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# Nonagenarians: a qualitative exploration of individual differences in wellbeing

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***ABSTRACT***

This paper focuses on the subjective experience of extreme old age for 12 people scoring high and low respectively, on wellbeing measures. The purpose was to illustrate and expand upon the quantitatively derived findings from a previous study of nonagenarians living in Stockholm, using a qualitative approach inspired by grounded theory. The results suggest that outlook on life, social and emotional ties, engagement with the outside world and physical capability are important contributors to subjectively experienced wellbeing in this age group.

***KEY WORDS*** – nonagenarians, experience of wellbeing, qualitative approach.

## Introduction

Studies of the wellbeing of old people are now quite common in the gerontological literature but these have mostly been based on young-old samples (for a review, see Diener *et al.* 1999). There are very few published studies which focus on very old people (exceptions include Bowling 1990; Bowling *et al.* 1996; Hillerås 1998; Hillerås *et al.* in press, 1998, 1999; Nilsson 1997) and so far we know little about the everyday life and wellbeing of this growing age group.

A study by Hillerås (1998) presented data on wellbeing for a population of very old people living in Stockholm. This study defined wellbeing as a combination of life satisfaction and positive and negative

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affect. Life satisfaction refers to cognitive judgements of one's life, and affects positively or negatively the experience of emotional wellbeing (Andrews and McKennell 1980; Andrews and Withey 1976; Argyle 1987; Diener 1984; Diener *et al.* 1999; Diener and Diener 1996; Diener and Larsen 1993; Kercher 1992; Larsen *et al.* 1985; Okun and Stock 1987). This study found, firstly, that wellbeing appeared to be slightly lower than has been found in other studies in which the samples were younger elderly people (Baiyewu and Jegede 1992; Chatfield 1977; Kercher 1992; Morgan *et al.* 1987; Watson *et al.* 1988; Wood *et al.* 1969). Secondly, as with the young-old (Kercher 1992), very elderly people who scored high on positive affect did not necessarily score low on negative affect. Thirdly, while levels of activity tended to be low, the kinds of activity varied quite widely. Fourthly, personality was a major determinant of wellbeing. Finally, different factors were associated with positive and negative affect and, to some extent, with life satisfaction (Hillerås 1998). Another study, which examined wellbeing among very elderly people in terms of life satisfaction and its associated factors, found that the most important predictor of changes in life satisfaction up to three years later was baseline life satisfaction (Bowling 1990; Bowling *et al.* 1996). In addition, the authors found that physical health status was a stronger predictor for wellbeing than social network characteristics.

These kinds of quantitative data can be generalised to some extent. However, neither of these studies focused on within-group differences between individuals. One qualitative study which looked at people over 80 years of age found six dimensions that were important to quality of life (Nilsson 1997). These were: health, relationships, activities, philosophy of life, past and present lives, and future perspective. Nilsson also described five 'meanings of life' in old age, which she termed successful ageing, good old age, comparatively good life in old age, bad ageing, and a miserable life in old age.

Most theories about the stages of ageing such as disengagement theory, activity theory and Erikson's theory (Adams 1969; Cumming and Henry 1961; Cumming 1963; Erikson 1982; Henry 1964; Hochschild 1975; Lemon *et al.* 1972) largely ignore individual differences (Bondevik 1994; Stevens-Long and Commons 1992). In many respects older people differ just as much as younger people. In a representative sample of 90-year-olds there is likely to be a wide variety of living conditions and experiences. Some may be married, some divorced, some single and some widowed. Some will have children, grandchildren, and even great-grandchildren, others no descendants at all. Some will have outlived their children. Some will be in good health,

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others ill or disabled. Some will live in institutions, others in their own homes, either alone, with their spouse or with other relatives. There are many possibilities in addition to widely differing lifestyles. Apart from demographic factors it is important to take into account the impact of lifestyles, life events and personality on wellbeing in old age.

The emphasis on the problems and difficulties of extreme old age contributes to commonly-held stereotypical and prejudiced views. While there is some research showing that many very elderly people do not fit the stereotypes (Kimmel 1982), negative and detrimental views persist (Bondevik 1994). Such views can be directly and indirectly damaging to elderly people, contributing to low motivation, behavioural decline and poor physical health (Kimmel 1982). It is necessary, therefore, to show that elderly people are a heterogeneous group, and that wellbeing is not much different from earlier in life (Hillerås 1998). Earlier studies of this age group have dealt with the 'average' person based on statistical profiles rather than on individual variation (Hillerås 1998). These statistical patterns fail to show differences in the experience of wellbeing between individuals. Wood and Johnson (1989) suggest, therefore, that the first stage of research should be based on quantitative analyses, and that a qualitative approach should be considered for the second stage in order to gain a deeper understanding. In addition, in a review article, Bondevik concludes that 'further research on elderly people and particularly on the very old is necessary and desirable. Themes of interest are how old people subjectively experience their total life situation' (Bondevik 1994: 73).

In the present study, we wanted to examine this 'subjective experience' in a sample of the participants from the Kungsholmen 90+ wellbeing study (Hillerås 1998). Our purpose was to illustrate and expand upon the quantitatively derived findings from the earlier wellbeing study using the qualitative data collected in that study. By combining several lines of insight we hope to obtain a more substantial and complex picture of what it is like to live beyond 90 than could be conveyed using quantitative methods alone. As Henwood and Pidgeon (1994) point out, the aim of qualitative analysis is to produce 'a meaningful account, which knits together the multiplicities, variations, and complexities of participants' worlds'. Bearing this in mind, we have looked at how the interviewees themselves described and evaluated their lives rather than imposing our own preconceptions of what might be positive or negative about living beyond the age of 90.

