“It’s not how old we are; it’s how we are old”: A salutogenic approach to how older Australian women experience ageing and respond to life stressors

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A thesis submitted for the degree of

Doctor of Philosophy

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Statement of Originality

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Statement of Contribution

Statement of contribution

This is to certify that Research Higher Degree candidate has contributed to the following paper by her contribution in developing research questions, methodology and analysis of data, interpretation of findings and writing of manuscript.

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Date

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Date

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Kennaugh, R “Ageing, stress and ageing well: Stories from older Australian women” 49th AAG Conference: November 2016; Canberra, Australia.
Two roads diverged in a yellow wood,
And sorry I could not travel both
And be one traveller, long I stood
And looked down one as far as I could
To where it bent in the undergrowth;

I shall be telling this with a sigh
Somewhere ages and ages hence:
Two roads diverged in a wood, and I—
I took the one less travelled by,
And that has made all the difference.
(From: The Road Not Taken
Robert Frost)

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enthusiastic and dedicated friends to help a mature age student complete a PhD. To my
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express how grateful I am for you. Adam, Luna, Tazeen and Xenia, and Yodi, together we
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<td>ADL</td>
<td>Activities of Daily Living</td>
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<td>ALSA</td>
<td>Australian Longitudinal Study of Ageing</td>
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<td>ALSWH</td>
<td>Australian Longitudinal Study on Women’s Health</td>
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<td>ACLS</td>
<td>America’s Changing Lives Study</td>
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<td>BMI</td>
<td>Body Mass Index</td>
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<td>CLOC</td>
<td>Changing Lives of Older Couples</td>
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<td>DVA</td>
<td>Department of Veterans’ Affairs</td>
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<td>EPC</td>
<td>Enhanced Primary Care</td>
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<td>EQ-5D</td>
<td>EuroQol five dimensions questionnaire</td>
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<td>GRR</td>
<td>Generalised Resistance Resources</td>
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<td>GRD</td>
<td>Generalised Resistance Deficits</td>
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<td>HAIL</td>
<td>Health and Independent Living</td>
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<td>Health related quality of life</td>
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<td>HRS</td>
<td>Health and Retirement Study</td>
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<td>ICAA</td>
<td>International Council on Active Ageing</td>
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<td>MCS</td>
<td>Mental health component score</td>
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<td>MELSHA</td>
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<td>MEPS</td>
<td>Medical Expenditure Panel Survey</td>
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<td>MIDUS</td>
<td>Mid-life in the United States Study</td>
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<td>NSDE</td>
<td>National Study of Daily Experience</td>
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<td>PCS</td>
<td>Physical health component score</td>
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<td>RCT</td>
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<td>Specific Resistance Resources</td>
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<td>TA</td>
<td>Thematic Analysis</td>
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<td>United Kingdom</td>
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<td>United Nations</td>
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<td>U3A</td>
<td>University of the Third Age</td>
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<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>USA</td>
<td>United States of America</td>
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<tr>
<td>WHI</td>
<td>Women’s Health Initiative</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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Abstract

The number of older people within the world’s population is rapidly increasing. Within that group, the number of women outnumber men, and as time passes, the number of widowed women has become greater than the number of married women. The impact of this change requires adequate preparation, and understanding the experiences of ageing is an essential step to develop policies regarding appropriate physical and social environments. In addition, adequate services and programmes, aligned with the expressed needs of older adults, can be prepared and implemented.

This thesis focuses on the experience of older Australian women, and how they manage the challenges of ageing. The intent of the research was to understand the main issues that are reported by older women to be important, how they cope as they age and how they adjust following changes to their marital status. In addition, the research aims to identify evidence of a Sense of Coherence (SOC), as described in the theory of salutogenesis, particularly as it is identified in the experience of women who describe that they are ageing well.

Studies in this thesis applied qualitative longitudinal analyses of data. The method of Thematic Analysis (TA) was used to identify the main themes described by older women during the period in which they were participants in the Australian Longitudinal Study on Women’s Health (ALSWH). A conceptual model was developed, and was applied to the data, which were free-text comments.

The main findings were first, that women reported a wide range of stressors throughout their ageing process. Second, women described resources which they could access and use appropriately to counter the negative forces of stressors, and to minimise the reaction of stress that could follow. The third main finding was that many women reported that despite the challenges of ageing, they found ways to manage the circumstances of life, and reported that they were indeed ageing well.

