removed or added as necessary.

Within the semi-structured interview process the establishment of the researcher - interviewee relationship is integral to the success of the interview, which potentially impacts on the research results. The vital elements of this are the development and establishment of the relationship, maintaining and then ultimately concluding the relationship. I found that finishing the interviews was a challenge, as noted in Minichello, et al. (2004) and utilised the following strategies they suggested to assist with this; slowing down the interview, turning off the tape - referring to the length of time that the interview

has so far taken. These strategies proved effective and useful in drawing the interview to a conclusion.

All interviews were conducted in the narrator's choice of location, in all cases this was their home. By interviewing in their own home, the story was able to be told in the context and culture the narrator lived in. Valentine (1997) recognises the benefits of interviewing people in their own homes, "talking to people in their own 'territory', in their home, can facilitate a more relaxed conversation. Interviewing at home also offers the possibility of learning more about the person as they are being seeing in their own environment" (p. 118).

One of my personal goals was to interview as many centenarians as possible. As part of the sampling strategy and with the assistance of a third party there were five centenarians identified, unfortunately I was only able to interview two of these. This was due to the family of three of the centenarians having family members who would not allow me to contact them. Leahy, Thurber, and Calvert (2005) suggests that often family act as the gatekeepers for older people, this is with regard to accessing services and support as well as allowing access amongst wider family members.

Interviews were at least 45 minutes in length; the amount of time they took was dependent on the narrator and how much they wanted to share in the interview. It was important to ensure that the narrators were comfortable and at ease throughout the interview therefore; interviewing at their home was the choice they made and as such was an appropriate choice. The interviews included many personal details both past and present about what narrators believed contributed to them being able to live in their own homes. The use of a portable data recorder was invaluable in the accurate recording of the thoughts and feelings of the narrators. None of the narrators refused to have the interview recorded with most being interested in how the technology assisted the process. The use of the data recorder and subsequent transcription process allowed the interviewer to accurately use direct quotes from the narrator. Butler (2001) posits that the use of direct quotes from the narrator allows their voices to be heard. Braun and Clarke (2006) emphasis this by encouraging the transcriber to ensure the accurate content of the entire data set. This would include all the peculiar aspects of someone's speech – perhaps a stutter over a particular word(s), repetition of a story, the halting speech when the narrator is telling a

particular aspect of the story. To assist with this I listened to my recordings regularly to ensure I was fully immersed in the data as well as transcribing from the tape to computer programme. This is congruent with both the methodology and thematic analysis itself.

No narrators chose to have a family or support person present as was offered in the information sheet. One participant had her disabled son present during the interview; this was not for support but was how they lived their lives with the son receiving no visitors or friends of his own. This raised associated questions for the researcher regarding the lives of older New Zealanders who are living and providing support for their disabled children, particularly in rural areas.

4.5   CONFIDENTIALITY AND INFORMATION STORAGE

The opportunity was given for narrators not to use their real name and select a nom de plume for use in the taped interview, the transcripts and in the final written report. This provides an increased opportunity to speak freely, particularly when there is a possibility of identification occurring. Along with the opportunity of a nom de plume, narrators were advised that all information revealed during the interview will remain confidential and not discussed with any other person except my supervisor. Information has been stored on my personal computer and is password protected. Transcripts and computer files will be stored at Massey University and destroyed as per the Health and Disability Ethics Committee requirements. All material associated with the interviews was kept in a locked cabinet during the research period.

4.6   ETHICAL ISSUES

In this section, the ethical considerations for the study are presented. Polit and Beck (2012) presented three major ethical principles to consider in research, these include beneficence, justice and respect for human dignity. Ethical approval is central to the research process therefore prior to commencing this study an information sheet was provided to potential narrators. The information sheet was prepared and tested on a small group of older people for readability and ease of understanding. The information sheet included my own details, what the research was about as well as the process for being included in an interview, transcription of data and the use of the data once it is collected. At all times in the pre-interview, interview and post-interview process when transcripts were shared with the

narrators, it was explained that they could withdraw from the research. The use of these principles addresses the ethical issues in this study;

A. Beneficence:

<u>Freedom from harm</u>. The nature of the interview process is the potential for sharing with others personal information that may upset the participant by sharing personal details that they may not have shared with others before. The process of how the interview would take place was carefully considered along with the questions asked. Given that the geographical area that these interviews occurred in, all references to town, school or other geographical markers were altered to ensure privacy.

All the narrators were closely observed for signs of distress, given the nature of the topic and process it was anticipated that some distress may occur. When three of the narrators became upset the interview was slowed down and as the researcher I actively sought a question or alternative topic to assist the narrator to regain composure. The three narrators who became upset were offered the opportunity to have a counsellor to speak with, however none took this opportunity.

<u>Freedom from exploitation.</u> Informed consent is a critical element in research with all narrators being fully informed of why this research was being conducted. The purpose of the consent form was to ensure that they understood what was required of them as well as what I would provide such as language support. Narrators were encouraged to ask questions at all times and this assisted with ensuring people felt free from exploitation.

<u>Risk benefit ratio.</u> The benefits of research should always outweigh the risks. In this research the potential for risks included the choice of welcoming of a stranger into their home, there was the opportunity to have the interview occur somewhere else, the disclosure of personal information and the potential emotional distress from engaging in the interview and reviewing and contemplating their life past and present. The use of the informed consent process which includes assurances of confidentiality and privacy contributes to minimising any risks.

B.   Respect for human dignity;

Right to self-determination. All narrators were given the opportunity to determine if they required anything in particular as part of the interview for example the venue or the involvement of a third party. There were several potential narrators and families who after reading the information sheet exercised the right of self-determination and chose not to be involved in the study.

Given all of those interviewed were more than 50 years older than I, there was a potential for a negative power dynamic to have occurred as this cohort are seen as vulnerable and potentially marginalised (Holloway, 2005). Three of the narrators lived at the retirement villages where I am the Director of Services for Older People. Although I am aware of the power dynamic in this situation, I do not believe this occurred as evidenced by the choice of at least one narrator to not discuss certain matters at our interview. Given the deeply personal information that is shared between the narrator and researcher there was also the potential for the interviewer to become over-whelmed. As well as this, there is the possibility for the researcher to believe the narrator is in an unsafe environment. None of these situations occurred in any of the interviews conducted in this research.

C.   Right to full disclosure; the nature and purpose of this study was fully described to all narrators and those associated with them. This included a right not to participate, turn the recorder off at any time, as well as withdraw from the study. The latter two options were detailed in the information sheet and the informed consent process (Appendices A, p. 195 and C, p. 200).

D.   Informed consent; all narrators had already talked to another person as part of the recruiting process for this study so all were aware of the information sheet by the time I contacted them. At each discussion and at all interviews there was an explanation of the study, this supported the information sheet and the consent form. Drever (2003) suggests this verbal preamble will remind participants what the interview is about which will enable the interviewer to offer more detail than has been provided and the interviewee to ask any questions they have. All the potential narrators became aware of this study through a third party. This means there is always an uncertainty regarding how the third party had

described what the research was about and how they introduced the reason for the research to be taking place. Consent was gained and the consent form was signed.

E. Principal of respect; the collection and use of all information from this study was fully explained to the narrators. All of these interviews occurred at the home of the participant so there is also the increased knowledge of the contextual environment; this includes personal items such as photographs and other memorabilia. This gives opportunities to reflect on other elements in the environment - this could be advantageous or equally disadvantageous as it may lead to inappropriate conclusions being drawn. Given the importance of the home environment for older people I found the photographs and other memorabilia gave opportunities for further exploration of the ideas such as family, hobbies both current and those in the past as well as location (older people often have pictures of their former homes). All of the information that was shared as part of the interview was transcribed and no covert data or information was gathered.

F. PRINCIPLE OF JUSTICE

A) RIGHT TO FAIR TREATMENT; narrators in this study were treated fairly and equitably, they were offered the right to non-participation, to withdraw anytime after the collection of information and have the tape switched off.

B) RIGHT TO PRIVACY; the study required the narrators to select a nom de plume and be anonymous. All narrators were offered to choose a nom de plume for the transcript and report. However, given the small number of people within the potential participant group and the relatively small geographical areas there is the potential for identification of individuals. Transcripts generated in this study were stored in a locked filing cabinet in a secure office at my home. Audio files were destroyed at the end of the study except for those narrators who requested a copy of the audio file. Transcripts and password protected computer files are to be kept for ten years at Massey University and destroyed by an identified representative from the university.

4.7 ETHICAL APPROVAL

Ethical approval for this project was gained from the Southern Health and Disability Committee. This research met the criteria to undergo an expedited review process. This is

when the research involves no more than minimal risk and does not include intentional deception or employ sensitive populations or topics and includes appropriate consent procedures. In this instance minimal risk means that the probability of harm or discomfort anticipated in the research would be no more than what would be encountered in daily life. However, those over 95 years are seen as a potentially vulnerable group and as such the ethics approval group required consideration given to ensure that they were not exploited in any way. It was noted as part of the expedited review process that I was not able to recruit narrators in any situation that could be construed as a power situation such as through their General Practitioner. Certainly, my position particularly with those narrators living in the retirement village which is part of the group of facilities where I work was also a potential position of power. This is one of the reasons a third party was used to assist with recruitment. The ethics process required consideration of Māori consultation with all local runaka. Despite it being highly unlikely that there would be Māori who would meet the inclusion criteria this consultation was undertaken as there may have been a possibility of a narrator that identified as Māori.

4.8 THEMATIC ANALYSIS

Whether the research methodology is qualitative or quantitative, the analysis of the data is a critical element in all research. This study is based on the naratives and all narratives are concerned with context. Thematic analysis is when the content – meaning is the exclusive focus and theorising occurs from the component themes. The researcher is able to look for patterns in the data, label and group them, putting like with like (Morse & Field, 1995). This can be completed with a simple listing of themes (Gordon & Turner, 2003) or utilising template analyses as suggested by Crabtree and Miller (1999) and further described by Fereday and Muir-Cochrane (2006) and Braun and Clarke (2006).

Thematic analysis is a qualitative technique that Boyzatis (1988), Fereday and Muir-Cochrane (2006) and Braun and Clarke (2006) describe as an accessible and flexible approach used across a range of theoretical approaches, in this case a narrative methodology informed by critical gerontology. Braun and Clarke (2006) describe it as an approach that can potentially provide a rich and detailed "yet complex account of the data" (p. 78). They add despite thematic analysis appearing to be poorly branded as a qualitative

method there is a great deal of analysis undertaken in qualitative methods which is indeed thematic.

Thematic analysis was utilised for a number of reasons. Firstly, as Reissman (2008) suggests it is an approach that is often selected by novice researchers, such as myself, as it is a straightforward and logical process. Secondly perhaps one of its greatest strengths is that it is not tied to any one theoretical or epistemological outlook so it can be successfully used across a range of approaches (Joffe, 2012) making it an ideal tool for a new researcher. Thirdly, and concurrent with Braun and Clarke's (2006) thoughts, thematic analysis is particularly useful when working with an under-researched area or when working with participants whose views are not well known, as is the case in this study of this oldest-old group. Finally, despite comments suggesting a lack of system or process in qualitative data analysis Braun and Clarke (2006) and Fereday and Muir-Cochrane (2006) identify six stages of thematic analysis.

Table 4 *Phases of Thematic Analysis*

Phase	Description of the process
1. Familiarising yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking in the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells; generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Phase 1 is the transcription of the data - reading and listening. This was done by typing the transcripts and listening to the recordings that had been made. This allowed listening to the voices not only at the interview but afterwards as well. This enabled me to become fully immersed in the data, hearing the full range of emotions of the narrators. It is important to note that these processes are labour intensive and ensure that the researcher becomes sufficiently familiar with the data collected. Through this data, immersion takes place – through active listening and searching for meaning and patterns emerge (Braun & Clarke, 2006; Fereday & Muir-Cochrane, 2006). During this phase Boyzatis (1998) and Braun and Clarke (2006) emphasise it is important to start writing, that it is not something that occurs at the end but should begin in phase one and continue right through the entire coding/analysis process. The initial writing took the form of journaling the process, thoughts and questions that were developing as the study began.

Phase 2 is the generation of codes described as data reduction (Lathlean, 2006). In this study this was data driven and occurred in a three step process. Initially I used a coloured highlighter to identify areas of interest whilst listening to the interviews and reading the narratives. These areas of interest were removed from the data and put onto separate pages which eventually became a large table with the code on the left and the data on the right. I also created a hand written coloured version of this ascribing each of the initial codes a colour and writing them on this very large piece of paper. At this time it appeared that five themes had arisen from the data.

Phase 3 Subsequently the codes from phase 2 are developed into themes, this is when the codes from phase two become themes – they may be over-arching themes or subthemes (Braun & Clarke, 2006). A theme is described as capturing something important about the data in relation to the research questions; there are no set rules about how themes are identified except that the approach is consistent (Braun & Clarke, 2006). They add that a theme might be given considerable space and time in some data items and relatively little in others. This means it is the judgment of the researcher determines what the theme is and its overall importance. Ely, Vinz, Downing, and Anzul, (1997) suggest that themes do not emerge from data but instead reside in the heads of researchers. This is the result of the hours of thinking and considering the data. At this time, I was continuing to journal and considering the themes and what they were in relation to the narratives.

Phase 4 This phase was carried out some weeks after the initial work. The coloured set of codes that had been developed in phase 1 were reviewed and rewritten as a thematic map.

Phase 5 From the thematic map a table which has the overarching level one themes and the subthemes was developed and is presented as table 6 in chapter 6 page 102. A further discussion with my supervisor occurred at this time and a re-ordering of the subthemes occurred.

Phase 6 This is the final stage where the themes are reviewed within the context of the literature and must be linked back to the original data. This involved reviewing the initial areas of interest I had collected in phase 2 and refining them as necessary - some were too big and some were too small. They needed to be substantial enough so that the story is easily understood by the reader.

4.9   MAINTAINING RIGOR AND TRUSTWORTHINESS

The trustworthiness of qualitative research is difficult to establish, however, Koch and Harrington (1998) suggest the reflexivity and self-awareness of the researcher are two key elements in ensuring this. When considering rigor and trustworthiness Lincoln and Guba (1995) simply ask, "are the findings of the study worth paying attention to and worth taking account of?" (p. 290). To assist in determining the trustworthiness of this work I have used a framework proposed by Koch and Harrington (1998) who suggest there are three categories of trustworthiness; credibility, fittingness and auditability. These three categories are addressed in relation to this study.

1   CREDIBILITY

This refers to being faithful to the data (Koch & Harrington, 1998). Reicher and Taylor (2005) suggest a "systematic method whose assumptions are congruent with the way one (the researcher) conceptualizes the subject matter" (p. 549) will address aspects of rigor. An alternative method to assure data credibility was; identifying themes. This was initially done by myself and then further by the research supervisor for confirmation of the themes that I had identified, the use of the narrators in the review of the transcripts and the subsequent narratives that were drafted from the original interview. This part of the process was useful in determining fittingness and credibility. Finally credibility is achieved by the dissemination of the research results amongst colleagues and peers.

2   FITTINGNESS

Fittingness is described as the "everyday reality of the participants" being "described in enough detail so that others in the discipline can evaluate importance for their own practice, research, and theory development" (LoBiondo-Wood & Haber, 2006, p. 168). Therefore, fittingness expresses transferability of the data and will be shown by providing sufficient contextual information and analysis to allow comparisons being made to other situations a process of the information being able to be transferred.

3   AUDITABILITY

Braun and Wilkinson (2005) state that in order to evaluate research it is necessary to have the researchers' methods of analysis and the assumptions informing it clearly identified and articulated. I have endeavoured to ensure that auditability is demonstrated in this study through the clear articulation of both the methodology and associated methods. Given the many possible faces of both narrative methodology and thematic analysis this is particularly important in this study. Ensuring auditability means either the reader or another researcher is able to follow the process and the researcher's decisions are transparent.

Writers such as Morse, Barrett, Mayan, Olson and Spiers (2002), state "…audit trails may be kept as proof of the decision made throughout the project, but they do not identify the quality of decisions, or the responsiveness and sensitivity of the investigator to data" (p.7). There are numerous ways to assist this, all of which are around ensuring transparency and honesty in the research process. There are various things that will contribute to this, these include confirming that the narrator is aware of what is involved in the process and ensures that a full description of all the steps are provided. As well as this I completed an activity log which develops methodological awareness fostering on-going reflexivity and critical self-awareness and the impact of critical decisions – these all contribute to and promote overall truthfulness (Reissman, 2008).

4.10 CONCLUSION

This chapter has provided an overview of the research methodology and process required for this work. This involved reviewing the question and aims and then identifying the methodology and methods of the work undertaken. Reissman (2008) suggests that staying close to the method will assist with valid interpretation of the data collected. I view old age as part of an individual's life course not as a discrete event within life. Older people come to

old age shaped by the preceding events and experiences therefore the culture(s) older people have experienced have a significant influence on them. Therefore, the design and analysis fits with who I am as a researcher, aligning with the aims and objectives.

5. Narratives

5.0 Introduction

The purpose of this chapter is to provide the abridged narratives of the ten oldest-old people that consented to be interviewed. A commitment of this study was to privilege the voices of the ten narrators and have their thoughts and feelings heard. These excerpts introduce the narrators and provide an opportunity for a greater depth of understanding with respect to the material collected; they demonstrate that the oldest-old are cumulative beings - a sum of all that has come before them. The narratives are not presented in any order or categorisation.