The Kungsholmen area was chosen for a major long-term study of people aged 75 years and older (Fratiglioni *et al.* 1992), mainly

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because of the high numbers of people in this age group living there, largely of Swedish descent. Kungsholmen is a large area in the inner city of Stockholm. Formerly an industrial and working class area, it has gradually changed over the past 90 years to become more socially heterogeneous. It is now both a residental area and a commercial and administrative centre (Holmén *et al.* 1991; Hillerås 2000).

In 1987, Kungsholmen had one of the oldest populations in the world with 31.2 per cent of its population aged 65 years or more (USK 1988). Migration rates have been low and although a younger generation is now moving in, the average length of residency for people over 75 is 40 years (Agüero-Eklund 1998).

## Method

All subjects in the Kungsholmen study who were aged 90 years and older at the second follow up (n = 365) and scoring 24 points or above (M = 26.6, SD = 1.8) on the Mini-Mental State Examination (MMSE; Folstein *et al.* 1975) were invited to participate in a wellbeing study. Out of 128 possible candidates, there were 11 refusals, mainly due to declining health. Twelve people died before they could be interviewed. The final sample of 105 participants ranged in age from 90 to 99 years (Figure 1).

For the present study we selected two small and well-defined groups for further analysis. Each group consisted of six people who scored high and low on wellbeing measures respectively. The measures used for this selection were the life satisfaction indices LSI-Z (Neugarten *et al.* 1961) and LSI-B (Wood *et al.* 1969), as well as the 10-item positive (PA) and negative (NA) affect schedule (Kercher 1992). All those selected for the high wellbeing group had relatively high scores on these four different wellbeing scales, and all those selected for the low wellbeing group had relatively low scores on the same four scales. There was some overlap on the NA scales because one person who scored low on PA also scored low on NA and another who scored high on PA also scored high on NA. This is regarded as a common phenomenon (Hillerås *et al.* 1998; Kercher 1992).

The study group consisted of people of Swedish descent who had good physical health, were not depressed, had a reasonably high cognitive level and were reasonably well off economically (Hillerås 1998). However, despite these similarities, there were considerable individual differences. Age, gender, dependency and wellbeing scores

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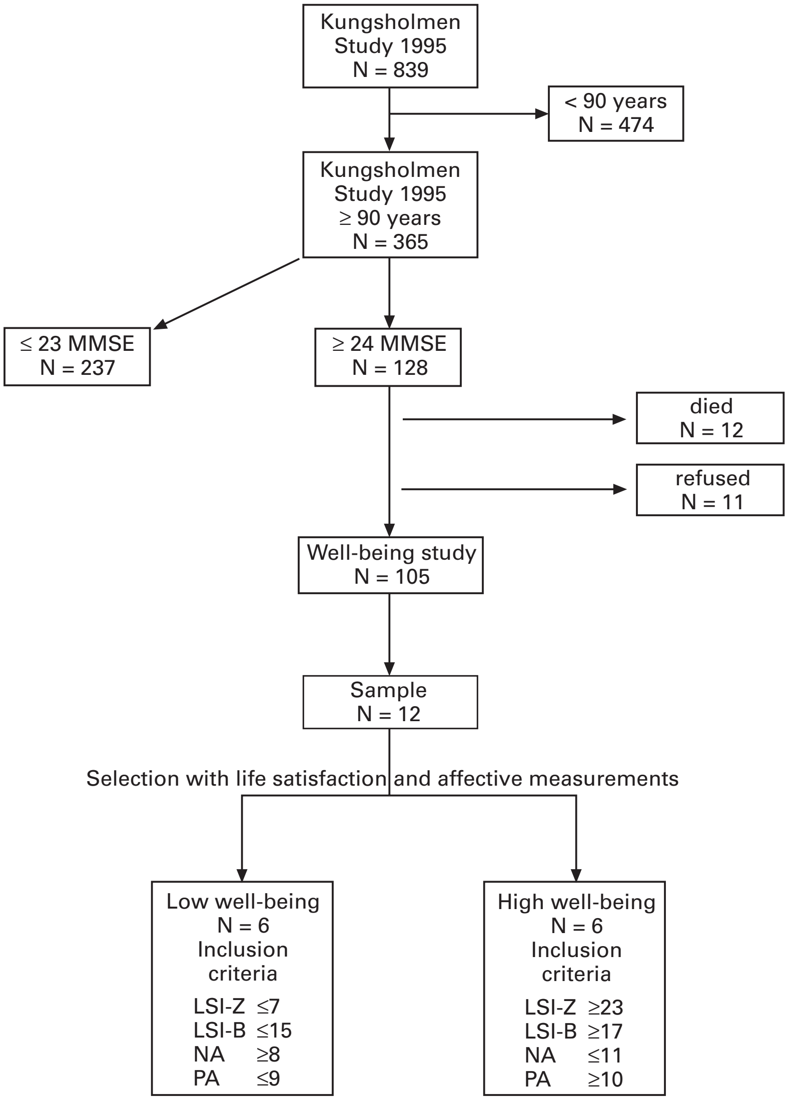