5.1 Alice (99)

Alice emigrated from Ireland to Dunedin, NZ at the age of 12 in 1924 with her parents and brother, joining other family already here. Alice recalls a happy and healthy childhood. Unfortunately, her mother died soon after emigrating. Alice describes her mother as not really fitting into their new life. Her father lived until he was 65 years, at the time anyone over 60 was considered old. Alice's siblings were also long lived, with two living to over 80 and the eldest brother dying at 70 years.

Leaving school at 14 Alice became a florist until she married at 22 years in 1936. She bore four children, who along with working in the family electrical business, consumed all of her time. Alice has kept regular hours throughout her life rising at 8am and retiring to bed at 9pm. Retirement for Alice and her husband meant a change of lifestyle from operating motels in Central Otago until they finally did retire to Tauranga where her husband died. She says;

> "that get up and can do attitude probably kept me going. Hard work!! – has kept me healthy. You find some people when they retire; they just go to the pack. After we retired we started another business - we were retired but we didn't feel old enough to be retired."

Subsequently she returned to Dunedin as her four children were living in the South Island. She moved to a retirement village where she still lives. Soon after her return south she

experienced her life's nadir with the tragic death of her eldest daughter in a road traffic accident on her way to visit Alice.

Alice attributes her ability to maintain an independent home to her supportive and loving family. Alongside this mobility is important, she now uses a "marvellous" walker. Alice appreciates advances in technology as they help people stay in touch. It is with some sadness she says only her family visit now, grandchildren and great grandchildren.

> *"All my old mates are gone. I am the last one. I seem to be the oldest and they are all dying before me, Margaret and Daisy – they both died last year. I don't want to live until 100 and have my face in the paper. No, I have seen enough of this world."*

5.2   ESTHER (96)

In 1915 Esther was born in rural Southland. As an only child she was fortunate to have cousins and neighbours to play with. She recalls a happy, healthy and enjoyable childhood.

Esther established a successful nursing career, travelling to Fiji and undertaking post graduate training in Wellington. She would have preferred to complete teacher training, however, at that time the closest training facility was in Christchurch and her parents would not allow her to go that far.

Esther's mother became unwell during the World War Two (1939-1945) and she was only allowed leave monthly to come home and care for her. Sadly she died in her mid-fifties with her father dying some years after in his mid-sixties. Esther doesn't recall any other family members living as long as she has.

In 1950 she left nursing, married and stayed at home. She has only one son who is 60, unfortunately, they also had a child who was still-born. Esther's nursing experience was utilised extensively as her husband suffered considerable ill-health. This also meant that she had to develop new skills to manage the small farmlet they lived on. Esther was an active volunteer until she retired from that and driving in her late 80s. After her husband's death she moved into town to a smaller house with a garden which at first she could manage but since she broke her hip she now requires assistance.

Esther has no family living locally but her son visits regularly and she has a niece who is also very close to her and takes her shopping when in town. Esther reflects that until nine years ago she had good health. Since that time she has suffered a broken hip, a slight stroke and currently lives with cancer of the bowel. Due to her health she doesn't go out any more.

We talked about planning for retirement and old age. Esther says that they didn't undertake any retirement planning as her husband became unwell at an early age. When asked about how she has managed to live at home at her age, she said she would not be there without the significant amount of paid support she receives. This support includes showering and managing her ostomy, however this also includes doing crosswords, going shopping and other activities. Esther enjoys watching her support worker using her smart phone to access the internet and understands new technology. She enjoys the opportunity of learning new things and is an avid reader. Apart from the support that is provided for Esther she also pays for other assistance to do the garden and maintain the substantial number of trees around her property.

5.3   HEATHER (98)

In 1912 Heather was born into a family of five children on a farm in rural Southland. Some of her siblings lived into their 80s while other siblings and her parents died relatively young. Like many of this generation she left school early and worked on the family farm until, at 27, she married.

Whilst growing up she recalls there were hard times but believes this was good preparation for her long life and has contributed to her incredible good health "I haven't had time to do anything else." Heather has had high blood pressure for years, breaking her hip last year temporarily slowed her down for a few months and she still suffers from on-going hip pain. However, Heather is remarkably fit and still drives. These days she drives to church on a Sunday morning when there is not too much traffic and it is not too busy.

After marrying Heather moved to a nearby town into the house where she still lives 70 years later. Being able to live independently in this house is extremely important to Heather. It is this house where her memories were generated; where her four children grew up. The house still has the original coal range and Heather keeps a small garden; "nowhere as large

as when my children were growing up." However, over the past year she has had to get the "boy next door to cut the grass."

Heather's husband died 41 years ago and at that time she bought Garth her youngest son home to live with her. Garth has Down Syndrome and she worries more about his health than her own.

Heather has never worked in paid employment but has always been busy with her children, particularly Garth, and the church. Heather's greatest heartbreak was the death of her eldest daughter who left a young family behind. This occurred just a few years after her husband died but was a far greater tragedy for Heather.

Did she anticipate living to this age or make any preparations to? "Absolutely not!" What assists her in sustaining her own home this age? Her own hard work, determination and minding her own business. Heather receives no government support or assistance for herself or her son Garth, for whom she is the sole caregiver. She has regular visits from her children, two of whom live close by and she is very interested in where her grandchildren and great grandchildren are.

5.4   LILY (100)

Born in 1911 Lily was one of five children. She was born in the same house as her father and lived on their family farm until a few years after his untimely death at 39 years (as the result of pneumonia). Her brother died tragically in World War Two. Lily's mother and one sister lived to well over 80, with another sister dying just after she turned 90. Lily recalls a happy and healthy childhood and going to school by train with all the other local children. After Lily left school she worked for a short while and then went nursing. Amongst many other student nurses Lily contracted Tuberculosis two years into her training and consequently was not allowed to return. Her overall health has improved after her 40s when she had a toxic goitre – a potentially life threatening illness in the 1950s.

Lily describes a good life – she married at 23, bore seven children all of whom are alive and well and most live locally. Lily and her husband retired from their farm in 1968. She enjoyed the busyness of the small town and her lovely garden. Living in a small town also allowed her to be involved with local activities and crafts which she enjoyed.

Three years ago she moved to a retirement unit at the local resthome. Whilst she enjoys her unit, the company of the other people in the units and knowing there is support in the resthome she finds it very quiet as it doesn't have a street view.

Lily cooks for herself believing good food and good habits may have contributed to her long life. She has someone who comes in for an hour a week to do the "luxing" and the outside of the windows. Lily says her home help is "good social contact though, you like them to sit down and chat for a while and tell you what is happening in the world, not exactly gossip but you know, what's going on."

Lily appreciates that technology has made life easier; washing machines and ovens. She is certainly aware of other types of technology such as computers saying that she knows nothing about them but that she observes her children and grandchildren using them and they help them all keep in touch.

Lily has "23 grandchildren, I think if I remember rightly." Lily talked about her children, grandchildren and great grandchildren, where they are in the world and what they are doing. She is well supported, particularly by a grandson's wife. Lily says she "is reliable, she takes me shopping, she takes me anywhere I want to go."

When asked how she manages staying at home – she states "I don't know, I just don't know." Whilst reflecting on her life she thought she should have got her license to drive, "my husband would drive and then the children were driving, I think now I should have done it." However, she does have a mobility scooter which enables her to get out and about.

When I visited Lily she was preparing to go on holiday. Where do 100 year olds go on holiday? "The same place as always" replied Lily, with a smile.

5.5   BEATRICE (100)

Beatrice was the eldest of three children born in 1911. She has no clear recollection of when her parents or siblings died.

Beatrice has two children, a son in Dunedin and a daughter in Paerora, both of whom visit regularly. Working life started with her first job at 15 in a coffee shop. Beatrice went on to own a coffee shop/restaurant. Once married, she and her husband managed hotels in

various spots in Auckland and Wellington. At 60 rather than retiring, they brought motels in Tauranga. Beatrice asked "have you heard of the Tavern in Rotorua – well we opened that." Beatrice describes herself and her husband as hard working, not retiring until they were in their 70s. Did they make any plans regarding their retirement ? "Not at all."

At 90, Beatrice and husband visited Invercargill and decided to settle here. She lives in a sunny, ground level unit, Beatrice describes herself as "very happy." Beatrice's husband died five years ago at 95 years.

Beatrice faces particular trials as she is legally blind and lives alone. However, she says she has never thought about going into a retirement village. She loves her home and receives assistance and support; "a girl comes to make the bed each morning, and helps me to shower." Someone also does her shopping which means Beatrice doesn't go out as much these days. Beatrice prepares and cooks her own lunch, including the vegetables, a challenge for someone who is legally blind.

Beatrice enjoys her hobbies – although she no longer reads, she listens to three books a week. She also listens to talk back radio. Although Beatrice doesn't go out much she does visit friends nearby and has people visit her. Around the house, she uses her walker which she finds so helpful that she bought her daughter one too, "I bought one for my daughter I thought it would be good for her when she goes shopping and she comes in with it loaded up with parcels."

When questioned about how she manages to live in her own home and how she has lived to over 100 years she says she really does not know. However, she believes that good food – "lots of vegetables and hard work have helped."

5.6   MADGE (96)

Madge was born and raised in a small rural town in Southland, above the shop her grandfather had bought in 1879. She is the eldest and has six brothers most who have also lived long lives, with her last surviving brother living to over 90 years. Her mother died at 80 however, her father died at 54 and she remembers a cousin who died at 96 years.

Madge recalls a happy childhood and describes herself as lucky as the shop provided adequate food. She was very aware this was not the same for everyone during the World

Wars and the Depression. She does not remember being sick throughout her childhood but if they were they would have had a "lemon drink or something."

Madge started work at not quite 14 years "my life was all work, it was the Depression and you didn't have much choice." Despite never marrying she has several nieces she is very close to, one in particular that visits from out of town. The subsequent generation of her family is large with one of her brother's having ten children and the rest having "three or four."

She believes that worrying shortens your life and is sure that is what happened to her father and eldest brother. Madge has a deep Christian faith which ensures "you'll be ok." As part of her faith she subscribed to the local Presbyterian Support and moved to an independent unit approximately 12 years ago. She still attends church with friends and occasionally goes to the facility chapel as well. For the past seven years she has received household support but does not receive any assistance for personal care such as showering. The unit she lives in is fully accessible and she is positive that living in a home where she can fully access the bathroom, kitchen, and bedroom assists older people to be able to stay at home.

What has enabled Madge to live independently? "…hard work, faith, determination and resources." Having adequate financial resources makes a difference, "to be able to do things you need and want to do." She also thinks todays' technology also helps older people remain independent – "washing machine/microwave and such like." She also believes it is important to do what you enjoy and keep mobile. "I go around the block – might take me 10 minutes, might take me half an hour – I used to do it in 10 minutes." Madge reminds me that there are many losses associated with ageing for example she loved to read which she misses greatly as she has lost the sight in one eye. Despite this Madge is optimistic and says there are alternatives such as listening to the radio.

Madge says she has "never felt her age", smiling, saying that she hopes she "doesn't dress that way either." Today Madge keeps well, she takes "six tablets a day, and two calcium tabs for the bones – that's eight in total with some glucosamine." There is a sense of vitality about Madge as you speak with her, however, there is a sadness too "I don't want to live until 103. There's nobody left - everybody is younger."

5.7   LENA (99)

Lena was born in 1915 in a small rural part of Southland and is the third eldest of her family of seven. Two of her family are still alive however, neither live locally.

Her youngest brother is 88 years old and her younger sister, who is in her 90s, has lived in a nursing home for over 10 years. Lena's parents also lived long lives; both were around 80 when they died. There have been other long living family members too; an aunt who was 99 and a half years, a grandmother who was 84 and an uncle who was 94 years.

Lena was never sick as a child – but did require some major surgery in her 20s, so she could have children. "I had four children (I did lose a baby as well). When my son (in his 60s) died, it broke my heart." Lena has two surviving daughters; one close by and the other lives overseas. She keeps in close contact with both, seeing her daughter who lives locally regularly and taking turns with her other daughter who lives overseas to ring, which keeps them in close contact. She has been in close contact with her grandchildren that live locally, they have been like her own children. Like other grandparents she easily articulated what her children and grandchildren are doing and where they are living and working.

After leaving school at 13 years old Lena stayed at home until she was 19 years and left to marry. Some years after marrying they moved to a three bedroomed cottage, "I loved my house and lived there until I was 80." At this time she moved into the small pensioner unit where she now resides. When asked if she had planned for her old age, she adamantly said no.

Despite minor health issues, two knee replacements in her early 80s and being legally blind, she only takes tablets "some water pills" and something for pain. Lena describes herself able to do things many people younger than her cannot. She described losing her eyesight, just a few years ago as difficult – as she could no longer cook for herself safely and consequently receives Meals on Wheels. She said she would have preferred to have been lame; "I would love to pick up a book or my crochet." In order to take her prescribed pills she requires assistance to "cut into the halves and wholes" which she cannot see to do alone however, Lena and her neighbour "get it all sorted."

Lena has used community provided meals-on-wheels on and off since she was 80 years. When she turned 92 she got "a lady in once a week to change my bed and wash my sheets."

Lena thinks it has always been important to "look nice and always make sure I have a matching outfit and earrings. I sometimes don't manage navy blue and black." Spirituality has been important throughout her long life however, some years ago she stopped attending church. New friends, "have restored my faith in human nature" and her spiritual side. They are no longer living locally and she keeps in touch with them by phone, "they say they'll be back to celebrate my 100th birthday."

Lena associates hard work, good food and taking care of yourself as factors contributing to her living independently. These combined with determination and the assistance and support of her family, friends, neighbours and her doctor. Lena hypothesises that longevity may also have "something to do with her family" as a number of them have lived long lives.

5.8   SARAH (100)

Sarah was born in 1911 and although not born in Dunedin she has lived there for 98 years, 74 years in the same house. There were four children in her family but Sarah is the only one still alive. Whilst happy to talk and share pieces of her long life Sarah did not want to talk about her wider family; her parents and siblings.

Sarah remembers suffering a lot of headaches and nose bleeds, particularly on hot days during her childhood. Her schooling started at the local school until standard one when she transferred to a convent school where she stayed until she left at 14 years.

Throughout her long life, Sarah has had only one episode of paid employment, after which she stayed "home to do the vegetable garden, lawns and things." As a young woman, she went to night classes to learn millinery and dressmaking. Sewing became a lifelong interest and she sewed up until she was 90 years, when she could no longer see to thread the machine.

Sarah has married twice, the first time at 21 years; she has outlived both her husbands. She has one child who lives in the North Island. She used to visit her daughter regularly in the North Island but has only been up there once since she was 90, however they keep in frequent phone contact.

All of Sarah's life has been about keeping busy, with her various hobbies, her daughter/family, a love of gardening and running her household. Three years ago, she stopped doing her garden which included a substantial vegetable garden. Somebody now comes in to do the garden and her great niece now supplies her with fresh vegetables. By her house, she has the old caravan she still relaxes in every afternoon. She lives on a busy street and in the early evening enjoys sitting up the front in her lounge looking at the people going past.

Good health has been part of her life up until quite the last few years. At the time of the interview, she was both the oldest person in NZ receiving Herceptin, and the oldest oncology patient. A number of years ago she put her name down for a resthome and consequently has not spent any money on her house. However, she did modify the bathroom in the 1950s and it is accessible for her which enables her continued independence. She believes she is not ready to go into a resthome and is better at home.

A fiercely independent woman Sarah is still cooking and showering and managing to do some shopping herself. Her groceries are delivered as they have been for more than 50 years. Sarah uses a walking stick and feels it won't be long before she is using her brother's walker.

Sarah states her friends have all gone now, however she keeps in touch with the children of old friends and also with some of her daughter's friends. Sarah is interested in lots of things and is articulate about local happenings and her family, in spite of seeing them rarely. Sarah has some regrets for example not learning to drive and she says "if I was 80 now and looking forward I would probably exercise more."

When asked about what may have contributed to her ability to live independently, Sarah describes eating well with plenty of vegetables, "a routine of living and cooking, I have to have my breakfast by 9 o'clock, dinner at 12 and tea about 5 o'clock." At about 7pm she has some fruit, she only drinks tea and has never had a cup of coffee, "I drink cranberry and plenty of water, and a (small) glass of red wine every evening." She normally goes to bed about 9 pm and "turns the radio off around about 11 or 12 o'clock." Sarah says she never worries or thinks about when she might die as she believes she will die "when my time is up... I think your life is planned out for you, I am a great believer in that." Although not

attending church she described an adherence to a religious faith. Had she ever planned for old age? "No not really." Both of her husbands had died by retirement age.

5.9 BOB (98)

Born in 1913 on a North Island farm he was one of four children. Three of the four children are now in their 90s, one of his brothers died in an accident in World War Two. Bob also did military service and says he "feels very, very lucky" as he should have been on a plane that crashed on it's way back to New Zealand. As a child he had the usual illnesses but has lived a healthy life as an adult. His parents lived into their 70s and 80s residing until their deaths in the unit that Bob now resides in at the retirement village.

After service in World War 2 Bob returned to Southland where he worked as a woodwork teacher and with his wife raised their three children. All of their children are alive and healthy but none have settled locally. His two sons visit regularly when they are down on business. "If they come to Invercargill they stay with me for a night you see, and away the next morning and that will be perhaps as much as I will see of them." Bob doesn't see as much of his daughter but there is the "telephone." Contact with his grandchildren is infrequent but mostly he hears about them from his own children.

Bob and his wife lived in various houses in Invercargill - using their bikes a lot or walking, his wife didn't drive. They lived conventional lives following a routine in their daily lives. Bob smoked a pipe most of his life giving up when he retired. In their 80s they decided their townhouse was too big and moved to a retirement village. This was a planned move as they viewed it as a way of taking care of themselves, Bob says their children "were really pleased" about their parent's decision to move to the retirement village. At 98, he is still driving but goes to areas where he is familiar and when the streets aren't "too busy."

Bob's wife died just a few years ago and her death deeply affected him. When retiring he is sure "some people make the mistake, do nothing –and all of a sudden you see their name in the death column." He adds "it takes a wee while to relocate yourself into something new … well look at me - 98."

5.10 TIM (97)

Tim was born in 1913, one of five children, two of whom live in Canterbury. Their only brother died during World War Two and a sister died some years ago. Tim's parents also lived long lives well into their 80s.

Growing up he describes his early years as tough and certainly sees the benefits that technology has on lives today. His father had a small piece of land which fed the family and he recalls having good health as a child and benefited from attending Scouts.

Tim followed his father into work as a photo engraver. In pursuit of work he and his wife moved to Invercargill in 1937. Military service called and Tim went overseas for the first five years of his son's life. They had a further child after he returned. Tim established a successful Invercargill business; he was a hard worker and determined to make a better life for his family.

Tim formally retired at 60 years to make way for his son in their family business; however, he continued to pursue his photographic passion. In the 1980s there was a story written in our local newspaper about Tim, who was described as a "busy and sprightly octogenarian."

During Tim's life he has had very little ill health – his first period of ill health was during his military service then again ten years ago when he had a "hip done" and more recently some prostate problems. Tim is also very deaf, no doubt, the result of his occupation using presses. Recently his son who lived about two hours away moved to Christchurch - "that's a bit of a knock – I have been up there, but I doubt I will ever go again."

Tim did do some planning for his old age. This planning included moving to the retirement village just in case he died first as his wife was three years younger than he and she wouldn't be alone. However, his wife died before him and since then his world has shrunk, he lives alone in his townhouse requiring domestic assistance which he funds himself. Recently Tim gave up driving and sold his car.

He believes that money helps him to live a comfortable life, having good health and it is all of course dependent on living that long, which he attributes to good genes. With a smile Tim says he might "go on to be 120 as I don't have any reason to die."

5.11 Conclusion

The purpose of this chapter was to give the narrators' voice in order to hear and subsequently share their story in regard to their lives and how that has contributed to their ability to live independently as the oldest-old. It must be noted that these are very abridged narratives as there is no room to provide the full transcript. As is noted in other places their perception of health, life and independence varies however, there are some things that have been said by most narrators and these are reflected in the themes and subthemes that have been developed from the full transcript.

6. FINDINGS

6.0 INTRODUCTION

Chapter five briefly introduced the narrators all of whom were over 95 years at the time of the interview. It is the intention of this chapter to explicate the findings gathered from the themes and subthemes that stemmed from the ten interviews. The themes that emerged were staying socially connected, managing the physical environment, keeping and ageing well. The stories were not just about this group of people's lives since retirement or the past five or fifteen years, they included not only what they attributed to their long lives but also about those aspects that may have been out of their control such as genetics and good luck.

The focus for this study was to hear and understand from the narrators' view what, if any are the reasons that they were able to live independently at home aged 95 years and over. The four associated aims were to firstly increase the understanding of what contributes to people over 95 years of age staying in their own home. This will influence my personal understanding in an ageing population. The second aim is to enable the narratives of people over 95 years to be heard with the third being to unsettle what is currently known about ageing and ageing in place. The fourth aim is associated with the first, which is to influence the provision of appropriate support services that enable people over 95 years to continue to age in place/stay living independently at home. Did the narrators take any particular actions or prepare for their advanced old age and living alone - did they anticipate being as old as they were?

The question that was initially posed – "what enables people over 95 years to be able to live independently at home?" had specific inclusion and exclusion criteria. To be considered living at home independently meant that they need not live alone but could not reside in a resthome or hospital. However, they could live in a townhouse, cottage or independent living unit as part of a retirement village. The narrators lived in a variety of living situations. Table 5 provides the details the regarding the narrators. From the literature, it was expected narrators would live in a wide variety of living situations such as living with family either children or a spouse. This was not the case as all but one lived alone. Only one lived with another person - an adult child. However, the adult child in this situation had an intellectual disability and despite a level of interdependence, he was probably more reliant on his

mother rather than her depending on him. Over the past five years three of the narrators' spouses have died.

Table 5 *Profile of narrators*

Pseudonym	Age	Living circumstance	Dwelling type
Alice	99	Widow, 15 years	Studio retirement village, 12 years
Esther	96	Widow, 35 years	Family home, 12 years
Heather	98	Widow, 30 years, lives with disabled son	Family home, 74 years
Lily	100	Widow, 46 years	Unit, retirement village, 3 years
Beatrice	100	Widow, 3 years	Family home, 10 years
Madge	96	Never married	Unit, retirement village, 12 years
Lena	99	Widow, 36 years	Pensioner housing unit 18 years
Sarah	100	Widow, 48 years	Family home, 98 years
Bob	98	Widower, 8 years	Unit, retirement village, 22 years
Tim	98	Widower, years	Unit, retirement village, 22 years

6.1   SUMMARY OF THEMES

Thematic analysis which is a reading and re-reading - a distillation process used to identify the themes and associated subthemes.

Table 6 *Themes and subthemes*

Living at home after 95 years

Staying socially connected	Managing the physical environment	Keeping well/ageing well
Family	Using aids - hearing glasses, walkers	Health – eating well
Help – paid/unpaid help	Using appliances - washing machine, handrails	Taking medications
Keeping busy	Changing where and how I live - downsizing, accessible areas	Keeping mobile
		There's nothing I've done!
		Not worrying

6.2.1 Socially connected

Antonucci et al. (2001) suggests the social networks of the oldest-old are only slightly smaller than others. They add these networks are no more or less dense but older people have more contact with core confidants. All narrators talked about staying socially connected to the various important people in their lives. To them these connections were contingent in enabling them to stay at home and maintaining independence. Staying socially connected as reported by the narrators involved more than was initially expected. Certainly, it was about immediate familial relationships amongst primarily children. However, there are other important relationships which often include grandchildren, siblings, nieces, and friends. Social connectedness also included the ordinary day to day things such as hobbies, employment, paid and unpaid help as well as where these people chose to live. Most narrators had shifted various times in their life, with some in the past fifteen years choosing to move to either pensioner housing or retirement villages. For those who had moved to retirement villages their express reason for this was to access the support provided there. Two narrators remained in homes that they had lived in for more than 70 years and were happy and able to continue to live independently there.

Narrators reported various constructs which assisted in keeping them socially connected. These included ordinary interactions such as; sharing a meal, grocery delivery, shopping with family friends and home help to familiar places, staying employed, hobbies, going on the buses and shopping, being visited. For the majority of younger people these activities are taken for granted however, for these oldest-old achieving these tasks has become increasingly complex, requiring the support and assistance of others. Other activities such as shopping at certain perhaps favourite places, using public transport or driving the car had changed and in some instances ceased as a result of the limitations of age but also by the increasing "busy-ness" of society and by themselves not wanting to be a burden to others. Amongst this was a persistent engagement with life and the activity of life that seems to provide monumental support to these oldest-old.

Subtheme i) Family and friends

All narrators were visited regularly by family and identified them as the support that was critical to them and their way of life. Alice had returned to where her children were living in order to be closer.

I just look forward to Masha and Helen visiting me, there's nothing really – and Alec – he's in Central. I am lucky they are all sort of close. Do you think it contributes to you being able to live here – on your own? (Interviewer). *I think it would. (Alice).*

*…before I shifted up here, and I said to somebody "I am downgrading" when they wanted me to come up here, because they said "well you are going" but I had been so ill that year and that's what made me come….*Do you speak to your daughter in Dunedin every day? (Interviewer). *No, no, I don't speak to her every day, but she usually comes out once a week. She keeps an eye on me. I don't know what I would do without them. (Lily).*

Alongside of this well described social connectedness amongst the family and a wider circle there is evidence of contentment in their current life as evidenced by Beatrice who is happy spending time in what might be described as a relatively lonely existence.

…I am just pleased to be at home - had too much of the public. (Beatrice).

Family includes spouses, siblings, children – sons and daughter in laws, grandchildren, nieces. Those most often referred to as support were daughters/daughters in law, nieces and granddaughters. For many narrators they identified the closeness of their relationships with their children as paramount to their well-being and being connected to them enabled them to stay living independently.

…I talk to her two days a week – I have a daughter over in Centre Bush …just the other side of Winton and I talk to her about twice a week. (Lena).

…well Heather rings so we have a great old chatter…. I always talk to them before I make a major decision. (Alice).

Oh, yes quite well spread but all keep well connected…they all ring me. (Lily).

Telephones were an important means of support and communication. In a study of European women, Maier and Klumb (2005) identified telephone use as critical for maintaining communication amongst the oldest-old, perhaps more important than being

visited. The narrators in this study supported this; Lena with family out of town and out of the country talks to them on the phone.

> *I have got one daughter in America – she is 66, I talk to her two days a week – I have a daughter over in Centre Bush just the other side of Winton and I talk to her about twice a week and meeting up with her on Friday. (Lena).*

> *… telephone's a great thing. (Bob).*

Heather uses the phone to keep up with her friends she no longer visits.

> *I don't go and visit them either and they don't come and visit me. They ring me up on the phone most days to see how I am, if they don't ring me up I ring them up. (Heather).*

For Alice newer forms of communication such as Skype had started to be used over recent years to keep her family in touch.

> *I haven't got a computer, but I go to Marion's...but now with the tv you can talk to them (family), its uncanny, isn't it… and we talk to Alec in Central, and it's like he is right in the room. (Alice).*

In the future technology will become increasingly important for all people including the oldest-old. Technology will provide opportunities to assist in communicating with those not immediately available. Despite their advanced age, several of these narrators were aware of new technology and the benefits of it.

Only one narrator; Heather appeared not to be happy with her daughters involvement in her day to day life. While she had this to say it is this daughter who visits weekly from some distance despite other children living closer:

> *…she's a fair old domineer at me – growls the whole time at me…daughter, the cheek of her too, she doesn't run my life. (Heather).*

Alice, Sarah, Lily and Madge identify that in many cases the connections/visitors they have today were the families of their old friends and wider family as the people they were originally close to had died.

Interviewer -All of your old friends, there is nobody you went to school with or? No, No they are all gone. Interviewer -How does that may you feel? *A bit lonely…Oh, I hope I don't live until 103…There's nobody – everybody is younger. (Madge).*

Well I have got no friends of my own age now – they are all sort of gone. (Sarah).

…but they were younger than me – I seem to be the oldest and they are all dying before me – so that's Margaret and Daisy – they both died last year. (Alice).

Sarah best describes this telling how new relationships have developed with a new generation.

Well I have got no friends of my own age now – they are all sort of gone, but I have got younger friends, now Margaret used to live across the road, Margaret's 82 now, well she still comes to see me, you see, because her mother is dead now, but a lot – now Bronwyn – Bronwyn still comes to see me, Bronwyn's in her 70's, I don't know what it really is, about 77 or something, well you see I knew her mother – my first husband and I were great friends of her mother and father before ever Bronwyn was born. (Sarah).

For others who had children who were not able to support their parent(s) there were members of the extended family, such as grandchildren stepped up for example Lily's granddaughter in law and Alice's grandson.

Sarah who has lived in the same house for 74 years talks about being connected to neighbours and the support they provide.

...they are good neighbours and every day he comes in, he's in every day, every day, sometimes twice a day, and he stays a wee while. He comes in to see you, says how are you, and he does an odd message for me – he's a good neighbour. (Sarah).

For those whom had relocated to a retirement village they described new relationships not only with older people but the staff they were involved with.

I've been here about three years … I moved from the house we retired to in 1968…. Everybody is friendly here, we are not in and out of people's flats all the time – we don't exactly take turns, but we all get together for afternoon tea occasionally and that sort of thing. (Lily).

Anybody that comes in here – I was talking to somebody at one stage after we came here who said they would never go into a retirement home/village, and I said why. "Oh family will look after us" and I said what happens if the family are unable to look after you! "Oh, oh, we will do something", but they hadn't thought of that. …and we decided right we will come into A to the consternation of all the families because they were relying on June because she was the youngest to look after them, and so we came here. But no, way back, well my parents were here you see, and I think I have told you, and they were in the cottage next door – well they had a few years here and they were quite happy, they didn't die of an illness, it was just old age, and so when Jess and I had decided… (Bob).

Yes has been really. Oh yes it is – oh I don't know, it's just you have got your own place and there are so many different ones – like you know you might cotton on to somebody you know, but you can just come here and forget all about it – and yet you are part of it. …Oh, I had been subscribing to A for years you know through the….and I just thought – oh well it was a bit lonely on your own so I had my name down for about three years and I was lucky I got the choice of this one, because it was the only one vacant…. Well, it (the Village) is great really because you mix with people, and especially going and having a meal you get to know the people and you are sort of a little family in a way, because everybody is sort of interested in the other and some of the ones coming in now, they don't do anything they just sit in their cottages you see, and we don't sort of bother about them the same. …. Well I cook on a Saturday because they just sort of have an easy day, and yes we do and we

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> *get great meals – always tell them to cut them down a bit because oh they*
> *are far too big. (Madge).*

Tim's view did not concur with others' positive experience and description of retirement villages.

> *It hasn't helped me at all because I go to dinner, I don't have any conversation*
> *with the people that are there - I come home from dinner and that's it.*

Tim's life at the retirement village is an isolated existence. He does not describe the same positive experience that other narrators expressed.

Interest and knowledge of what is going on with family, children - grandchildren demonstrated the narrators' engagement with life. Almost all narrators could name all their grand and great grand-children as well as talk in detail about where they were in the world and what they were doing. This is an example of what Rowles (1978) considers as geographical imaginations which can be both temporal through reminiscence - visitors and story-telling as well as spatial as these oldest-old engage with experiences of their wider family in other places.

> *Oh yes, oh well, I know all my grandchildren and they all keep in touch too…*
> *Oh yes, they are all leaving the country now….They stray away now to all*
> *sorts of countries. (Lily).*

> *My oldest grandson is 27, and he is now a dad. (Alice).*

> *She's an occupational therapist … so that's what she is doing – she is in an*
> *office and the middle one, the boy, he's in Perth – south of Perth, Yallingup is*
> *the place and he's a carpenter now and he's good with his hands. The other*
> *boy was academic but Mark, he's a carpenter and he was at Wanaka and he*
> *was in a café there as a chef and he started off when he was at school going*
> *around the cafes and he started off cleaning toilets I think and then – oh he*
> *might have been washing dishes, I don't know what he was doing – but he*
> *ended up so that he could cook the meals there, and then he left there (he*
> *was in Mosgiel) and then he left there and went up to Wanaka and got a job*
> *up there in one of these chef places and after he had been there a good while*

he decided he would take his training as a carpenter so he is qualified as that now – but you see he was a snowboarder. (Esther).

For mothers and grandmothers like Lena there was the input they had provided to their own children and grandchildren.

… she has been a great little mother with my help of course, and I love those kids – it's like me having a second family….Scott was living in Milton but he's down at home just now because they are people who have always worked in the bush, and he's been down cutting the trees down on Bluff Hill – him and his gang – oh they are great workers, so she's got Scott and the youngest one at home – I don't think he will ever leave. (Lena).

Whilst many of the narrators – Alice, Lily, Heather were fortunate in having their children living close by and "doing for them"; other narrators such as Beatrice, Esther, Tim, Bob and Sarah did not and recognised that families are dynamic and transform over time. Families increase and decrease in size with births and deaths as well as family members moving away or not being as available to visit; such as Sarah's daughter who doesn't keep well. These changes affect not only the amount of support but also the way it is provided.

…Oh, I think so, and I like young company, I enjoyed Isa's two sons, two boys – wee boys I always call them wee boys…No, they have always got something to tell me, show me something …but I have a lot of company, I am not lonely or anything, I am not a lonely person, I am a home person, I always have been…My daughter is 70… Sally comes down about every year, she used to come down more often but she doesn't keep – well. …well, you see my daughter lives in Hastings, and all my grandchildren don't live here – I have got one in Australia in Cairns, and one in Palmerston North, and one in – granddaughter lives in Whakatane – Maurice and Jan they are in Poirua, so they are all away. (Sarah).

When my son lived in town here, at that stage he was married with three little children, and he lived in Terrace Street, so we came around and we found this house was quite close to Terrace Street, and then I was here three weeks and

he went to Dunedin and he has been there ever since…. but he rings me two or three times a week, and he comes down very often, and if I am in the hospital he always just comes down and stays here while I am in. (Esther).

…none of our family are in Invercargill – one's in Christchurch – two in Masterton you see. It was awkward for them to be able to do anything for us so going into a home was a great move for them, and we never regretted it. (Bob).

…my son has just moved to Wellington from Wanaka – that was a bit of a knock, but I doubt whether I will go again. He plans I can go again, I can go in the plane – I can, but I don't think I will bother. (Tim).

Heather highlighted the ways of maintaining social connectedness with friends had changed over the years with phone calls rather than visits as their means of communicating and staying in touch.

I have got some good friends from around the town – very good ladies they are and I don't go and visit them either and they don't come and visit me. They ring me up on the phone most days to see how I am, if they don't ring me up I ring them up. (Heather).

Sarah reflects on her interest and joy of younger people and says;

I enjoyed their company really – I like company … and I like young company. … she takes me anywhere I want to go. (Sarah).