Figure 1. Overview of the study design.

of the 12 people selected are shown in Table 1, and marital and residential status, children, housing, home help and perceived health in Table 2. Dependency was rated using standard instruments which measure the ability to perform activities of daily living (ADL), covering personal care (bathing, dressing, toileting, mobility, continence, feeding; Hulter-Åsberg and Sonn 1989) and the instrumental activities

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TABLE 1. *Description of participants*

| | | | | Wellbeing scores | | | |
|---|---|---|---|---|---|---|---|
| Pseudonym | Age | Gender | Dependency | PA | NA | LSI-B | LSI-Z |
| Low wellbeing | | | | | | | |
| Britta | 92 | Female | High | 8 | 5 | 11 | 6 |
| Elisabeth | 97 | Female | High | 10 | 6 | 11 | 7 |
| Ester | 94 | Female | High | 9 | 5 | 4 | 6 |
| Ingrid | 90 | Female | High | 11 | 7 | 3 | 6 |
| Lisa | 90 | Female | High | 6 | 9 | 15 | 6 |
| Erik | 90 | Male | Low | 17 | 6 | 12 | 7 |
| High wellbeing | | | | | | | |
| Karin | 92 | Female | High | 5 | 12 | 22 | 24 |
| Margit | 90 | Female | Low | 11 | 15 | 18 | 15 |
| Hugo | 93 | Male | Low | 5 | 10 | 21 | 23 |
| Viola | 91 | Female | Low | 5 | 12 | 21 | 23 |
| Alexander | 93 | Male | Low | 7 | 16 | 17 | 24 |
| Harald | 96 | Male | Low | 5 | 18 | 18 | 24 |

All the names in this study have been changed to pseudonyms to protect the participants' integrity.

TABLE 2. *Description of participants*

| Pseudonym | Marital status | Co-residence | Children | Service house | Home help | Perceived health |
|---|---|---|---|---|---|---|
| Low wellbeing | | | | | | |
| Britta | Widow | No | Yes | waiting list | Yes | good |
| Elisabeth | Unmarried | No | No | No | Yes | poor |
| Ester | Widow | No | Yes | Yes | Yes | poor |
| Ingrid | Unmarried | No | No | No | Yes | good |
| Lisa | Widow | No | Yes | No | No | poor |
| Erik | Widower | No | No | Yes | No | good |
| High wellbeing | | | | | | |
| Karin | Widow | No | Yes | Yes | No | good |
| Margit | Widow | Yes | Yes | No | Yes | good |
| Hugo | Married | Yes | Yes | No | No | good |
| Viola | Widow | No | Yes | Yes | No | good |
| Alexander | Married | Yes | Yes | No | No | good |
| Harald | Married | Yes | Yes | No | No | good |

of daily living (IADL: cleaning, buying food, transport, cooking; Hulter-Åsberg and Sonn 1989). Those who scored zero on both measurements were classified as independent in ADL (low dependency).

The first author, who is experienced in working with elderly clients, conducted the interviews, using a semi-structured questionnaire with 136 items. Each individual was interviewed at home with the exception

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of one woman (who we have called 'Lisa') who preferred to be interviewed at the Stockholm Gerontology Research Centre. The questionnaire has been previously described (Hillerås *et al.* 1998, 1999, 2001). A series of instruments were used including questions regarding life-satisfaction, positive and negative affect, education, pensions, religion, self-rated health, activities, disability, marital status and family, social contacts (*i.e.* contacts with friends and relatives, church membership, group membership), personality and major life-events (*e.g.* death of a close family member, major illness of spouse). The interviewer wrote down additional information provided in response to the questions. The interviews ranged from 45 minutes to four hours in length. A typical question for the dimension 'attitude to old age' was 'What are the best things about being the age you are now?' and, for 'future plans', 'What will you be doing one year from now?'.

### *Ethical considerations*

The wellbeing project was approved by the ethical committee of the Karolinska Institute, Stockholm. Participants were invited to take part by a personal letter explaining the aim of the study, stating that participation was voluntary and that data would be treated confidentially. It also included the name of the interviewer (*i.e.* the first author). Participants were told that she would call to ask them whether they wanted to participate or not. If they wished to do so, they could choose to be interviewed in their own home or at the research centre. As this study only included people with a relatively high cognitive level, we accepted their own informed consent.

### *Data analysis*

The transcribed and translated interviews were analysed by a process adapted from grounded theory (Strauss 1987; Strauss and Corbin 1990). Three researchers each highlighted those parts of the text they thought were particularly relevant to the experience of wellbeing and made interpretative observations in the margins of the text. They then met to discuss the transcripts virtually line by line, with each researcher indicating those parts of the text which had been highlighted and the interpretation given. Discussion continued until a consensus was reached about what was important and how it should be interpreted. These consensus observations were then organised into overlapping categories. The most important of these were designated as 'core categories'. The remaining categories were grouped beneath the core

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| Core categories | Dimensions |
|---|---|
| Outlook on life | Presentation of the past<br>Satisfaction with past roles<br>Functional role now<br>Attitude to old age<br>Future plans |
| Social and emotional ties | Satisfactory relationships with adult children<br>Satisfactory relationships with friends<br>Aloneness |
| Engagement with the outside world | Direct<br>Indirect |
| Physical capability | Perceived health<br>Adjustment to dependency |
| Objective measure | Level of dependency<br>Service house<br>Home help |

Figure 2. Core categories and their dimensions.

categories and designated as dimensions. The individual responses in relation to each theme (core category plus dimensions) were incorporated under the relevant headings.