The importance of the narrators' children in the theme of social connectedness was evident. Three women had adult children who had died traumatically or as the result of illness. These tragedies had a significant impact with them identifying these events as the single greatest trauma in their lives even greater than the death of their spouse. Through these losses the importance of family and social connectedness is heightened.

I'll never get over that (tragedy). (Alice).

Rex was 69 when he died, and it broke my heart as he was a lovely boy. (Lena).

I think Anne's death was the thing that got me most …and my eldest daughter, that was so sad, she had three children. (Lily).

Of the ten narrators, only three had siblings who were alive and none had siblings living close by. For the three with siblings living in another location there was no opportunity for physical support however, there was still the opportunity for support via telephone and letters. They were realistic in acknowledging they would not see them again. Within this realisation, there was a sense of sadness as they spoke of their brothers or sisters and their lives and how they were in some cases inter-woven whilst in others quite distinct with little interaction. The very essence of the interview process encouraged narrators to reflect on their lives and as much as this was about them as individuals it was an opportunity for them to make sense of their lives which included those people that were part of their story.

Narrators often identified loneliness as part of their lives. This was due to not only their decreasing or changed ability to do the normal daily tasks or visit places they were used to going but that they are alone. None of the married narrators had a living spouse. Both Bob and Tim expected to be outlived by their spouses. Surprisingly both wives had died first leaving Bob and Tim expressing surprise and loneliness, Bob commented on his wife's death saying.

…it was a bit of a shock really. (Bob).

Tim frequently visited his wife in the retirement village's hospital and during this time became familiar and comfortable in that environment. When she died, he lost not only his wife of many, many years but also contact with the hospital staff and during our interview expressed sadness and loneliness.

…she died and I just stayed in the unit. (Tim).

For many (seven of the ten narrators) they were the only child remaining in their family as well as amongst their friends. This of course affects the ability to remain socially connected and it becomes potentially harder to be socially connected.

I seem to be the oldest and they are all dying before me – so that's Margaret and Daisy – they both died last year. (Alice).

…the people that I knew have either retired or died, and it's amazing when

…you look back on the number of people that you were friends with that

…have passed on. (Bob).

… my in-laws they have all gone too – all my husband's people – they have all

gone, but I suppose it happens to a lot of people. (Lily).

Mm, well I have got no friends of my own age now – they are all sort of gone. (Sarah).

A bit lonely…. You know something will happen in the family – like a cousin died a while ago in the North Island – well if Mervyn had been alive – we would have talked about things like what he had done and different things – well now you have nobody – nobody understands now – there's nobody. (Madge).

Of the ten narrators only one had no children, she spoke of the importance of children to other older people she knew. Madge had also not married and acknowledged that this was a different life than her contemporaries who had married and had children; throughout the interview she reflected an intense feeling of "alone ness" despite active involvement in many groups and activities.

…you have got to look after it yourself and that was the attitude, you know. I had to manage the business for a few years and nobody told me what to do or anything – you just had to do it yourself. (Madge).

However, she had a niece who visited monthly of and spoke warmly of.

I have got a niece in Queenstown who comes down about once a month and we go out for a meal on a Sunday and do shopping. (Madge).

As would be expected there was a variation in the amount of time families were able to provide to narrators with some families not as available as others.

…none of our family are in Invercargill – one's in Dunedin – two in Wellington you see. It was awkward for them to be able to do anything for us so going

into a home was a great move for them, and we never regretted it.…it doesn't

worry me much because I see them – they come down with…their business. If

they come to Invercargill they stay with me for a night …you see, and away

the next morning and that will be perhaps as much as I will see of them – but I

see them… telephone's a great thing. (Bob).

As identified by You and Lee (2006) an important part of social connectedness for this generation is being married and having a spouse is frequently identified in the literature as a means of staying at home for older people. None of the narrators had a living spouse, one had died within the previous year and both the male narrators' wives had died within the past three years, despite their wives being younger than them. With a tear in his eye Tim talked about his wife Jocelyn.

Well, we sort of thought that she was three years younger than me, so she

ought to have lasted longer. (Tim).

Lily matter of factly talked about the death of her husband, she does this in much less emotional terms than the death of her daughter.

I think Anne's death was the thing that got me most…when my husband died,

of course that was sad, but we had a good many years together – he was 72.

(Lily).

Other narrators had more than one partner/spouse. Given the age of these narrators it could be assumed that their views on marriage/relationships would be conservative. After the death of her husband, one narrator had not married her subsequent partner. Alice explains their relationship and that she returned "home" after her partner died as her children were all in the South Island.

…you are probably a bit old to have a boyfriend, though (interviewer). No, he

was only a partner. He was good, we played bowls and then the hot pools –

they are wonderful – we seemed to – anything I went to he always seemed to

be there Ha, ha, ha – but, no he was very good – did the garden and helped

me a lot – I was driving then, I didn't drive much up there, he did most of the

driving after that. Oh no, that's why I am here – his legs were playing up and

he was in the garden and he thought he would go and have a lie down before
afternoon tea and I called out – tea's ready and no reply and I said it about
three times, and I went along and I knew from the look of him that he had
gone. (Alice).

Sarah, Lena and Heather spoke about staying socially connected with others, wider than the circle of family. Often the oldest-old are seen as withdrawn and isolated from the community. In contrast to this Lena describes being an active community member; a source of knowledge for the community as she was the oldest person living in it, this is of course the reason for her inclusion as a narrator in this study.

I had a policeman come to the door in full uniform and nobody seen him – he
was after information and I still get people after information. (Lena).

SUBTHEME II) HELP - PAID/UNPAID HELP

Help for the oldest-old is provided in a variety of shapes and forms. There is of course paid help with nine of the ten narrators having some form of non-family paid help - not all of this was paid for by the state but by the narrators themselves. The physical importance of the domestic assistance should not be minimised. However, the oldest-old identified the social aspect of assistance as a crucial element in remaining at home – assisting them to age in place.

Esther clearly articulates how "help" both paid and unpaid, assists in her living in her own home.

And you see I get all this help. The Disability Resource people are very good
and I get a home aide through them and I have got a lady that comes in every
Thursday from them for an hour, Thursday morning and we do different
things together – we do crosswords or rugby picks in the rugby season, and
we made some money this year – not a lot but we made some, and she takes
me anywhere I want to go. She took me to the Hospice one day, the day I
spent there, and then another day to see the Doctor down there, and she will
take me to the eye specialist or something like that. Oh she is very good!
(Esther).

> *Yes, I have a gardener, and Phil cuts the lawns, but Beverley is here longer than an hour… I look forward to Mondays – you know she has always got something to tell me and things like that, she tells me a lot of her own private business and things, you know. (Sarah).*

There was most often a precipitating factor that had led to the start of paid help, most often this was a major health event such as a fall or an operation.

> *I was 80 years of age that is when I first got help, that's when I had my first knee done. (Lena).*

> *I have got a home aide that comes on Monday morning for an hour and a half, and I have got a lady I get to do my garden – she's been coming for a long, long time. I broke my hip, I fell out there and broke my hip – I did that about oh 16/17 years ago and she's been coming ever since and she does my garden just on the private. (Esther).*

Paid help is part of the retirement village fee and provides gardening, basic laundry services with other services such as meals, domestic assistance provided as an extra service or provided by the local district health board if the person meets the criteria. For the five narrators who had moved to a retirement village the move was related to a real or perceived change in their health status.

> *I kept falling. (Alice).*

> *Ah, no, I just felt with everything that I was going to lose hold of things, the garden was sort of getting, the trees needed cut and different things – I just felt that it was about time to do, you know. (Madge).*

> *I knew things were changing. (Ted).*

> *I could see she wasn't managing so well. (Bob).*

> *I hadn't been well so my family sort of said… (Lily).*

When asked why Madge first received home help and when she reflected.

… I think they have been doing it for seven years – when I came here I didn't have it straight away – it was a while afterwards, I think it was about two years….I don't know really, I think it might have been because everybody else was having it! (Madge).

Paid help doesn't come every day of the week and narrators accept this and make other arrangements.

A girl comes to make the bed each morning, and helps me to shower, but not on the weekend. (Beatrice).

Oh no, I get meals on wheels, but today's weekend you don't get it at the weekend…. Well, today since you were coming I just put on potatoes and I have got a, what do you call it, from Irvines. (Esther).

Some relationships with paid home help were as close as friends, and with family members living out of town and working during the day, people working as home help were seen more frequently than family members. Narrators such as Sarah, Lena and Lily described their longstanding relationships with them.

I have had a home help, well I have had Beverley for about 19 years…. The only day I am late having my dinner is on a Monday when my home help is here. (Sarah).

…and the last twice she has taken the sheets home and washed them at home, cause with me being sick I couldn't do them. (Lena).

…he come along and had his meals with me [but didn't stay with me] because he didn't want to put me to any trouble or anything like that. (Lena).

… good company that's exactly what it is – they are cutting people down now to half an hour, and by the time somebody comes in, you like them to sit down and chat for a while and tell you what is happening in the world, not exactly gossip but you know, what's going on, but that's cut out now because if they take it down to half an hour (Lily).

Heather was the one narrator who received no paid domestic help or personal care for either herself or her son. At 98 Heather cares for her disabled son, manages her four bedroom house and small garden on a large quarter acre section. In recent years she has given up trimming the large macrocarpa hedge and pays someone to do this as well paying the boy next door to do the lawns. This is not a formal arrangement but happens informally.

> *…sometimes….Well the boy next door comes in - he hears me starting the mower up and says "I will mow the lawn for you." (Heather).*

When discussing how Heather manages she describes herself as "no longer keen on driving." Her daughter comes from Invercargill every Thursday and takes her to the local supermarket. Heather described herself as an extremely private person, not wanting strangers in her house, knowing her business. This is no doubt a reason why the only support she receives apart from the lawns and hedges is from her immediate family.

Several narrators noted that being financially comfortable ensured that they were able to afford some extra things such as the hedge/tree trimming.

> *…the other thing that made the extra bits affordable was not spending your money on other things – such as going out/ holidays. (Esther, Alice , Tim)*

Lily and Sarah identified having the groceries delivered to them as helpful. However, this was not a new phenomenon for them. Lily had received this service since she had moved to the small rural town she had retired to in the 1960s and Sarah had also utilised this since she was in her 40s or 50s. Notably neither of these women had ever driven a car which would make having their weekly shop delivered both sensible and practical. Other narrators talked about this being a service they had started using more recently with supermarkets providing it at a cost for people – particularly older people. Perhaps recognising and utilising the various services that are available in the community is part of what keeps people living at home. The services these narrators used may be have been accessed by the narrator themselves or by their family or other associates such as the DHBs needs assessors. The Berlin Ageing Study (1998) identified those accepting of their age as living two years longer. Further to this they posit accepting services and support is needed to enable independent/interdependent living. This is consistent with these narrators all of whom were

accepting of increasing social support as a result of their advancing age and associated limitations.

SUBTHEME III) KEEPING BUSY

Keeping busy or an equivalent notion is regularly considered when discussing the lives of older people and how they successfully age. Often this is thought to be part of social connectedness. There is an intersection between employment and hobbies with both contributing to keeping busy. Often our place in the world – the status we have and community standing is defined by our occupation/hobbies such as teacher, business owner, mother, champion baker and sports person gives meaning to the things we do and are engaged in. They also provide us with opportunities to maintain social connectedness (Register & Herman, 2010).

As part of the interview, the narrators were asked if they thought anything through their life course had contributed to them being able to live independently at over 95 years. They went on to talk about work, retirement, hobbies and interests. All the narrators have had various ways of keeping busy over their life course which included an array of hobbies, interests and work and these have continued as they aged – perhaps in a modified way. For many narrators their occupation was also a hobby and interest and this was demonstrated by the number of those that worked after retirement age. What became clear both in the literature and in the narrators stories was that keeping busy changes over the life course with the activities younger people would consider as being busy are perhaps not the same as the oldest-old. In their earlier old age paid work is often replaced by unpaid work, such as volunteering - caring for grandchildren. However, by the time people are over 95 years this unpaid work has stopped; families have often moved away and grandchildren are grown up and now having great grandchildren.

a) Hobbies and interests

Hobbies and interests provide a variety of things for people including; keeping people busy physically and intellectually as well as contributing to keeping them socially connected - giving them something to talk about and share with those with whom they speak to on the phone and visit. An example of this was Alice's interest in preparation for the then upcoming Rugby World Cup and Esther's seemingly solitary pursuit of reading however, she

regularly shared books with others and enjoyed talking about authors. With some narrators, lifelong pursuits such as handicrafts are limited as a result of disability leaving these people with a sense of leaving things unfinished. Lily had some unfinished knitting - it wasn't that she didn't want to or could not remember how to knit; she had lost the function of one hand and as such could no longer able contribute with hand knitted garments for her family and friends as she had done when she was younger.

> *I can't knit now, and that's what I miss, in that basket I have got a bit of embroidery work I don't think I will ever finish. I just can't – my hand cramps – you see what those fingers are like, and I have lost the feeling in those, I cut that point off there the other day and you know I didn't even know I had done it – those fingers they are dead for picking up anything – this is the best hand. (Lily).*

> *I don't know, I used to, well I made all my children's clothes, and made my own too really and I did cane work – that's some of it there– I made those, for a few years I made cane work, we had a woman here in Lawrence who was absolutely excellent and she held classes so it was quite good and what else did I do – well I did knitting and all that sort of thing. (Lily).*

> *….I was a good sewer, I will say it myself - …I have always had a garden and a veggie garden, I tell you what I did when I was in my late 70's – I started, I have always been a beautiful baker – so I started selling it and I got a great name around the place, I was selling 20 dozen queen cakes for weddings and I loved it – I just absolutely loved it, and every cake I put out was perfect – I took a great pride in doing everything right and they were all the same size and I wish I had all the words said to me in complimentary words – I wish they were down on paper. I can still cook a feed for myself and you, and you if you needed it – on the top of the range – I don't do the oven at all now, after being a champion baker I can't do the oven at all….I was still doing it [baking] when I was 90 – I had lost my eyesight. Well, I am very independent – they call me the old independent so and so, but my neighbours have always – I have got a lot of friends around, but not friends that will come and help. (Lena).*

Reading the narrators stories was not the same as listening to them, listening to them gave the opportunity to hear the profound sadness in their voices. Lena talked about the loss of her sight. These are further losses of lifelong activities - the things that have kept them busy over a life time. As they are able they have adapted to new ways of doing things - doing it cooperatively such as; Lena and the gardener, Beatrice using talking books rather than reading the book, Bob listening to the radio. Loss of an enjoyable pass time was part of the pattern of loss for older people and contributed to the deep sense of sadness of yet another loss for them.

> *…and I can't read much now because I have lost the sight in one eye you see – like an old car – parts are going, and oh I listen to the radio a lot. (Bob).*

For others spectator sports such as football and television were their passion, their knowledge of this was something that could be shared with her family and visitors.

> *I am interested in the football and things like that, just reading in the paper…Yes, I am mad on football. (Alice).*

> *The only time I was always late to bed was when that dancing was on – Dancing with the Stars or whatever it was, I forget now. (Madge).*

Keeping their brain active is important and television contributed to this as well as programmes such as Coronation Street that they had watched since it began.

> *I enjoy watching some tv – It's sort of a, not a quiz thing but you have to do things, and, oh it was very good. (Madge).*

Narrators such as Tim talked about withdrawing from clubs that he had belonged to with others discussing the groups they continue to belong to, perhaps this was part of the loneliness and lack of social connectedness he had described earlier. Esther had volunteered into her 80s. As in other areas of their lives reasons for no longer participating included; transport, mobility and general health. A notable exception to this was Bob whose bowling had become something of an occupation particularly since his wife's death.

> *To tell the honest truth I do more bowling now than I ever thought about in the first place when I retired… Yes, and I enjoy it…usually bowl in the*

> *mornings – keep my afternoons free for other things like shopping or visiting or sitting here reading or something.*

Bowling had become Alice's new form of exercise.

> *So I play indoor bowls now but not bending right down – that table is marvellous. (Alice).*

The competitive aspect of hobbies and sports was evident in Lena's pride when she was picked for Western, this is not only something to be proud of but a conversation piece.

> *I was still playing indoor bowls at 92 and I got picked to play for Western at 90! (Lena).*

Sarah reflected on the shared interest of bowling with her second husband and while she no longer bowled – on a sunny afternoon she would read a book in her caravan which they had gone to bowling tournaments in which was parked close to the house.

> *…we were both bowlers and we used to go up Central Otago playing bowls and out at Riverton when they used to have the tournament on for league, we went out there, and been all around the North Island in the caravan.*

For those narrators who had moved into retirement villages or pensioner housing they are now fully involved in the community life and the new companionship resulting from this.

> *We belong to the Senior Cits here and every month we go somewhere and have a meal. (Lena).*

> *It's just you have got your own place and there are so many different ones (people) – like you know you might cotton on to somebody you know, but you can just come here (cottage) and forget all about it – and yet you are part of it….It's the best thing I ever did (come to a Retirement Village) cause you are no trouble to anybody like being on your own you are not a burden to your nieces and that because they know you are looked after. (Madge).*

For others this was not the case. Sarah had contemplated a possible move into a resthome or retirement village.

> *Into Oaks, into care, and as Dr D says "I don't think so yet." What is it he said to me? "I think you would get bored". (Sarah).*

Work was identified as major part of all the participants' lives with many attributing lifelong hard work as the reason for their long lives.