### *Translation*

A native Swedish speaker carried out the initial translation of the interviews. An English speaker then checked the transcripts and corrected the English language. To minimise the possibility that this process might have changed the meaning, important segments of the transcripts were then back translated to Swedish by a person who had not read the original Swedish version. Any discrepancies between the original transcripts and the back-translations were discussed and a more equivalent English translation was provided.

## Results and discussion

The following core categories, or themes, emerged from the analysis: outlook on life, social and emotional ties, engagement with the outside world, and physical capability (Figure 2). These core categories provided a conceptual framework for interpreting the ways in which

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wellbeing is experienced. In the following section, the core categories and their dimensions are described. Because of the nature of the data, some overlap is inevitable and some quotes illustrate more than one dimension.

## Outlook on life

This core category covers the different ways that people in the group evaluated their lives as indicated by their attitudes to, and ways of talking about, their past and present. It also includes attitudes to the future, and perceptions of current roles as well as their past roles and achievements. The manner in which people spoke about themselves was sometimes an indication of how they wanted others to see them as much as what had actually happened in their lives. For example, some people compared their own determined cheerfulness in the face of difficulties, with the complaining manner of others. This somewhat moralistic attitude contrasted with that of those who attributed their life pattern to such factors as luck or being blessed with good health. The evaluations thus reflected personality and self-perception as much as the actual circumstances of the individual.

### *Presentation of the past*

This dimension encompasses not only what the people in the group said about the past but also how they compared it to the present. Any one who reaches the age of 90 will have experienced some negative life-events. What varies is the effect these past events now have on the ways in which they evaluate their lives. For six people the difficulties of the past had been left behind. For example, Harald referred to the 1930s as the dreariest time in his life because of problems at work, but he did not talk as if this was important to his life now. Alexander spoke in terms of having had a hard life, of having been involved in two wars and having his first wife die of cancer. However, he had remarried and at the interview he said 'This is the happiest time in my life'. Margit and Karin both spoke about hard times when close family members had died but both had moved on and were enjoying their lives.

For the remaining six persons, the past had made a more lasting and painful impact. Britta commented 'When you lose somebody like your husband, the ground is torn away from under your feet'. Although her husband had died when she was 23, she spoke as if it was a recent event. Elisabeth had suffered sexual harassment as a young woman and,

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because her boss was 'running after her', had been forced to quit her job. She saw this as the reason both for her current poor economic situation and for her loneliness. Her distrust of men had left her single and childless. Both women gave the impression of being dominated by their past difficulties and tragedies. Some saw their whole lives as having been difficult. Erik explained that he had not had much luck: 'I have had a lot of sickness such as tuberculosis … I didn't have much happiness when I was young either'. Ester also said that she had been sick all her life and was very unlucky compared with others.

In some people's minds, the past represented the best time of their life and it was the present that they found disappointing. For example, Ingrid, who was once an artist and had travelled widely, now found herself confined to a wheelchair: 'I think that everything has become worse … there were different times in the world before'. Lisa had been involved in various clubs and societies but her deafness now meant that she preferred to keep herself in the background. She mentioned that she 'maybe had big expectations' of her old age and that formerly she had felt much happier.

Thus these people have experienced very different histories but even more than this they evaluate their life events in different ways and this influences the way they see their present lives. For some, the past was seen as a drag on the present, whilst for others it had been left behind and they had moved on.

### *Satisfaction with past roles*

This dimension encompasses expressions of satisfaction with past roles and achievements in the sense that the individual felt he or she was now reaping the rewards or benefits of such roles or achievements.

Expressions of satisfaction often referred to good relationships with family members. Karin said 'It is enough with my family', adding that her son and grandchildren were the most important things in her life. Economic security was also important. Harald had run a successful business and took pride in being financially well off in his old age. Satisfaction sometimes involved a lowering of expectations and a preparedness to adapt to the way things had become. For example, when asked whether she had got what she wanted from life, Viola said, 'I didn't have high expectations … I had a good husband' and Hugo said 'I'm satisfied. It's unfair not being so'.

For five people, there were regrets about the choices they had made earlier in life and disappointment that the roles and responsibilities they had undertaken had not resulted in a sense of fulfilment in their

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old age. Two people felt they had not been sufficiently rewarded for working hard. Britta felt that her children, to whom she had devoted a large part of her life, were not providing enough assistance to her now when she needed it. Ingrid was proud of her educational and artistic achievements but these had ceased to be of importance in her old age as no one was interested in what she had done in the past. Thus, her life's work seemed to have been for nothing. Three people had simply given up on life. For example, Ester who contrasted her unhappy life now with 'the calm and nice time' when her husband was alive just wanted to die 'in order to be with him'.

### *Functional role now*

This could mean a lifelong role such as that of parent or spouse as well as a newly acquired role such as that of carer for a disabled partner. Satisfying roles included that of caregiving spouse or the mutually supportive roles in marriage, keeping the family together, and being an active member of an association or community. Hugo stated that he felt there was a purpose in living 'as long as I can support my wife'. For Viola, life revolved around the activities where she lived: 'I'm a part of some of the activities … it's bingo tonight … everybody knows me'. Karin had an open house for her relatives each week and saw one of her main roles as providing a focal point for her family. Some people saw it as their role, perhaps more accurately phrased as their duty, to keep healthy or self-sufficient and thus not become a burden on their children.

Having an extended family, however, did not always guarantee a role. Some people who were parents, grandparents and even great grandparents, spoke as if they had little or no involvement in these relationships. In three cases, the absence of responsibility appeared to be a relief: '[my sons] just want me to exist' (Margit), or 'nobody puts any claims upon me rather it is they who help me' (Britta). Viola commented 'I don't worry about anything – what I can manage I do, and I leave the rest'. Lisa, on the other hand, not only had no functional role, she had also experienced a reversal of roles as her son was now looking after her. These examples illustrate the paradoxical situation of many old people. Having few or no responsibilities can be both welcome and unwelcome; that is, on the one hand, not having to worry about meeting demands or expectations but on the other, having no role or contribution to make to others. Five people who felt that they no longer had a purposeful role made comments such as 'I was involved in clubs, societies and organisations before, but not

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now … and I have poor hearing so I keep myself in the background … ' (Lisa). Erik, whose wife had recently died, had lost his role as husband and carer and said 'There is nothing that is important in my life right now'.

### *Attitude to old age*

This dimension includes various perceptions of what old age was like for the people in the group, and incorporates how well they had adapted to being old and to related circumstances such as health decline. Many of these people spoke very positively about their lives: 'A better life I can hardly think of … this is the happiest time in my life' (Alexander), and 'My personal life has become better than expected and even society has become better' (Hugo). Others expressed a quieter satisfaction: 'I am lacking nothing and I am quite satisfied' (Viola). Six people manifested an overall positive attitude to life which included their old age; for example, 'I have always been cheerful and positive for the whole of my life … this is how I am … there are enough whining people around me' (Karin).

Sometimes they talked about their old age in terms of their health. Alexander commented: 'I'm a very happy person and don't have infirmities as others have'. Similarly, when asked what was the most important thing in her life right now, Margit replied 'to keep in such good health that I can enjoy life', and Harald claimed that 'overall being healthy' was the best thing about being the age he was. Some referred to the positive way in which they were treated because of their age: 'Everyone is considerate of me … I can't even get on a bus without somebody rising to give me a seat' (Hugo), and 'If you need any help you can get *everything*' (Karin). However, not all of the people in the group spoke positively about their old age. Some could not see any benefits in reaching the age of 90. For example, Erik commented: 'I don't know if there are any advantages at all … you get lots of infirmities, your senses disappear, you have bad vision and hearing and lots of pain … I think that it becomes worse and worse the older one gets'.

Others went even further claiming they no longer had a reason to live. For example, Ester said that she didn't 'expect to be alive another year' and that 'it's meaningless being alive'. Often circumstances were blamed for unhappiness: 'living in the city', 'losing a husband', 'being at this age'. For some, their expectations of old age had not been met. Britta, for instance, thought that life was no longer interesting because she was limited in where she could go, and she wondered why things

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had not become better with age. Elisabeth felt very handicapped because she had a bad heart and was worried about getting enough help if her condition worsened. Ingrid was confined to a wheelchair and felt that no one understood her needs.

Thus attitudes to being old were very varied, half the group had adjusted to their limitations and were happy with their lives, while the other half were critical of what their lives had become and had found little happiness in old age.

### *Future plans*

Here we look at how the people in the group thought and talked about the future and the sorts of goals and plans they still had. We looked at whether they continued to look forward even if only in the very short-term, or whether they had given up and were simply waiting to die. Six people did speak about a future. For example, Karin talked about attending her son's 60th birthday party in the coming year, Hugo was planning his summer holidays and his wife's 90th birthday party, and Alexander was planning to finish writing his sister's memoirs. Others looked less far ahead and talked about taking each day as it came: 'I don't make any plans … instead I live for the day, with the possible exception of travelling' (Viola). Rather than look to the future, some just wanted to hold onto the present, to keep their lives staying the same. For example, Harald wanted to keep his good health and have a 'pleasant time and enjoy [my]self and feel happy', and Margit simply wanted to be able to remain in her apartment. Some were indifferent about their own future. Ingrid commented: 'In one year from now I will be sitting here and I have no idea what I will be doing'. Both Britta and Lisa said they kept going only for the sake of their children. Britta made the comment: 'I sometimes wish that I could die tomorrow … but probably I should not want to because of my children'. Others, such as Ester felt they had no future at all and even looked forward to dying.

There was evidence then, that some of the group did make plans at least in the short term, others took each day as it came. But, for some, the future was not something to contemplate, they had either ceased to live for themselves or were waiting to die.

Those with a more positive outlook on life had adapted more successfully to their changing world and had continued to make plans for the future. They were generally not disappointed with their old age. In contrast, amongst those with a less positive outlook there were more varied perspectives. For some people, old age had not met their

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expectations and they were unprepared for the restrictions imposed on them by ill health and disability. For others, it was more a matter of regret that they had not been able to live the life that they would have liked.

## Social and emotional ties

Data have been grouped according to the manner in which the respondents spoke about their relationships to others; by the presence or absence of close relationships with family members, friends and/or others.