> *What did you do in your leisure time? (Interviewer) …we were always busy working really. (Beatrice).*
>
> *…after I retired – what did I do – I did something! I was occupied with something – can't think what it is now – it kept me going two or three days in the week – part of the time you know and by doing that I was sort of occupied then. (Bob).*
>
> *…hard work. (Lena. Alice. Beatrice. Ted, Bob)..*
>
> *And I was still working actually when we were there (after retirement). (Beatrice).*
>
> *No, I do a lot of those word puzzles. (Esther).*

Listening to the narrators, few had retired from their occupation at 60 which was the NZ retirement age in the late 1970s and early 1980s.

> *What did you do when you retired? (Interviewer) … we bought a motel. (Beatrice).*
>
> *No, we hadn't done anything – we were all right out there – we were more or less retired out there (on a 20 acre lifestyle block). (Esther).*
>
> *I decided that I would do something, (after I retired). I can't think what I did – oh yeh – I went back to Tech, that's where I was teaching, I was a woodwork teacher you see – I went back there and did maintenance work of equipment all around the place. I worked there for about three or four years. (Bob).*
>
> *You find some people when they retire they just go to the pack … So he said we are going to look for a warm spot and we brought motels up there*

> *(Alexandra)...Well, that is hard work – we were retired but we didn't feel old*
> *enough to be retired. (Alice).*

Sometimes the choice was forced.

> *So you worked until you were 65? (Interviewer). 67. Because 65 came in – the*
> *rule came in that anybody over 60 who had to retire, and so, I forget who the*
> *man was now, he was a nice chap, he had a bit of a job telling me that I was*
> *due to retire. (Madge).*

All narrators indicated that retirement was a significant life event – a time when life changed for narrators. For Heather, Sarah, Lily and Lena this was not only about their retirement it was the retirement of their husband's and for some the death of their spouse. Bob noted that a number of people died shortly after retirement. He believed this was due no longer being meaningfully occupied.

> *Look, if you have been in an 8 to 5 job for years – all your life – to suddenly*
> *retire and do nothing – you are completely lost – and you know its amazing*
> *how many people die, they might be around for two/three years and then*
> *they suddenly die. You retire and get something to do – even voluntary*
> *work which gets you going every day – you last for a long time – well look*
> *at me – 93. (Bob).*

Those narrators who worked past retirement; their retirement occupation was less busy and highly pressured than their previous work more of a lifestyle choice. Bob sagely adds:

> *The secret is when you retire to get into something else to occupy yourself.*
> *That gives you exercise which you were getting when you were working.*
> *Now what some people make the mistake of is they retire and do nothing –*
> *they haven't thought about what they are going to do – they do nothing*
> *and all of a sudden you see their name in the death column. (Bob).*

6.1.3 MANAGING THE PHYSICAL ENVIRONMENT

A paramount consideration for this study is the affect the physical environment has on the ability for the oldest-old to negotiate it and remain living independently; this is of course a

concern for many others across the life course. Due to the various physical and sensory deficits including; decreased mobility, deafness, blindness, forgetfulness, aids such as walkers, walking sticks, hearing aids and glasses were increasingly required to support them at home. For those wearing glasses they usually had started doing this much earlier in their life so what may have been an occasional requirement or something more easily managed became a critical need in order to function normally. All narrators wore glasses with a number wearing hearing aids with various levels of effectiveness. The accessibility of these due to the costs may impact on some people accessing these as Heather explains.

SUBTHEME I)   USE OF AIDS - HEARING AIDS, WALKERS, GLASSES

… it cost me $500 by the time I had finished – all the run around getting the licence – by the time you go to the Doctor its $67, by the time you go to the eye specialist it was $95, by the time you do something else, get down there its $57 and another $41, have you got another $41 on you to pay the – she says to me. The cheek of them – they don't tell you – how did she know, I might not have had the $41 on me – and I counted it all up – by the time I registered the car – it was $200 and something – and all those kind of things – it cost me $500. (Heather).

Other aids such as walking sticks and walkers assist in maintaining older people at home by maintaining their mobility and enabling them to do activities of daily living. These excerpts demonstrate the contribution of aids to the narrators living at home.

…you see I have got to use the walking stick, it won't be long before I got to use my brother's walker but, the District Nurse said to me before you start using the walker, she said practise up and down the footpath first, but she said don't really start using a walker unless you have really got to. (Sarah).

…I have things to help me along and things like that – and I can shower myself easily because I only have about two or three a week – it all depends – and every night I have a wash too before I go to bed, but what I do with the shower gel – I pour it on myself, rub it all over and then I stand under the shower, like that and I get a bath brush – and while I do my back you see I

hold on to the rail, because I am frightened I might slip, but I have never slipped on anything. (Sarah).

I am not steady, that's why I need the walker and that, oh they are marvellous, …they give you the balance. (Tim).

Beatrice identified her walking frame as an essential part of her life important.

…I brought one of those for my daughter – I thought it would be good for her when she goes shopping and she comes in with it loaded up with parcels – she pops them on them you know. (Beatrice).

SUBTHEME II) APPLIANCES AND TECHNOLOGY

Narrators identified various aids they used – most aids used were concerned with the functional activities of daily living such as walking sticks, rails, walkers. However, aids and their uses are much broader than just the functional activities of daily living. As mentioned earlier the telephone was a positive factor, contributing to the oldest-old remaining at home as an aid in the home providing a means of getting assistance (urgent or otherwise). With ever increasing technological improvements there will be increasing numbers of affordable assistive devices that will contribute to living independently for example, a door alarm to assist a wandering person from leaving an area can now be purchased for $10 and costs nothing to install.

Oh yeh, telephone's a great thing…they keep in regular touch with me. (Bob).

I had to buy a special telephone – it's got big black numbers on it and I can handle it. (Lena).

Lily comments that listening to a book is not the same as reading however, talking books enable her to continue her lifelong hobby.

…as long as I could read. I would love to pick up a book and read, I would love to do my crochet again, I would love to do all my hand work, and I love gardening – you can see out there. I had help, not planting – I bought some of those and I clean my troughs out and I had a friend help me fill them – I can plant, ha ha ha, I feel around for weeds and I have got a habit of poking

125

> *something in here and something in there and forgetting what I have poked in.*
>
> *(Lena).*

Improvements in appliances such as washing machines that are used across the life course have improved the day to day lives of many narrators.

> *Well, it's no trouble to wash you just throw the things in, push a few*
>
> *buttons…. Oh yes it's been wonderful. (Madge).*

Other narrators have stayed with the technology they have always used and as they remain in their own homes as evidenced by Heather talking about keeping her coal range.

> *I wouldn't know how to work an electric one. (Heather).*

The ability to stay at home - where everything is accessible and known to the person becomes an issue when visits to other places occur. These visits may be difficult, decrease in number or completely cease because of the absence of accessible bathrooms, taps that are easy to use and flat access at the front door. Comments about inaccessibility to buildings and places they may like to visit were issues for all narrators and limited their on-going ability to be mobile, socially involved and part of the community. Whilst the oldest-old are experiencing inaccessibility and it is impacting on their lives they are not raising it as an important community issue – this does not mean we should not be thinking about age friendly towns and cities for all of those who are getting older.

> *You might not use it (handrail) but you know it is there. (Madge).*

Indeed Madge didn't think she would still be able to shower on her own if the bathroom was not fully flat entry. A number of narrators took great pride in describing or showing me the bathrooms, and small and well planned galley kitchens and serveries with everything in reach.

> *Everything is handy; the bedroom is there and just straight over is the*
>
> *bathroom – where I go about three times in the night. (Alice).*

SUBTHEME III)   CHANGING HOW AND WHERE I LIVE

Home was identified by numerous researchers, as discussed in chapter 3, as an integral part of the self of older people, assisting them to identify who they are. This is congruent with

the literature as all the narrators talked about their homes – past, present and for some the future which may include the possibility of needing to be in a resthome or hospital bed. The narrators talked about changing home in a variety of contexts. Lena talked about the loss experienced about leaving the family home and garden she loved. Bob and Ted talked about the need to downsize and look more practically at the physical environment as they were ageing. This consideration of needing to downsize to a smaller home is a way of managing the physical environment. Whilst not formally planning to make changes to assist them to be able to age in their own home the two male narrators demonstrated an underlying 'common sense' about what these men thought their spouses could manage. Tim talks about making the changes to benefit his wife as he expected her to be left without him and not the other way around as has happened.

When considering what it is that allows the oldest-old to live independently the immediate physical environment including where and how they live were most often seen as what enables people to do this. Moving house over the life course constituted a change in situation such as increasing numbers of children and then; children leaving home, not needing the same amount of garden space and also reflected increased financial comfort. For two narrators since marrying neither Sarah nor Heather had shifted house, however, over time these houses had undergone a series of modifications to meet the needs of children, hobbies, physical requirements dictating many of the changes.

> *I have had the bath taken out – for a shower, I had that put in when I was married to my second husband…...only put the step down there (front door) recently actually – built one up. (Sarah).*

Sarah adds; *I haven't spent any money on it because different ones have told me not to spend any money on it (the house). (Sarah).*

Modification to home is not only to the physical building but can include relocation to a new home that is more suitable and practical. Madge describes the move.

> *…oh well it was a bit lonely on your own so I had my name down for about three years and I was lucky I got the choice of this one, because it was the only one vacant. (Madge).*

Six narrators had chosen to live in retirement villages or pensioner housing. Reasons for this choice included identifying their future needs and the potential for support in the village environment which they didn't have as the result of their personal situation.

I might be like the next door ones, getting my meals from the hospital. (Lily).

The following excerpts demonstrate the benefits for the narrators of having managed their physical environment by moving.

I was talking to somebody at one stage after we came here who said they would never go into a retirement home, and I said why. "Oh family will look after us" and I said what happens if the family are unable to look after you! (Bob).

Madge enjoys her home in a retirement village and the company this situation provides.

…you mix with people, and especially going and having a meal you get to know the people and you are sort of a little family in a way, because everybody is sort of interested in the other and some of the ones coming in now, they don't do anything they just sit in their cottages you see, and we don't sort of bother about them the same….but you can just come here and forget all about it – and yet you are part of it. (Madge).

Lily moved to a retirement unit which is well off the street and unlike her previous residence on a busy central town street she doesn't see as many people walking past.

…was three bedrooms, and a nice lounge right across the front, I could sit there in the sunshine and watch the world go by – that is what I miss here, it is so quiet, there is just no life about here at all… could sit in my lounge up there and just watch the world go by, watch the kids going away to school and what they were up to and that. (Lily).

Sarah still lived on a busy street and she describes her enjoyment in watching her surroundings.

> *Yes, often at nights I go and sit up the front and have a look – watch the ones going past, going to the Stadium, see them going past – you have no idea the ones that go walking past, you know where they are going because they generally have something on their backpack – you know tennis rackets and things. I often sit up there at night 5 or 10 minutes before I go to bed.*

Alice had stepped down into a smaller house.

> *I was in a house to start with and then I started falling over so I thought I would get a wee bit nearer, and I am on crutches, and it's much smaller than the house, but I quite like in there, once I have all my bits. (Alice).*

With Lena it is a demonstration of her immense desire to both be and remain living as she does.

> *Dr J when he was here, he said, you have got to give up the oven, you have got to give up cooking and I looked at him – and he said "yes, if you burn yourself Lena, I will have no say in the matter – they will take you away." (Lena).*

Lily thought that she would enjoy living in her resthome if she needed to.

> *…I suppose I go over there or a place in Dunedin. I wouldn't go to my family – it's not fair on anybody. (Lily).*

Madge's description of moving to a retirement village concurs with Alice, Lily and Bob.

> *…it's the best thing I ever did. 'Cause you are no trouble to anybody like being on your own you are not a burden to your nieces and that is because they know you are looked after.(Madge).*

Madge, Sarah, Lily and Lena talked about the benefits of a physical environment that promotes their ability to "do for themselves." Madge comments that others in her Retirement Village agree that accessible bathrooms were part of being able to live independently. For Tim living alone in his unit in a Retirement Village was no longer of any benefit to him as following his wife's death he no longer needed to visit the hospital area.

Tim has subsequently moved to the resthome area and is exhibiting a new lease of life. Beatrice had moved locations from Tauranga to Invercargill but at more than 100 she was not expecting to move again believing that all the support she required could be provided where she is now.

6.1.4 Keeping well/ageing well

Food and nutrition are essential for health and life, without it there is no life and health may be compromised. This may seem an obvious statement however, as people age particularly the oldest-old it appears that society forgets the benefits of food for people. Not only in just taking in sufficient calories but eating well, maintaining the habits of a life time, it is evident that these narrators are doing exactly that, perhaps adding in something extra like a glass of wine

> *Well, I only have three cups of tea a day Mm, I have never had a cup of coffee, and I have a drank of cranberry drink, and I will have a glass of red wine   Not quite every day, sometimes it might be every day, it all depends, I don't have it after 7 o'clock. (Sarah).*

Subtheme i) Health and eating well

Health, like other themes exists as for other ages across the life course. All narrators were older than 95 years and all reported long periods of good health throughout their lives. Others were able to identify that they had self-care routines that they followed.

> *…I sort of know what agrees with me. (Sarah).*

> *We just have a lemon drink or something like that (if we were sick). (Madge).*

At the time of the interview, two narrators were receiving cancer treatment. Despite this diagnosis they did not identify themselves as sick or that the cancer they had may result in their death. This concurs with Cartensen, Mikels, and Mather (2006); Kaul and Lakey (2003); Evert, Lawler, Bogan and Perls' (2003) that despite what may seem as extreme ill health, the oldest-old do not identify themselves as sick, often referring to others as less well off than themselves.

However, while not being concerned about their own possible death, mothers like Lily were concerned for their children's health.

> *I should say no – I am worried just now with my son and that he is having – starting chemo and he only had four doses when it started and then he went back and they told him to carry on and he had another two – my word he nearly died, he was a whole month in hospital – and you worry about that sort of thing. (Lily).*

Wham et al. (2011b) advises that good nutrition contributes to good health which in turn promotes longevity. For several narrators food and the rituals associated with it were identified as a major contributors to good health.

> *I think it's the way you eat and look after yourself I eat well, and I like my vegetables. (Esther).*

> *I eat a lot of fruit, but in the day time I will have a couple of drinks of cranberry, or a couple of glasses of water. ...and I have my meals always at a certain time. I have got a routine of living and cooking, you know, I love to have my breakfast by 9 o'clock and I like to have my dinner at 12, I look at the clock – I might be a bit late if somebody has been in – think gosh, 5 past, 10 past 12, you know, I am late having my dinner today. The only day I am late having my dinner is on a Monday when my home help is here, and I have my tea always about 5 o'clock… I am ready to go to bed about 9 o'clock or half past 9. (Sarah).*

> *I always have lots of vegetables and different things like that. (Beatrice).*

> *…I have never broken a bone, and neither have any of my family, and I am quite sure it's the calcium of the milk……we were a healthy family, well, I say that, then I say my dad died at that age. (Lily).*

> *Oh yes, I am lucky, I have been lucky…I don't know – oh we just lived a normal life – good food and everything like that – we had a shop you see …so we lived*

pretty well that way in food and that, but we really had a nice upbringing. (Madge).

Comments made about health were mainly limited to physical health however, Esther, Madge and Sarah refer to the positive benefits of both keeping their minds active and having a faith in assisting them to stay living as they were.

I do a lot of those word puzzles. (Esther).

It's sort of a, not a quiz thing but you have to do things, and, oh it was very good. (Madge).

I think if you have a faith you are right … with a Christian upbringing you have got hope, you have got faith – well, they haven't got that. (Madge).

SUBTHEME II)   MEDICATIONS

Medications are an important aspect of older people's lives, with medication management identified as a major concern in this age group (Henriques, Costa, & Cabrita, 2012). Amongst this group of narrators medication compliance was not a cause for concern, all were taking some form of medication and taking them diligently whether independently or by the help of a third party. Not all narrators were sure of the names of all the medications they were taking.

…have half an aspirin, and another tablet. (Alice).

With others, such as Lena, knowing the names of the tablets and Lily noting that the medications contribute to their longevity.

I have got them all in a little container and I got every one marked with black pen – what the hang's on there – see Capoten – see Amy marked them this morning and she has not marked them like I did. That's frusemide – my pills – I got the half one in there somewhere – that's my panadol – Capoten, so I have got them all marked, I know them by feel – the half one, that must be the half. (Lena).

> *I go very seldom, I have to go with these, apart from anything like that I just go every three months to get my tablets   To keep me alive I think – keep me going – blood pressure. (Lily).*

> *I have only had the glucosamine for about – oh it will be coming two years…so he put me on a stronger pill and boy what a difference it has made – its wonderful improved my mobility…its Fosomax Plus 70 something plus something else – I am wondering how much further it's going to go – but how it did make a differen**ce** – it's marvellous. (Madge).*

There is also the place for over the counter remedies.

> *I sit with my foot in vinegar, it's supposed to be good for corns. Haven't you read that in any of your books? (Heather).*

These excerpts demonstrate the use of the medications by these narrators and the means they employed to manage them.

SUBTHEME III)   KEEPING MOBILE

All narrators were aware of the need to keep mobile and if they were unable to be mobile they were aware this inactivity would affect them being able to stay living at home. Mobility was identified as an ability younger people take for granted, mobility contributes to being able to travel and go visiting. If narrators did not speak about mobility directly then they identified it as important and it arose as part of a conversation when talking about what they do to be able to stay at home or indeed demonstrate their use of something to assist their mobility. Others talked about not going out now as the result of declining health, decreased mobility problems with accessibility to places and areas and the reliance on others as a barrier. There were also many references to assistance with mobility to get somewhere and keep in touch with the world outside.

> *…I get picked up to go to Church and picked up to go to the Institute and all those sort of things. (Lena).*

Despite knowing that mobility is changing and a fall may have serious consequences Lily wishes to maintain all the independence she can.

> *I fell in the garden the other day, I have known for some time I will lose my balance and go, and I went backwards, and why I did, I don't know, I went backwards and my head went crashing into that board. (Lily).*

Madge and other narrators reflect on the changes to their mobility that have resulted as they have aged. Whilst still being mobile their description of not being able to stay away due to lack of aids and an inability to easily access the residence of her niece seemed to be more about confidence and not wishing to be a bother.

> *…can't go there now (visit and stay over) because her place is on three levels and there are too many stairs you see there's not the rails and when you go to these places and shower well there is not a rail there and there you see and you miss all that and you get nervous and that sort of thing – because you have everything here. And everybody says the same. (Madge).*

> *I am better off at home. (Beatrice).*

> *I haven't been to Hastings since my 90th birthday….it's too much for everyone. (Sarah).*

For some they are fortunate enough to still be driving.

> *Yeah, well I drive my car so, it's just as easy for me to go up there where I know everybody. (Bob).*

For others –

> *I gave up driving when I came here (back from the North Island), because I thought oh everything will be changed, I will probably go down the wrong way…the driveways are very tight and confined. (Alice).*

The ability to mobilise independently in the community was something to be proud of and something that all narrators wanted to be able to do. The ability to stay mobile means for they can continue to participate in lifelong activities. Lily at 100 years old was going on holiday just as she always had, to a familiar and accessible facility which assisted with her mobility.

There are of course treatments to assist in maintaining mobility. Narrators also understood that if they do not keep mobile then their mobility could be lost.

> ….keeping mobile – starting to use Fosomax. I take about six a day (tablets), and I had to take two calcium for the bones – that's 8. I had such pain in my leg and could hardly walk. Because they are encouraging everybody to use that and to make sure they get enough sunshine and all those sorts of things…you have got to walk too – not sit. Sometimes I go around the block – might take me 10 minutes, might take me ½ an hour – used to do it in 10 minutes, and then I come back and I can't read much now because I have lost the sight in one eye you see. (Madge).

> …then I could walk everywhere and I have been walking every where, I gave my car up – walking after you get your knees replaced – you have got to do that – and I have still got them – they are 16 years old. (Lena).

> Well, she takes me shopping otherwise I have got my scooter and I am quite able – I like going out on it, you get a bit of fresh air. (Lily).

The importance of life long habits was reinforced here with their habits supporting challenges to mobility of the oldest-old as well as hobbies such as gardening – which of course you need to be mobile to do.

> I mostly biked, and when I started teaching at Tech I used the car because I was perhaps coming home and then having to go back again, I enjoy walking put it that way – walking anywhere doesn't bother me – some people would hop in the car to go round the block, I would walk around it because its exercise and it's amazing what you see when you use your feet.   I enjoy walking put it that way – walking anywhere doesn't bother me – some people would hop in the car to go round the block, I would walk around it because its exercise. (Bob).

> …when I had the second one done I walked and I walked and I walked – I had elbow crutches. I get a ride to Church and I walk home every Sunday, even now. I walk up to Senior Cits, I walk home again, if I am able. If I am not, if

it's windy or raining I will get a ride – they all, sometimes there will be anywhere up to six people saying "Lena, do you want a ride?" There's always somebody there that will give me a lift. I get a ride to Church and I walk home every Sunday, even now. (Lena).

I enjoy walking and I think if you enjoy a thing, you will do it more than if you hate it….I love to garden, yes we had a lovely garden,… I had a garden all around, and anyway I joined the YM walking club you see and made more friends there and it was great, and I went to Church and things like that you know, but didn't do anything special. (Madge).

Tim puts it succinctly… *if I couldn't walk I couldn't stay at home. (Tim).*

SUBTHEME IV)   THERE'S NOTHING I'VE DONE

When directly asked what it was if anything that these narrators did to achieve their age and live independently in their own home most narrators said that they had not actively done any one or series of things to live to this age. The following points are the 'nothing' they did.

I don't think you get to be 90 something just like that (interviewer) Oh no, you have got to do something nothing happens without a lot of hard work…Well yes – I worked 16 hours a day for quite a lot of it. (Tim).

a) *Good luck*

Many of the narrators talked about the reason for their long lives just being plain good luck. Bob described luck as the reason for his long life as during the war he was nearly placed on a plane that was lost at sea. Others talked about the good luck of having good health which consequently led to their long lives.

Oh yes, I am lucky, I have been lucky……I don't know – oh we just lived a normal life. (Madge).

Some had smoked (Bob, Sarah, Heather) – others not exercised as much as they now thought they should have (Sarah), many had gone to war (Bob, Tim), with Esther having been manpowered (compulsorily working on the land during World War 2), (Esther). A number of people described periods of poor health throughout their life - poor health that

could have been life threatening with such illnesses as tuberculosis and pneumonia (Tim, Lily).

b) *Genetics*

In a similar way to the theme of good luck for numerous narrators there was an expectation that their parents had lived long lives (relative to the time they were alive) so they would also. As part of all the interviews, questions included how long had their parents and siblings lived. From their information, it appears that their own longevity may be associated with longevity of their parents, siblings and children. For some families the lives had been cut short due to war or the unavailability of medications that we expect to have available to us such as Lily's father dying at 39 and Bob and Tim's brothers being killed as young men in World War 2.

> *I think I was born like that – it came in families, but you know – families both sides those days were reliable and I suppose I got all the genes – I don't know, but I was always there anyhow because I was always a healthy – I was a 10 pound baby…….but we all survived and we are all healthy. (Lena).*

> *Yes, oh they would be in their 80s (when they died). (They came to the Retirement Village)– oh I don't know what age they were – they would be in their 70's I think – they must have been – because they were here for a few years and enjoyed life here too. They both kept good health. My brother and sister are still alive – both in their 90s. (Bob).*

> *My two sisters are in their 90s. (Tim).*

Many narrators had family members, siblings, parents and aunts that lived into advanced age.

> *The family consisted of Maurice born 24/10/1911, me, Kathleen 22/12/1917, Edna 17/2/1919 and Olive 12/2/1923. Arthur died in Egypt 1/8/1942 after being wounded at Alamein, but the others are still going strong – the girls are all widows. That's wrong, because one girl has now died – about a couple of years ago. (Tim).*

> *My children are now in their 70s. (Alice, Lily).*

My mother was 80 years old. (Lena).

I am the oldest. One died – the oldest brother died at 55, and my father died at 54, they both died in their mid-fifties, so I was always glad when each one got past 55 – you know you thought … Mum had a cousin and she lived until 96. (Madge).

c) <u>*Faith*</u>

The possibility that there may be something greater than human beings themselves determining the path of our lives is of total disregard to some narrators whilst being of significant concern to others. The narrators were raised and educated in a time that attendance at a church and following of a faith would have been expected. However, of the ten narrators only three referred to faith and that it was important to them as part of the interview.

Like many areas affecting the lives of the oldest-old the aspect of faith has lacked research. For those narrators who identified a religious faith as a part of their life they identified it as an essential for them. These narrators identified faith as part of all their life. For some it included schooling as they attended religious schools. Heather and Madge talked of religious faith earlier in their lives as important now as it was then.

> *…oh you have got to have faith! Does it have to be religious faith? (Interviewer). Yes. I think it does. (Madge).*

> *…I believe in going to Church – it's only the old ones going more now. (Heather).*

Others, such as Sarah, Lily, Alice and Lena, did not identify an outward demonstration of this as an essential part of their current life, although it had been in the past. Despite faith not being essential to them several commented that they believed in an ultimate power that determines the length of your life.

> *…there's only one person who can tell how long you can live, isn't there? I always think your life is planned out for you and there is only one person who knows when your time is up….. No, I never think about when I am going to*

die, I will die when my time is up, I think your life is planned out for you, I am a great believer in that. (Sarah).

...an inner sense because I have been doing things all my life I can still do them. (Lena).

For others who did not have religious faith there appeared an inner faith and strength within themselves, to be able to do for and take care of themselves. This was not only in what was said but the manner in which it was said and was one of the benefits of listening and re-listening to the interviews. These narrators are resilient and have emotional intelligence, they are cognisant of themselves and express an air of confidence and security when discussing how they live alone at over 95 years.

Subtheme v) Not worrying

All of the narrators talked about not having any control over the length of their lives with other reasons accounting for it – some of these are identified in other theme and subtheme areas such as genetics, good health and family. Like other themes and subthemes not worrying was something that narrators had done from a young age. Alice had come from the other side of the world to New Zealand, at 12 years old establishing as a lifelong habit (except when her daughter died) of not worrying.

...and said you poor wee thing you will be eaten by Māoris, ha ha, ha, and when I think, it's a wonder I didn't worry about that. (Alice).

When asked what may have contributed to their longevity various comments were elicited.

What do you think has contributed to your long life? (Interviewer). *I couldn't tell you. I don't worry – I think that is a big thing. (Alice).*

Oh, if you worried about it, heavens, we have got some there and they talk themselves sick really. (Lena).

...I would never worry about it either – I'm 97, hell, god!! I am getting on – you know three years to 100. (Bob).

What do you think has contributed to your long life? (Interviewer*). No idea.... No, I never think about it. (Heather).*

No, I don't worry about things you don't need to worry about. (Lily).

The possibility of physical disability and illness has contributed to some narrators worry.

These hands are the things that worry me. I am not telling you very much about my hands but that is what is worrying me. I might be like the next door ones, getting my meals from the hospital. (Lily).

This theme collected the narrators' thoughts about the 'other' considerations to their very long lives. These are currently not well researched but are areas that are recevign increasing amounts of attention.

6.5   CONCLUSION

This chapter has outlined the three themes and eight subthemes that have been inductively derived from the interviews with ten narrators. These are the voices of the narrators speaking about what they believe as the experts on being oldest-old and living at home independently. It is apparent that the ability to live alone as voiced and experienced by the ten narrators was the ability for them to self-determine what they receive, undergo and do as part of their ordinary daily and weekly lives. These narrators support researchers who propose the third age could be a life stage of possibly twenty or thirty year's duration prior to the point where health problems interfere with one's independence (Weiss & Bass, 2002).

Chapter 7 as the final chapter is where there is a critical discussion of the research themes in the context of the literature. It concludes with a discussion about the strengths and limitations as well as the potential impact on nursing education and research.

7. Discussion

7.0 Introduction

The previous chapter presented the findings of the narrators' interviews following thematic analysis. In this final chapter there is a brief summary of the research findings and a critical discussion of the themes that emerged. This outline is followed by a discussion of how these narrators, all over 95 years live independently in their own home will be discussed in the context of the initial question and aims of the research. The purpose of this analysis was to determine what it is that contributes to those over 95 years to be able to live independently by giving voice to a group of narrators who were over 95 years and for their stories to provide the detail of this the final chapter. The aims of this study were:

1. To increase both my own and the organisation's understanding of what contributes to people over 95 years of age staying in their own home
2. To enable the narratives of people over 95 years to be heard
3. To unsettle what is currently known about ageing and ageing in place
4. To influence the provision of appropriate support services that enable people over 95 years to continue to age in place/stay at home.

The unique aspect of this study is the use of the oldest-old narratives to achieve its' aims and purpose. As Holmes (2006) explicates there is sparse literature where the voices of older people, especially the oldest-old have been listened to. As is evident in many aspects of human enterprise and existence it is language that determines outcomes. There can be no doubt that the very language used in referring to ageing and older people is a large contributor to the way both the general population and the oldest-old themselves experience ageing – this includes all aspects of ageism both negative and positive ageism. This group of narrators were not a homogenous group waiting for God at the end of their life - they were still actively engaged with their lives and the lives of their significant others, the community, the nation and the world.

The methodology used in this study was narrative gerontology informed by critical gerontology. By utilising critical gerontology there is the opportunity to take a holistic, non-medicalised view of ageing which provides the opportunity to challenge contemporary thinking of who is this rapidly increasing, diverse group of people who are quietly keeping

busy and living independently? Thematic analysis was utilised to illuminate the themes and subthemes, this is congruent with both the methodology and thematic analysis itself and the established set of themes with subthemes encapsulated in the narrators' stories. The subthemes support and further illuminate the detail of the theme itself. Following the ten interviews the data were analysed utilising Braun and Clarke's (2006) thematic analysis framework. From this analysis three themes emerged each with several subthemes.

1. Staying socially connected

2. Managing the physical environment

3. Keeping and ageing well

Both the themes and subthemes demonstrate the interplay of many factors that influence both well-being and the physical decline associated with ageing. It is not possible to determine if one of these themes is somehow more important than the others as they are all interwoven, for example if you are mobile then it is easier to be socially connected. Register and Herman (2010) describe a term of connectedness which they believe is QoL from a "generative perspective" (p. 53). They believe the basis of human existence is the occurrence of connectedness that contributes to QoL, which is a significant concept when considering the lives of older people.

7.1   Summary of findings

The narrators in this study ranged from 95 to 100$^+$ years. This global trend of increasing numbers of older people - particularly the oldest-old (United Nations, 2010) is reflected here in NZ (Statistics New Zealand, 2007). An immensely gratifying aspect of this study has been the opportunity to listen to these narrators talk and hear rich descriptions of their lives and experiences. These interviews occurred in the narrators' own homes and this assisted in giving context and place to the information provided. Randall (2001) says narrative provides a framework to get inside ageing. In this study, it was intended to visualise the oldest-old from a completely different view and as Ray (2003) suggests this experience will change the researcher's perspective forever. This is consistent with critical gerontology as identified by Moody (2008) who encourages each of us to find our own voice as we age. Little is written about the daily lives of the oldest-old including the thoughts and views of the oldest-old themselves. Ray (2007) reminds us that as researchers we "cannot take for granted that

participation in research is inevitably a positive development" for older people (p. 87). The question of who stands to benefit from these processes must be kept at the forefront in all research as it was here. The use of narrative provided the opportunity for these narrators to engage in the human art of telling their story. Within each life story Kenyon and Randall (1999) suggest there is an existentialist perspective in which a paradoxical situation exists. This is where each narrator concurrently creates and re-creates themselves and as this occurs their story changes over time. The stories told here are excerpts from the narrators' life course – these are unique and personal to each narrator and provide insight into the reasons why people over 95 years are able to live independently in their own home.

1   Staying socially connected

This theme embodies staying socially connected with the subthemes of family, both paid and unpaid help and keeping busy contributing to the overall theme. Social connectedness appeared in many forms and types and as described in the narratives there were many ways of maintaining connectedness. Of paramount importance were relationships with families and friends; these were usually younger family members children, grandchildren, nieces and were most often women. This finding is consistent with Fänge and Ivanhoff, (2009) and Antonucci, Akiyama, and Takahashi, (2004) who confirm family as the major contributor to connectedness of older people. The ways of maintaining social connectedness has changed over time for these narrators. All narrators used the telephone as their main way of keeping in contact with those near and far away, however for some newer forms of communication such as Skype are being used. The importance and effectiveness of short phone calls should not be minimised as evidenced by a Dunedin study by Heppenstall, Keeling, Hanger, and Wilkinson, (2012), which provided telephone calls as a means of supporting recently discharged patients from the acute hospital. These phone calls were received positively and identified as a means for keeping older people out of hospital in their own home.

Are these narrators living independently or interdependently? All were receiving assistance in a variety of forms both informal and formal from family members and paid helpers. The relationships that had arisen from paid help were important for these narrators. They were more than the function of assisting with the housework or shower, they included social connectedness and this was more evident for women narrators than the men. There is evidence of gender differences in the oldest-old and given the number of men in this age

group is increasing this should be a consideration for future research. For most, there was a paid helper that had been with them for many years. The ability and attitude in accessing unpaid and paid help has been identified in the Berlin Ageing Study (1998) as a contributor to longer lives. There are many types of paid help such as having the groceries delivered. For some, this support had started earlier in their lives out of necessity (not having transport) and is now seen as an important factor enabling them to remain in their home. Only one narrator, at 98 years, had no regular paid help although like her younger contemporaries she had received help following surgery and in more recent years she was paying to have outside chores done. This narrator was the only person to voice a level of dis-satisfaction with her family involvement, of note she was also the only narrator living with someone else, her disabled son and no doubt this relationship provided a level of connectedness. This situation was unique amongst the narrators but one that will progressively affect the community as there is an increased survival rate of disabled persons requiring supported living throughout their lifetime.

Most narrators articulated a restricted network of support. This confirms Firori et al's. (2006) reporting that the oldest-old are most likely to belong to a restricted type of social network as a result of the death and decline of those who had supported them in earlier times. One narrator described how she maintained her larger than most social network. Sarah achieved this connection by her interest in young people and was in contact with the children of her friends who had died and her own wider extended family.

The business of old age has been described as largely a women's issue as there are significantly more women than men. For five of the women their husbands' retirement had either not occurred or had been short lived as they had died shortly after finishing work. None of the narrators' spouses were living at the time of these interviews. All the narrators were living independently, despite living alone. The loss of a spouse and living alone is a well noted predictive factor for moving to a long term care facility and certainly for some who had experienced this loss recently the level of support they were receiving would have possibly qualified them for this. The gender imbalance of more women than men in the oldest-old group is a well-researched (but little understood phenomenon) and the resulting 'being alone' impacts on all aspects of life including the social connectedness of a couple versus a widowed person. For widowers this is perhaps reversed with the small number of

men available within a large group of women. However, assuming that women or men for that matter would wish to find another partner following the death of a spouse is not necessarily correct as evidenced by two of the narrators.