### *Satisfactory relationships with adult children*

When speaking about relationships within the family almost everybody spoke in terms of their children or, in Erik's case, nieces and nephews, that is, the generation below. Few had any relatives of their own generation left. The relationships which were described as satisfactory were those where there was frequent contact and ready provision of assistance when needed. Those living alone, whether in their own apartment or in a service house (sheltered accommodation), preferred visits to phone calls. For those living with a spouse or son, face-to-face contact with non-resident children was less important. Those who were satisfied made comments such as: '[My son and I] have a good relationship … he has always held my hand … he is the best son in all ways you can possibly think of' (Karin) and 'I have two sons and have particularly good contact with them, extraordinarily good' (Margit). For some people having adult children seemed to represent an achievement in itself. To them it meant having someone to look after them in their old age and never having to be lonely.

Others were less happy. While nobody actually said they were dissatisfied or felt neglected, three people made it clear, explicitly or implicitly, that they would like to spend more time with their children. In two cases, the initial description of a good relationship was qualified by subsequent comments indicating dissatisfaction; for example, Ester received regular phone calls from her son but few visits. Her desire to die to be with her husband suggested that her relationship with her son was less than satisfactory. Britta also wanted to die but felt she couldn't because of her children who, as in the previous example, made phone calls rather than visits. Phone calls made from filial duty could be dispiriting in the absence of visits.

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Some people were initially reluctant to make negative judgements about family members particularly their children or spoke defensively indicating an unwillingness to admit that their relatives were neglectful. But as the interview progressed they felt more confident about making critical comments.

### *Satisfactory relationship with friends*

This dimension relates to whether the people in the group had friends and if they did, whether they were happy with their friendships. Seven people had friends in whom they could confide and who made them feel cared about and needed. This included the three men who were all active members of clubs and reported having many friends, in Harald's case, 50. Erik said, 'I meet my close friends very often and they've been there for me … they're very kind and sweet'. Viola also had two very good women friends who she saw frequently and with whom she could talk about anything. Others had outlived their friends 'You don't get any new friends at this age' (Elisabeth). Three women each had only one friend left, one of whom was ill, another demented and the third lived too far away for visiting. The desire for friendship varied. Although Karin described herself as a sociable person she also commented that she was becoming less and less interested in meeting new people. Ester, on the other hand, said she worried that people didn't like her and that she felt too shy to make new friends.

### *Aloneness*

This dimension covers more than just loneliness. It also reflects the feeling of being cut off from society, a feeling that was clearly expressed in comments such as 'I'm lonely all the time … almost all of my friends and relatives are dead' (Ingrid). Not everybody felt this way; for example, Karin commented 'I'm not alone … everybody keeps in touch and everyday at six o'clock my son calls. I've got it made'. Those who were married said they didn't feel lonely: 'We can't be lonely as long as we have each other' (Hugo), but the fragility of the situation behind such statements was indicated by Alexander who said that while not lonely now, he worried about being alone were his wife to die.

None of the group who lived with either a partner or a son, said they felt isolated or complained of loneliness. However, many of those living on their own indicated that they felt alone and left behind, even those in service houses. Some were miserable in their loneliness, others were resigned: 'I've got used to [being alone] … I almost enjoy it' (Britta).

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## Engagement with the outside world

This core category covers the extent to which the people in the group had meaningful interactions with, and took an interest in, other people (beyond their immediate families) and in what was happening around them. This category was divided into two levels: 'direct' and 'indirect' engagement with the outside world.

### *Direct engagement*

This refers to activities where there is direct interaction with others – visiting people, attending clubs and other social gatherings – or where there is the possibility of meeting other people through going out for walks or to the shops. 'Direct engagement' does not only include face-to-face contact. It also includes communication by telephone or letter writing. Karin, for example, had many opportunities for interacting with others: she held 'open house' for her relatives every week, chose to eat her meals with the other residents in the service house restaurant, and had regular home help. Alexander, Hugo and Harald all had close friends they saw regularly, and all belonged to clubs or organisations that they attended at least once a week. By contrast, the only direct engagement that Elisabeth had was when she did her weekly grocery shopping with the home help. Ingrid's main source of direct engagement was with the home help and day-care workers, which she found unsatisfactory because she felt they were unsympathetic to her problems. The one friend with whom she maintained contact had dementia.

During the interview, the participants were asked to summarise what they had done during the previous day. This provided additional information about their level of contact with others. Several had spent time with at least one other individual. For example, Margit had been for a walk and talked to friends on the telephone, and Alexander had been to the shops and to the library. Others had had little or no social contact. Lisa's only outside contact had been a telephone conversation with a friend. Neither Ingrid nor Ester had seen or spoken to anyone apart from the home help.

### *Indirect engagement*

This is a more passive form of engagement with the outside world: through newspapers, television and radio. With the exception of Ester, everybody in the group read the daily paper and/or watched the

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television news. This was clear from both the summaries of the previous day and the answers to direct questioning.

## Physical capability

This core category includes the participants' assessments of their health and need for assistance as well as their attitudes to their dependency on others.

### *Perceived health*

This reflects the way the people in the group portrayed and evaluated their health. Most people in the group rated their health as good. However, there was a noticeable tendency to underrate health problems. Despite constant pain, Karin described her health as 'excellent'. Hugo also described his health as good 'except for my prostate cancer'. Viola, too, rated her health as good despite 'aches and pains … and bad hearing'. Despite being wheelchair-bound and severely disabled, Ingrid also regarded her health as good because 'nothing internal' was wrong. There is, however, a general expectation of declining health in extreme old age so Erik discounted his health problems as 'being normal for my age'.