The subtheme of keeping busy was an important one. All narrators described lifelong hard work and employment (not necessarily paid for the women) as contributing to their longevity with many actively working, volunteering well past the age of 60 years. These narrators were eligible for superannuation between 1971-76, when the mandatory age for retirement in NZ was 60 years. Most narrators chose to work after this time with some changing their occupation. Two of the women narrators worked into their 70s and 80s as a result of necessity. Working past retirement is consistent with what is known about the relative incomes of older women and men. They were busy then and they are busy now however, their activity levels have changed and continue to, these changes have not made the activity any less important. It appears that the need to be independent replaces such activities as going out. Tasks and actions that they once would have done easily are now more carefully considered. In years past a walk down the street or visit to the shops would have required no thought or assistance. Now there are considerations about how far is the walk – can I walk that far – will I have time - do I have my stick or walker? Favourite shops are not as accessible or are too cluttered to allow the use of a walker or wheelchairs so are no longer visited.

2 Managing the physical environment

The second theme was managing the physical environment as a contributor to these narrators living independently at home. Kontos (1998) describes home as affording "independence by defining space that is controlled by the individual" and adds that "home as a place is integral to how old age is experienced and constructed" (p. 179). Subthemes identified included; changing where and how I live using aids and appliances as more specific ways of doing this. Fänge and Ivanhoff's (2009) research confirmed that home was an important part of life for the oldest-old, not only for those that had lived in their houses for many years but for all older people as they spent increasing amounts of time there. These narrators seem to represent the desire to age in place in their home. Despite this some were aware and most appeared quite comfortable that a health event may require them to move into a long term care facility. It did not appear that the possibility of a move

into long term care would be worse than death itself for them. This supports Spillman (2004) and Gitlin et als. (2006) conjecture that there is a need for further research in the area of ageing in place as an international policy and what the views of the oldest-old are.

As well as accommodation, housing provides an economic base on which to be able to make other decisions. This will change in the future as there will be probably fewer older people who will be mortgage-free home owners (Statistics New Zealand, 2006). The result of this change will not only be a decreased ability for older people to control their physical environment which may lead to poorer health outcomes resulting from loss of independence and control. There is also the potential for the home environment to be of a poorer standard (Howden-Chapman, Chandola, Stafford, & Marmot, 2011; Stephens, Alpass, & Towers, 2010).

The importance of home in the wider context includes the community which people live in. This is a consideration requiring more thought and energy as increasing numbers of older people move into retirement villages or what have been considered as ghettos for older people (Kingston, Bernard, Biggs, & Nettleton, 2001). However, the narrators in this study, with the exception of one, spoke of the benefits of Retirement Villages for older people.

Over the life course most narrators had shifted house for a number of reasons. These included; finding work, meeting the demands of family, changes in circumstance and ultimately ageing. This had taken some narrators to smaller retirement homes which they were still happily living in, whilst others had made a further move to a retirement village. Two narrators had lived in the same houses since they were married, for one this occurred when she moved to Invercargill 98 years ago. This narrator described what Wiles et al. (2009) call a surveillance zone - a place of particular comfort and meaning for her. This concept is not specific to older people but contributes to their attachment and management of their home. For the two narrators that were in houses they had been in for most of their long lives both managed their homes to meet their needs. No doubt many family and friends think the homes these narrators are living in are entirely unsuitable; however, they had both made some alterations over time and were managing well. The level of attachment to home of these women was different to other narrators who had shifted more often with some moving over the past 15 years into retirement villages or pensioner

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housing. One narrator had relocated with her husband when they were both in their 90s from Tauranga to Southland. Like others who had shifted, she identified this as a positive move as she is now closer to friends and one of her children.

All ten narrators demonstrated tenacity - planning and determination to manage their affairs and lives. It was here I became aware of a further potential gender difference. The two male narrators displayed less attachment to their current homes - neither of them showed me around or talked about the benefits of the new house in a retirement village. Their behaviour was contrary to the behaviour and discussion of most of the women, who not only showed me around but also talked about the benefits such as accessibility, proximity of neighbours and storage. The male narrators also described a more planned approach to retirement, and the associated changes which included considering the needs of their wives – whom they assumed they would pre-decease. For those women who had shifted to smaller homes the reasons they had done so were about family (assisting in the decision) and being closer to them and whilst they did not describe planned moves, as the men did, the outcomes were similar.

The use of aids and appliances for various activities was a subtheme which contributed to the overall theme of managing the physical environment. When aids are considered those that immediately come to mind contribute to the functional activities of daily living such as walkers and sticks for mobility and long handled shoe-horns. All narrators had some form of mobility aid such as a stick, the use of which varied across the group and these are discussed in the next subtheme keeping/ageing well. Other aids included hand rails, accessible bathrooms, telephones with large numbers, glasses and hearing aids see pp. 128. Many of these aids are to assist with the issues that confront the old described in the literature review as geriatric syndromes such as incontinence, visual impairments and hearing loss. What became apparent at the interviews was the need for these people to be exposed to the range of aids available for two reasons. Firstly, so they could see the ever-increasing range of aids and have the opportunity to try them. Secondly, seeing what is available allows the opportunity to talk about areas that narrators may not have previously considered talking about as it would be considered too private a matter. The progression of technology will see a rapid rise in what is available to assist independent living at any age as well as the oldest-old.

3   Keeping well and ageing well

This theme included health and eating well/good nutrition, regular habits with food and exercise, mobility, taking medications, not worrying, spirituality, family genes and good luck. Many of the narrators had siblings, parents and aunts that were long lived. It is important when contemplating the impact of health on the oldest-old to understand that they were born in between the years 1911-16 and as such they lived in a time of no immunisation, through The Depression, wars and in an era of no antibiotics. No doubt that they survived through these times contributed to the subtheme of good luck that was mentioned by a number of narrators. This good luck was the result of good genes, environment, family relationships, the places and experiences that occurred throughout their life such as Bob not getting on a plane that crashed with no survivors. There was an awareness of self and their future requirements with several narrators commenting that despite their current wellness an acute event such as a fall may affect their environment, health and general well-being.

Health is contingent to living and like other themes, there is a spectrum of how narrators experienced it. At over 95 years, health remained a concern for these narrators who continued to reflect on potentially life threatening habits such as smoking, Bob and Sarah had given up more than 30[+] years ago. Sarah, at 100, suggested that more exercise might have been better for her. These narrators demonstrated the spectrum of health, two narrators were living with cancer, others taking few if any medications, two recently decreased or stopped medications for such things as blood pressure and prostate problems. Notably few in this group had experienced serious life threatening illnesses such as stroke in their 80s. This is consistent with research by Evert et al. (2003) into the health of centenarians. They concur with other literature regarding centenarians and the oldest-old that those with serious illnesses did not see themselves as being less healthy and overall compared themselves favourably with younger people - still over 90 years and believed their health was better than theirs. Kaul and Lakey (2003); Carstensen, Mikels, and Mather (2006) agree and the narrators in this study display what is described in the literature as a positivity effect. The positivity effect is where items such as social supports, housing and health are perceived as better than they actually appear. A further phenomenon of social comparison is where increased incidence of disability and illness is seen as normal for their age and therefore when they compare themselves with others they see themselves as better than

what they believe is normal for their age. The findings of this study confirmed the results of Carey's (2006) study where the ten participants interviewed noted their own relative strengths in comparison to others that they knew. This positive social comparison appears to be a means to affirm these narrators their own good health or fortunate circumstances.

All the narrators were independently mobile. Independence and mobility have been identified as constituents of well-being in later life. Mobility allows older people to engage in everyday activities outside the home that are meaningful and enhance well-being, whilst independent living gives older people control over the times and places in which activities are carried out (Peace et al., 2006; Ziegler & Schwanen, 2011). Physical impairments often contribute to the need to move into long term care facilities particularly with regard to mobility and achieving functional aspects of daily living. All narrators discussed mobility and the importance of it and how they maintained it by walking and house work. Three had received major joint replacements however; none described any type of mobility activity programme they were involved with. Many narrators were aware that decreased mobility which may be the result of a fall, are a significant cause for admission into long term facilities. However, is mobility an outcome or the result of other outcomes experienced by the narrators such as eating well, being healthy? Amongst the narrators, it appeared that those who were socially and materially independent were lest concerned about possible institutionalisation.

Given that the narrators grew up in a time where religion was a dominant paradigm in the lives of New Zealanders, I expected there to be a stronger notion of faith in what narrators identified as contributors to them living at home. These narrators confirmed McFadden's (2005) view that it would be important for some (three) with most (seven) not articulating this as a subtheme contributing to them living at home. For the three who identified faith it was more of a religious nature rather than spirituality which is a more modern term. Studies by Emery and Pargament (2004); Koenig, George, and Titus (2004); and Langer (2004) describe the impact of spirituality to assist in managing with well-being in older age, in particular those with physical illnesses. As identified in chapter three there is an increasing body of research identifying a link between spirituality and social connectedness. The literature reviewed and this study's findings lead me to conclude that perhaps there is something in this aspect of faith or spirituality. Perhaps, part of the social connectedness

and incredible resilience seen in this group. All narrators have experienced lives of hardship and difficulty – my words not theirs.

What was not expected and is apparent is that the narrators' experience and beliefs of what contributed to them being able to live independently in their own home are deeply personal, individual and varied. There is no recipe to achieve independent living at over 95 years. These themes had not suddenly emerged as they approached retirement. They were built from a life time – started in childhood by parents and were the ordinary day to day activities occurring across the life span including nutrition, exercise, tenacity and perhaps the results of good genes from generations past.

7.2 BEING THE OLDEST-OLD

The dominant view of ageing proposed by the media (which reflects societal views) is to strive to maintain ourselves as youthful as possible. For the oldest-old this might be a young - old self. The traditional western view sees ageing as a time of depression, despair, loss of function and cognitive impairment and awaiting the conveyor belt to take them to death. Determining it as either successful versus unsuccessful it seems that society is unwilling to consider the many factors which contribute to ageing. There is an urgent need to address this view as the life course lengthens. If we compare ourselves with our younger selves there will always be disappointment. With increasing numbers of older people there is a move away from seeing old age as a homogenous group and redefining old age to be so much more than the period preceding death, but rather as a time to continue to participate in personal growth and development. In line with the concept of social comparison Kotter-Grühn, Kleinspehn-Ammerlahn, Gerstorf, and Smith (2009) suggest older people compare themselves with their peers rather than a younger version of self, as plenty will be worse off and others will be an inspiration!

7.2.1 SUCCESSFUL AGEING

Whether the oldest-old have successfully aged is best described as a fluid concept (Smith et al. 2007). The very question and aims of this study place a potential value judgement on the narrators who were successfully ageing, and were over 95 years and living independently in their own homes. What has contributed to this? This study has taken a western view of all aspects of ageing. In a different culture with an opposing view of the constructs of

independence, ageing and living at home then the results may have been different. Biomedical theories define successful ageing in terms of optimising life expectancy whilst minimising physical and mental deterioration and disability. The psychosocial approaches to ageing emphasise the importance of life satisfaction, social participation and functioning, and psychological resources (Bowling & Dieppe, 2005). Both of these viewpoints have been somewhat distanced from how older people themselves define successful ageing from a lay perspective (Bowling & Dieppe, 2005). If successful ageing is defined as an optimal state of overall functioning and well-being, only a happy few meet the criteria. These narrators would concur with Bowling and Dieppe (2005) that older people considered themselves successful if they were independent and that personal autonomy is perceived as a measure of successful ageing (Arber, Davidson, & Ginn, 2003). These narrators demonstrate ageing as a process of adaptation, if this perspective were used many more could be considered to have successfully aged.

The keeping well and ageing well theme included the aspect of good health which most narrators had experienced throughout their lives – most were proud of keeping well and ageing well which concurs with Bartlett and Peel 's (2005) view of healthy ageing. Bartlett and Peel (2005) describe healthy ageing as good health and stated it is this criterion that older people agree is contingent to remaining independently at home. Many narrators were experiencing real functional problems affecting their function and mobility with two sick with cancer. Their day to day experience of dealing with a change in function including cancer treatment became an experience of the continuum of health. This supports Rowe and Kahn's (1999) view that older people perceive themselves as healthy despite real physical problems. This outlook occurs as a result of adaption, despite increases in chronic diseases and functional decline with advancing age people developing new ways of doing things to get the same or similar results. Bowling and Dieppe's (2005) proposition that reliance on others should not be seen as unsuccessful aging instead as a "continuum of achievements" (p.1550). This was the reality for these oldest-old. It is evident it needs further examination as there is interplay of various relationships and perhaps a critical consideration as it appears that no one lives completely independently as the lives we all live are the result of complex relationships.

7.2.2 AGEISM

Ageing is not unique to the oldest-old. It starts from the moment of conception or birth – all of us have or will experience a time when we are too old for something. Bytheway, Ward, Holland, and Peace (2007) propose ageism is woven into the fabric of our daily experience and discourse. It is demonstrated daily in the media and our day to day conversations. Society excuses behaviours such as forgetting things by relating this to developing dementia, using face cream to lessen the impact of age and take pride in not looking our age. The narrators in this study commented on their experiences and identified the lack of accessibility to buildings and transport as contributors to why they stopped certain activities such as going out. It is apparent to me that many activities that younger people take for granted become too difficult and older people stop putting themselves in situations where it is too difficult. This outlook demonstrated the oldest-old as a vulnerable group who for many reasons are less able to mitigate the effects of ageism they experience.

The narrators in this study who lived in Retirement Villages both enjoyed living there and believed that village life contributed to their well-being. This view certainly appears to be confirmed in the current literature (Shippee, 2012). Despite this it is a worthy to consider whether the segregation of large numbers in Retirement Villages of older people is ageism? There are other ways of providing social housing that are potentially more useful than what have been considered as ghettos for older people (Kingston, Bernard, Biggs, & Nettleton, 2001). There are opportunities to consider the current models of retirement living and ask whether they will meet the needs of the next cohort of older people.

The services older people utilise are provided within the cultural context of not valuing or hearing what it is that older people may require. Further limitations are what services can be provided - to whom and who by. In the early part of 2013, the SDHB reduced the number of providers in urban areas to two. The entire menu of services available to choose or be allocated from is not easily available. Despite the proclivity for information to be available on electronic media, for example Eldernet, an excellent computer based service providing information on all aspects of being older, the very people that would benefit most are not computer able and therefore are unable to access useful information. This is a further demonstration of ageism. There are current subtle and covert ways of ageism which contributes to silencing this already marginalised group. It is evident ageism affects the lives

of many of the oldest-old and they in fact contribute to some of it. There are opportunities and an urgent need to review ageism of all forms and actively seek to minimise it. As Neville proposes "

> "If health professionals are serious about providing a quality health service to older adults, then as a group, we need to promote a pro-ageing stance by including and valuing the perspectives of older adults."

<p style="text-align:center">(p. 23)</p>

These narrators and their peers should serve as models for the future to minimise ageism.

7.3 RESILIENCE

Resilience was discussed in chapter three as a concept that has been widely considered in both qualitative and quantitative research about how people live and survive to become the oldest-old. Edward (2005) defines resilience as being able to rise above difficult situations. Living to over 95 years means these narrators have confronted situations that are difficult and life threatening. As well as these demands, living at their advanced age poses other challenges. Edward and Warelow (2005) note there are numerous characteristics that contribute to being resilient and these are well described in the literature reviewed in this study. Inherent within the three themes that emerged in this study is the notion of resilience.

Research into the concept of resilience began with children and it is perhaps an intuitive finding that resilience in children may lead to this in older people. More recently it has been identified that resilience can develop across the life course (Mattsen & Wright, 2009). My own experiences of the many oldest-old I have known, worked with and provided services to, are a sense of awe as I see them and hear stories of incredible resilience. My appreciation was reinforced in meeting these narrators and listening to their amazing stories. Whether resilience is supported by such attributes and opportunities as; social connectedness, keeping busy, living independently or health, and tenacity or not does not matter, resilience exists. Does the presence of these themes provide the capacity to be resilient? Further research is needed in this area, in particular in hearing from the oldest-old themselves regarding their view of resilience – where it emerges from and how does it contribute to and affect their lives.

7.4   IMPLICATIONS AND OPPORTUNITIES

There is as much to learn from the research as the actual research process itself (Sin, 2005). With the opportunity to undertake research there is a responsibility to ensure something is done with the information that is generated and that information is disseminated to the appropriate people. The narrators in this study are amongst the oldest-old however they present a positive and encouraging view of being the oldest-old - living successful daily lives, participating with the people that are important to them and providing role models for the next generation(s) of older people. The purpose of this study was to identify the ways these narrators live independently. This new knowledge would be shared with and improve what I as an individual, member of my family, health professional, manager in an organisation working with older people, member of society contribute to the lives of older people. It is implicit that this information will be offered to my own professional group however, it has wider use than that. As has been stated ageing is something that all humans experience and so it is necessary to take the ideas of ageing and resilience to the wider community if we are to enable all people to make the best use of new knowledge.

As a result of this study the following actions have been identified by the researcher as opportunities for action and address the four aims of the research:

- a) Advocate against ageism at all times especially behaviour and language. This includes promoting older people in local media – television, newspapers, radio
- b) Develop a local consultation group to assist in considering future services. To get the oldest-old to be part of a group such as this would require careful consideration to encourage participation such as timing of meetings – how the group would share its ideas
- c) Develop age friendly environments that consider health issues for older people such as dementia, mobility and accessibility. Look at developing this in association with local businesses
- d) Review existing community services for community to see if there are opportunities for improving social connectedness and the range of activities

7.4.1   HEALTH PROFESSIONALS AND THE COMMUNITY

The experience of research into our daily lives is not an involvement that many older people have had or understand due to their own level of education and experience. No doubt, this is related to the limited amount of research undertaken into the lives of the oldest-old.