Some spoke as if their lives had been overshadowed by ill health and disability; for example, Elisabeth explained she had suffered a head injury a long time ago and because of that she now experienced frequent dizziness. Ester claimed that her lifelong nervous problems had affected her general health.

### *Adjustment to dependency*

What we have examined here is how well the people in the group appeared to have adjusted to their dependency on others, whether on their families or the services. Those who had adjusted well made comments such as: 'The best things about being at this age is that if one needs any help one can get everything' (Karin). Those who were less happy with being dependent made comments such as: 'The home helps always grumble about me … they don't understand that I can't move' (Ingrid).

Three people who were highly dependent were comfortable with their situation, as in the case of Karin who felt entitled to assistance at this stage of her life. For Ester, illness had become a way of life and she could hardly remember anything else. Three people resented

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their dependence. Some were worried about becoming more dependent.

## Objective measurements

A dependency measure has been included as a way of indicating how much objectively-rated need for assistance there was. We have also included whether or not the elderly individual received home help and/or lived in a service house. In addition to enabling the individual to cope better with everyday life and retain some degree of independence, these services both represent potential sources of social and emotional support and thus may substantially influence wellbeing.

### *Level of dependency*

This measure is based on ADL and IADL scores. We have used these ratings as a basis for comparison with the subjective reports. All were dependent to some extent. Dependency levels were low for most of those who rated their health as good. Those who scored low on dependency were largely independent and could choose whether or not to accept assistance. Married couples were clearly dependent on each other. In two cases however, health was rated good despite high dependency.

### *Home help and service house*

Apart from the three married men and the two women who received extensive assistance from their sons, the rest of the group were living in a service house or receiving home help.

The service house provided a considerable amount of social activity and thus for some it was an important source of social support. Some people clearly benefited from being part of the service house community: Viola, for example, enjoyed the gymnastic group and the choir and attended the bingo sessions. Although Karin complained about the 'whining people' around her, she chose to eat with them and take part in the house activities. Erik, however, found it depressing to be living among frail old people. We do not have data on whether or not these forms of interaction were emotionally satisfying. Most of the comments made by the people in the group suggested that they looked to family and friends for emotional support rather than to other residents or the staff in a service house.

The comments made about the home help service were negative or, at best, neutral. Earlier studies have suggested that their relationships with home helps are often very important to old people (for example,

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Edebalk *et al.* 1995). For none of our group, however, did this service appear to play a positive role either socially or emotionally. Four people who were receiving this service appeared to have no satisfying relationships with anybody. For them, having home help reflected dependency rather than a rewarding social contact or an emotional attachment. One woman, Ingrid, felt that the home help did not understand her and this was a factor contributing to her unhappiness.

## Further comments

The study was based on semi-structured interviews which, by definition, limited and shaped the data. Some themes that we thought were important could not always be included because the issue was not sufficiently explored in the interviews. For example, some people had religious beliefs which seemed to play an important role in their lives. However, as we were unable to make judgements about the religious beliefs of all those in the group, we omitted this theme. Several people enjoyed reading and this has been found to be important for wellbeing in this age group (Hillerås *et al.* 1998). This, however was not explored sufficiently during the interviews to be able to establish the importance of this activity for individual wellbeing.

How they felt about their financial situation was another potential dimension. Some researchers have found that reports of high wellbeing are independent of economic circumstances (Headey and Wearing 1992). Others have reported a tendency for those with higher socio-economic status to report slightly greater wellbeing (DeNeve and Cooper 1998; Headey and Wearing 1992). In our group, there was a reluctance to elaborate on questions about finances, consistent with the earlier study of the same population (Hillerås *et al.* 1998).

We have focused on the range of responses within the categories that emerged from our analyses as being the most important. There were also marked differences between high and low scores within the categories.

The core category 'Outlook on life' indicates how they viewed their lives. The comments and responses reflect personality as much as attitude and circumstances. This category differentiates between those who were satisfied with life in general and those who were not. Those scoring high on measures of wellbeing tended to have a more positive attitude to life and to old age, had adjusted well to being old, were not held back by the past or disappointed with their present life, and mostly continued to live in a way they found satisfactory. By contrast, those who scored low on wellbeing measures tended to be negative about

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being old either because they remained trapped in their past or were disappointed with what their life had become. Some felt that their achievements had not amounted to much. For this group the present had failed to offer much happiness and there was little to look forward to in the future. All of these elderly people had experienced loss to a greater or lesser extent. Some had also lost their roles and the meaning these roles gave to their lives. This amounted to a loss of self, family, friends, independence, mobility and their way of life. Ågren (1998) similarly found that this age group was increasingly affected by a non-existent future.

There were, however, discrepancies in the results found. For example, Erik did not always fit the general pattern for those scoring low on the wellbeing measures. Many of his responses seemed to be coloured by his grief for his wife and his subsequent move into a service house. Recent life-events (*i.e.* during the past six months) have been found to be important for wellbeing in this age group (Hillerås *et al.* 1998). Erik's low wellbeing may have been due to his wife's death but this does not imply that it was temporary. Diener *et al.* (1999) have indicated that people who ruminate unduly on negative life-events are likely to have lower wellbeing.

For some of those who scored high on wellbeing it seemed to be important to persuade others, particularly the interviewer, that they were happy. This was, however, not obvious during the interview but emerged in the process of analysis. Endeavours to present a cheerful and uncomplaining disposition were undermined by subsequent comments. Similarly those who scored low on wellbeing initially insisted that they had devoted and attentive families and only later revealed that this was not the case. A major advantage of our method was that it allowed such discrepancies to be understood.

The belief that attitude determined the way life treated one was more a reflection of personality than of actual circumstances. For others, it was more a matter of luck. Similarly people evaluated their life events in different ways. Some moved on from the past and appreciated what they had now, while life events had a more lasting impact on others. These findings fit with Erikson's (1982) 'integrity versus despair' model. In this, integrity involves the acceptance of the limitations in life, a sense of owning the wisdom of ages (as a development towards a higher degree of maturing), and the final integration of all previous stages. Despair is regret for what one has done or not done with one's life, fear of approaching death, and disgust with oneself. Nilsson (1997), following this model, found five different 'meanings of life' in old age which incorporated Erikson's concepts. While we found indications of 'integrity' in our group, we found less

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evidence of 'despair', particularly expressed as fear of death and self disgust.

'Social and emotional ties' indicate not only the level of contact with others but also how close these relationships were. In this respect, there was a clear division between the high and low wellbeing groups. Satisfying relationships with children and friends emerged as very important for wellbeing as shown in earlier studies of very old people (Bondevik 1997; Hillerås *et al.* 1998, 2001; Hillerås 1998; Nilsson 1997; Ågren 1992). All those in the high wellbeing group described satisfactory relationships with adult children and had either maintained past friendships, made new friends, or felt they had enough social contact within their families. Those in the low wellbeing group either had no children, or indicated dissatisfaction mainly expressed as wanting more contact. Only one person from this group described satisfactory relationships with both friends and family.

'Engagement with the outside world' has been shown in earlier studies to be important for wellbeing (Hillerås *et al.* 1999; Nilsson 1997; Ojala 1989; Miller 1991). Only those who measured high on wellbeing scales showed any interest in interacting with people other than close family, for example spending time with friends who shared similar interests. Indirect engagement did not emerge as a differentiating factor for the two groups as all but one watched television, listened to radio or read the newspapers. The data do not enable us to establish how important these activities were.

All those with high wellbeing measures evaluated their health as good, despite some having health problems. However those with low measures were more likely to perceive their health problems as being significantly debilitating and thus rated their health as poor. Subjective perceptions of health were not simply a reflection of the actual level of dependency. This has been found in earlier studies (Carlsson *et al.* 1991; Hillerås *et al.* 2001; Farquhar 1995; Nilsson 1997; Ågren 1992). In addition to playing down the negative aspects of their health, most people in the high group focused on what they were capable of rather than on their limitations. Ågren (1998) also found this to be one of seven strategies for adjusting to the weakening of the body. This dimension is similar to Nilsson's health dimension where those with a high quality of life perceived their health as good and were less concerned about, or had accepted, the infirmities of old age (1997).

The objective measurements – level of dependency, service house and home help use – have been included to provide a basis for understanding the other dimensions. Those with high wellbeing scores scored low on objective dependency with one exception, and those with low wellbeing scores scored high on dependency, also with one

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exception. Most of those with high wellbeing scores had little need for assistance other than that to be expected within the marriage relationship or between parent and child. However, among those scoring low on wellbeing measures, three people were highly dependent and were uncomfortable with this state. Declining mobility in conjunction with increasing dependency has been shown to lead to lower wellbeing (Hillerås 1998; Bowling *et al.* 1996). High dependency led to feelings of powerlessness unless, as in the case of Karin, there was a feeling of entitlement to assistance at this time of life in return for past contributions either to the family or to the state (as a taxpayer). The type of accommodation in which they lived did not appear to affect their wellbeing, which is in line with earlier findings (Hillerås 1998). While no clear pattern emerged among residents in service houses, we have not accounted for differences in the quality of service houses because of lack of data. Lastly, none appeared to have formed a relationship with their home help. It may be that some had lost the ability to form emotional ties with others. Or it may be that others make less effort to form emotional ties, possibly because they are aware that the elderly person might not have long to live. There could also be several other reasons behind this and it is an important area to highlight for future research.

## Conclusion

Our analysis has enabled us to see the range of experiences for this group of very old people. Our study also points to the usefulness of the qualitative method in giving people the opportunity to express, in their own words, what they think and feel, rather than simply answering pre-determined questions based on a structured questionnaire. The study confirms the importance for some of values such as pride, independence and not being a burden on others. While not wishing to under-emphasise the difficulties and losses of extreme old age, we believe that our study is important in showing that some very old people do not differ greatly from younger people in their capacity to enjoy life, plan ahead, think of others, and show a sense of humour. Extreme old age need not be 'another country' as so many of us fear.

Our results do not claim to represent the experience of all people over 90 years of age. We suggest that the themes presented here are important for understanding what subjective wellbeing is for some very old people. From the results, we can see that very old age takes on a variety of forms. We hope that showing this diversity will help to counter stereotypical views of old age. We also hope that these themes

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will be considered in future research on very elderly people. An increased understanding, based on empirical research, of the life situations of this age group could make a vitally important contribution to intervention strategies.

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