However, there is an increasing amount of research occurring, so older people will become increasingly familiar with the idea of being involved in research. These things probably contributed to some families not allowing me to speak with some of the oldest-old who met the studies inclusion criteria. Other reasons included their families' fears that the oldest-old may not be honest – they may tell me a story, repeat themselves or the experience would be too much for them. Attitudes like these are reflective of a lack of understanding of the following two points. Firstly, families have not understood the purpose and aims of research and in particular this study. Secondly, families not being aware the oldest-old experience in sharing the stories of their long lives. It is important for health professionals and the community to remember and value that telling of stories is an innate human activity and has a therapeutic beneficial aspect to it. This was commented on by a number of narrators who noted their enjoyment of the process. As educational levels increase and the amount of research being done in our community grows the attitude to research will change as people become more familiar with being involved in research and having their thoughts and opinions sought.

The gender difference was evident in aspects of this study and leads me on to consider the importance of having men involved in otherwise women dominated activities such as home health care or volunteer services. Service providers need to consider the effects of age and gender on who seeks help and uses services. That older people may have felt vulnerable in their home was not an active consideration of this study. However, these feelings of vulnerability have been identified as part of the consideration in changing where older people choose to live. If ageing in place is the way of the future for older people then having them stay in their communities will require new ways of encouraging communities to help support them to do so.

7.4.2 NURSING EDUCATION

Nursing education includes study across the life course which engenders an awareness that each life stage is unique and interesting including older adulthood, young-old, old and the oldest-old. Perhaps what is lacking is an awareness that this part of the life course covers a period which may be as long as 40^+ years. A possible reason for this is that these courses are being taught by people in their middle age that have been socialised within contemporary

culture and are themselves fearful of what becoming older may mean for them. There are opportunities here to make changes by looking to cultures who value older people and utilising relevant professionals such as those who have the time, perhaps retired, in the experiential learning of nurses both under and post graduate. The current nursing curriculum sees student nurses working with older people in their first year of training. Perhaps this institutional and professional ageism minimises the importance of caring for older people to something that anyone can do, rather than a professional speciality dealing with the complexities of the psychosocial aspects across a lifetime and the effects of old age on general health and function.

In the facilities and institutions where nurses are educated, there is a preponderance of older people – those 65^{+}years. Despite the numbers of older people nurses work with, new graduates and those who have been in practise for some time are unwilling to come and work with older people. The reasons for this reluctance are many but certainly are the result of society and professionals ageist attitudes. Those working with older people are their own greatest enemies when they foreground the hardships and difficulties in working with older people. Rather these are factors in the way long term care facilities and community providers are funded. This funding mechanism means staff are paid less than their peers working for District Health Boards which no doubt contributes to nurses and other health professionals not wanting to work in these areas. Until these issues are addressed, there will be a continuing struggle to attract staff to work in aged care.

7.4.3 RESEARCH

As has been noted various times throughout this study previous research about the oldest-old is generally quantitative with little qualitative work. As such there is little written from the view point of the oldest-old themselves. It is pleasing to see that new research projects such as LiLACs (2011) are including elements of qualitative research. Such studies utilise a combination of open-ended interview processes as well as forced choice items on surveys in quantitative research which assists in providing an increased richness and depth of data.

Ageing in place is the way forward, evidenced in both policy and what older people themselves articulate. The narrators in this study described the means they are employing to maintain living at home, it is evident not all older people have the same skills. Utilising

narratives in research and listening to the oldest-old makes available the ingenuity of these people to assist in preparing for the future where the numbers of oldest-old will be so much larger. Research into the life-long issues for people such as housing are required to confirm that such international endeavours such as ageing in place are in fact what older people want.

Several narrators identified difficulties and challenges in mobility and access to amenities such as shops and travel. There are research opportunities to study the strategies these oldest-old incorporated into their daily lives in order to remain vital and active. The results of those studies could provide information to design and sustain programs that will allow those large cohorts of future oldest-old to deal with the challenges of the third and fourth ages. The health care needs of individuals are important for all age groups in particular the oldest-old who are confronted with a barrage of health needs. However, in the future there will be increasingly large numbers of individuals who, like these narrators require quite small interventions such as doing cross words and keeping up with sporting interests as described by Esther to assist them to maintain active minds and bodies.

It is evident from the literature review, this study and my own experience that there are opportunities being missed to better understand the oldest-old. If they are approached in a way that is respectful of them and meets their needs then these oldest-old are willing to share. For example inviting this group of people to be part of a focus group would likely yield few participants. This would be because the language and the idea are unfamiliar. To access this group it would be necessary to go to their home or somewhere of known accessibility and work over a prolonged period of time. I hope that the findings in this study encourage others to look further into the lives of the oldest-old across all the ethnic and cultural groups that live in New Zealand.

7.5   STRENGTHS OF THE CURRENT STUDY

The narrative and critical gerontological lens utilised in this study are able to contribute to social change through the themes that emerged (Ray, 1998). These themes relate to the key issues and include ageism, resilience and the inaccuracies evident within of the dominant view of ageing. Perhaps the greatest strengths in this study are the use of the narrators own voices in the emergence and subsequent articulation of the themes and subthemes and the

open and transparent disclosure of my reflexive position. This study was undertaken in the SDHB, a specific geographical area of New Zealand – there has been no other work such as this undertaken in NZ.

7.6   Limitations of the current study

The major limitation for this study was that it was part of an academic requirement. This meant that the researcher was a novice and was on an exponential learning curve. There was also only a small sample where the narrators were only interviewed once. A larger group of narrators from other areas of NZ would have allowed the opportunity to include a wider demographic which may have included other ethnicities including oldest-old Māori. Being in more regular contact with the narrators may have provided deeper and more meaningful information and material. If the sample size was increased there may have been other themes identified. A broader approach would have provided further understanding of the lives of the oldest-old by providing an opportunity to better get to know what life is like for this group.

NZ has some specific and unique demographics. The use of narrative with the telling of their story is a means of ameliorating the following issues. As the general population ages the numbers of older people who are of an ethnic origin such as Māori or Pacific Island will increase and as such it will be even more important to consider their voices. As Erikson, Erikson and Travnick (1986) conclude irrespective of the personal situation of the older person, whether they have personal support or are more isolated it is challenging to elicit information from them – this difficulty increases the older they are.

7.7   Conclusion

This chapter has provided the opportunity to consider the findings and did they meet the aims that were set at the studies inception. Globally we are aware of the impact of the baby boomers, the oldest of whom started turning 65 in 2011. This study hasn't been about them as they are now but what they will become over the next 30^{+} years. This thesis began considering the deconstruction and reconstruction of new knowledge as a result of the research process. Through the careful consideration and application of the methodology and analytical tools this critique was achieved. Critical gerontology encourages us to

challenge the notion of infirmity, illness and general decline of the oldest-old. The voices of these narrators supports this challenge.

Three themes emerged with associated subthemes. It is in the exploration and consideration of these that the reason for undertaking this study was clearly evident. Ageing is something that we all do, and not everyone will reach 95 nor will they be able to live independently. However, whether we lived to an advanced age of over 95 or much less, it is evident that how we live as the oldest-old is the result of what we achieve and do as younger people. What sustains the oldest-old to live independently is not new to them but what they have done all their lives and include having family relationships, keeping busy and mobile, it is laid down in our genes and habits taught to us by parents in eating well and taking care of ourselves. All of the narrators were resilient – is that because to be to be over 95 years you need to have lived through two world wars, influenza epidemics, depression as well as the challenges of day to day living.

Every day ageism is rife in our communities. While we may assume that modern living with improved education has allowed society to be more inclusive by freedom to access services and obtain information. Inclusion is not the case, as a result of the fear of ageing we may in fact be increasingly ageist, including the education of student nurses. Like many things, it will continue to escalate if all people who have the opportunity, knowledge and skills fail to confront and challenge this. Health professionals have a vital part to play in creating a pro ageing stance within communities to assist and support older people in their lives.

The fourth aim of this study was to influence the provision of appropriate support services to enable those over 95 years to continue to age in place. Unfortunately, the global financial crisis means that access to funds for future projects for the oldest-old is limited. Despite this, there are small activities that can be undertaken to meet this aim as detailed on pages 164 and 165. The importance of advocating against ageism and promoting the interests of the oldest-old as well as developing a consultation group to provide ideas for services and how they would best be provided are both actions that can be undertaken without funding.

The purpose of this research was to give voice to those over 95 years who were living at home. In order to achieve the purpose it was necessary to consider the context of this group of narrators in 21st century New Zealand, a time of increasing anxiety of ageing baby

boomers and what their life will be. The narrators gave voice to lives that unsettled the ageist biomedical view of the oldest-old and what we think we know about them. They are not simply an ever-increasing homogenous group of people, meekly waiting for the anticipated disability and infirmity of old age. They are as they have been all their long lives, keeping busy in their own homes with their day to day lives and the people that are important to them. They are an extraordinary group of resilient people who have experienced good luck, great genes, eaten well, had a commitment to hard work, a belief in something bigger and more important than themselves and who understand the importance of social connectedness and the need to look after their health.

Reflexivity and narrative are considered as essential components of nursing practice. I began this thesis as a nurse, daughter, manager and community member. Through the research process, I have had the opportunity to further develop and enrich my understanding and use of these. I have finished this work changed, having benefited both personally and professionally from this experience.

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INFORMATION SHEET

Living at home as an older person.

I would like to invite you to take part in a study that aims to provide people over

the age of 95 years with the opportunity to tell their stories of how they stay living at home, this may include what has occurred in your past as well as what is happening in the present.

My name is Julia Russell, I am a Registered Nurse working at Presbyterian Support Southland as the Director of Services for Older People. I am also a Massey University student completing a Masters in Philosophy (Nursing).

I am undertaking this study, as I am interested in how people over 95 years stay living in their own home. This includes both past and present life experiences. I would like to be able to talk with you about what you think has contributed to you being able to do this.

Recruitment

If you live in Southland or Otago, are 95 years or older, live in your own home, a purchased or rental unit in a retirement village, live either alone or with family (this may include a son or daughter or other family or friends), do not live in a resthome or hospital then please consider becoming involved in this study. I am hoping to talk to at least ten people. Participants in this study will be approached through organisations such as Age Concern, Grey Power and Church Groups who have contact with people over the age of 95 years. If you are interested in participating please contact me by phone or give permission for your contact details to be passed on to me and I will call you.

If you accept this invitation to be part of this study, it will involve an interview approximately one hour long. In addition I will be available to discuss the research process with you and answer any questions. If you identify as Māori then cultural support will be available. If English is not your first language then an interpreter will be available.

Procedures

The interview will take place at a time and place that is mutually agreeable to both of us. The interview will be tape recorded and you may ask for the audio tape to be switched off at any time during the interview. If you do not wish to answer any question then you do not need to. You may also wish to have a support person with you. It is not expected that this interview should cause you any discomfort however if at anytime you express concerns regarding your situation I will assist in accessing appropriate support for you.

Confidentiality

Your real name will not be used at any time. You will be invited to provide a name of your choice to be used in the taped interview, the transcripts and in the final written report. All information revealed during the interview will remain confidential and not discussed with any other person except my supervisor – Dr Stephen Neville. Your privacy and confidentiality will be protected at all times. Following the interview, I will enter the information into my computer and save it there. You may review the transcripts or receive a summary of the findings from the interview. All research material will be kept in a locked cabinet and all the material stored on the computer will be password protected.

The tape recording will be either returned to you or erased after the research is completed. Transcripts and computer files will be stored at Massey University and destroyed after ten years.

Findings from this study will be compiled into a research report and submitted to Massey University for assessment as part of a Masters of Philosophy (Nursing) degree. Information from the research may be used as a basis for articles to be published in a Nursing Journal or presented at a conference.

Consent

If you wish to participate in the study, please either contact me or provide your name and details so that I can contact you. We will then decide on a mutually agreeable place and time for the interview. Prior to the interview, I will go through the information sheet with you and then ask you to sign a consent form agreeing to participate in this study.

Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- Decline to answer any particular question
- Withdraw from this study at any time
- Ask any questions about the study at any time during participation
- Provide information on the understanding that your name will not be used unless you give permission to the researcher
- Be given access to a summary of the project findings when it is concluded.
- If you have any questions about the project at any time, you are able to contact myself and /or my supervisor.

Contact details are:

Julia Russell	Dr Stephen Neville
193 Queens Drive Invercargill julia@pss.org.nz Ph 03 2174270 Mobile 0274335940	Postgraduate programme co ordinator School of Health and Social Sciences Massey University Private Bag 102904 North Shore City 0745 AUCKLAND S.J.Neville@massey.ac.nz Ph 094140800 extn 9065 Mobile 021666919

This study has received ethical approval from the Southern HDC LRS/EXP/034.

Living at home as an older person

Are you a person over the age of **95 years,** living in Southland and Otago in their own home (this may be with family or others)?

My name is Julia and I am a registered nurse completing a Masters of Philosophy (Nursing) degree. I would like to invite people over the age of 95 years who live in their own home to tell me about their experiences of what has enabled them to live at home.

This would involve an interview of approximately one hour. I am interested in hearing your experiences both past and present about how you have continued to live in your own home. All discussions will be kept in the strictest of confidence and your name or identity will not be revealed in any way.

If you are interesting in participating in this study please contact me:

OR provide your details to _____and I will contact you :

My contact details are:

Julia Russell, 193 Queens Drive, Invercargill

Contact numbers 03 2174270 (leave a message) OR mobile 0274335940

More information will be provided and you can decide if you wish to participate in this study.

Thank you for your assistance,

Julia Russell, Nurse Researcher.

Living at home as an older person.

This consent form will be held for a period of ten (10) years.

I have read and I understand the information sheet dated 1 August 2010 for volunteers taking part in the study designed to gain a further understanding in how people over 95 years stay at home. I have had the opportunity to fully discuss this study with the researcher and I am satisfied with the explanations I have been given. I have had the opportunity to include whānau support or a friend of my choice to help me ask questions and understand the study.

- I agree/do not agree to the interview being audio taped.
- I understand that my information will be held and maybe used for a period of up to ten (10) years.
- I wish/do not wish to have my recordings returned to me.
- I agree to participate in this study under the conditions set out in the Information Sheet.

REQUEST FOR INTERPRETER

Deaf	I wish to have a NZ sign language interpreter	Yes	No
Māori	E hiahia ana ahau ki tetahi kaiwhaka Māori/kaiwhaka pakeha korero	Ae	Kao
Cook Island Māori	Ka inangaro au i tetai tangata uri reo	Ae	Kare
Sāmoan	Ou te mana'o ia i ai se fa'amatala upu	Ioe	Leai
Tongan	Oku ou fiema'u ha fakatonulea	Io	Ikai

Signature: **Date**

Full Name – printed

APPENDIX D. TRANSCRIPT RELEASE AUTHORITY

Living at home as an older person.
AUTHORITY FOR THE RELEASE OF TRANSCRIPTS

I confirm that I have had the opportunity to read and amend the transcript of the interview(s) conducted with me.

I agree that the edited transcript and extracts from this may be used in reports and publications arising from the research.

Signature: **Date**

Full Name – printed

APPENDIX E.   INTERVIEW SCHEDULE

The primary source of data will be face-to-face semi-structured interviews along with open ended questions conducted with the participants. This will enable them share their life stories and voice what it is they believe, at this time has contributed to them being able to live independently at over 95 years.

The aims of the study will be kept at the forefront at all times:

1. To increase an understanding of what contributes to people over 95 years of age staying in their own home
2. To enable the narratives of people over 95 years to be heard
3. To unsettle what is currently known about ageing and ageing in place
4. To influence the provision of appropriate support services that enable people over 95 years to continue to age in place/stay at home

Interview questions

- Tell me a little about yourself;
- Name, age, place of birth, where have you lived most of your life – places that are important, children, siblings, did you expect to be this age – were there other family members who are as old as you? other people of importance.
- Begin by eliciting their initial thoughts on them staying in their own home
- How long have they lived in the house they are in - how did they get there (a recent move, necessity)?
- Did you expect to be living in your own home at this age?
- Who lives or has lived with you?
- Tell me about your experience of being able to stay at home - what have you needed to do this, what has helped what has hindered?
- Tell me what you think contributed to this (staying at home) earlier in your life?
- What activities have you been involved with that have contributed to you being able to stay at home?
- When you were younger did you plan for this - … buy a smaller house, plan specific things in a house such as no stairs
- Is your life today what you expected that it would be? If yes how and why, if no how and why

- Has anyone ever suggested that you shouldn't still be at home? – why do you think that they said this?
- What have been the major influences in your life as you have become older ?
- What have been the major milestones in your life as you have become older?
- What do you think would help people as they age to be able to stay in their house after the age of 95? …………. Services, activities
- If you couldn't be at home alone / with family where would you want to be?
- People often think that being able to stay at home after the age of 95 years is possible because ………..   you saved enough money, you have some or no children, you own your own home, you have no adverse health issues, you receive all sorts of health supports……………

Probes

- Does this seem accurate to you?
- How does this affect your ability to stay at home?
- Tell me more about
- Can you give me an example

Conclusion

As the time is drawing to a close, ask/check (if topics have not already been discussed):

Any other ideas on what other things may have contributed to you staying at home