The main implications of the findings are that a SOC is an orientation to view life in a way that supports a flexible approach in managing life’s events and associated stressors. As such, the development of a SOC should be seen as a useful strategy, which can be developed during
early life experiences, and can continue to be implemented and strengthened across the life course.
1 Introduction

1.1 Background

Since the early 1970’s there has been a consistent rise in the median age of the Australian population (Australian Bureau of Statistics (ABS), 2011; Wennerberg, Eriksson, Danielson, & Lundgren, 2016). This has had a strong influence on many areas of social interest. As the increasing numbers of older people impact on society, there is a need to deepen our understanding of their experiences. The value of their stories is important to discover and recognise. In doing so we can better ascertain how this growing number of people within our nation will affect the demands that may be placed on providers for care and services to their age group over coming years.

The 2011 Australian Census revealed that between 1971 and 2011 the proportion of Australia’s population aged 65 years and over increased from 8.3% to 14%. Women aged 65 years and above formed 15% of the total population of women, whereas men constituted a lower 13% in 2011. In the older age categories women significantly outnumber men. Of all people aged 65 and above, 54% were women and this increased to 66% of all those in the 85 years and over category (ABS, 2012b). The life expectancy for women remains higher than for men, and as of 2010, a woman could expect to live to 84.4 years compared to 80.3 years for a man (ABS, 2014). Women therefore constitute a greater percentage of the population aged over 65 years. The census information also revealed that 38% of women aged 65 years and over were widowed compared to 11% of men in the same age group (ABS, 2012b). Therefore, women can expect that as they age, there is an increased risk that their older years will be lived without their spouse.

Bereavement and widowhood form a period of transition in the lives of many older Australian women (Byles, Feldman, & Dobson, 2007). The loss of a husband is a significant life event (Holmes & Rahe, 1967). How this loss may impact a woman in the years that follow is worthy of further study given that the number of women in this situation is increasing. For an older Australian woman, it is possible that she may be living as a widow for up to 15-20% of her lifetime (ABS, 2007).
The process of ageing, spousal bereavement and widowhood is challenging and losses are significant for many women. However, despite the challenges women can make a transition to a new period of life. Although they may need to re-evaluate their roles and responsibilities within families and communities, there is evidence that adjustment to a new way of life is achievable (Boerner, Wortman, & Bonanno, 2005; Byles, 2007; Digiacomo, Lewis, Nolan, Phillips, & Davidson, 2013). Where women have been the main care-giver to the spouse, once relieved of the pressing and persistent nature of that responsibility, many of them have reported an evolution in their lives that allows them renewed opportunity to cultivate new and/or re-kindle old friendships, re-join social and interest groups and become more involved in the wider community (Bennett & Soulsby, 2012; Hahn, Cichy, Almeida, & Haley, 2011; Holtslander, Bally, & Steeves, 2011). In addition, the possibility to invigorate activities and interests has been linked to an assessment of a better quality of life and improved well-being (Bowling & Iliffe, 2011).

This study represents a longitudinal qualitative analysis of free-text comments made by older women, born between 1921 and 1926, taking part in the Australian Longitudinal Study on Women’s Health (ALSWH). The ALSWH has been collecting health survey data since 1996, including inviting women to record qualitative information at the back of their surveys (http://www.alswh.org.au). This research made use of the free-text comments to explore the stressors associated with ageing, the resources that women had available and utilised to help them cope with life, and how the use of resources contributed to ageing well. Consideration was given to identifying and contrasting how the effects of time and change in marital status, from married to widow, may be seen in older women, who form a significant proportion of the Australian population (ABS, 2012a).

1.2 Rationale for the study

The primary reason pre-empting this study was that it was seen first-hand by the researcher, when working professionally in the community, there was a wide range of life experiences for older women. Some women described their experiences during their older years in terms of challenge, and also of reward, contribution and enjoyment. Subsequently, the rationale for this project has stemmed from an ensuing desire to better understand how older women, both married and widowed, manage the challenges associated with ageing. In addition, it was of interest to identify the resources they use to adjust to different stages and potentially difficult transition periods of life.
The word salutogenesis comes from two words; ‘salus’ being the Latin for health and ‘genesis’ being the Greek for origin, and taken together, they mean the origins of health (Antonovsky, 1993). The theory of salutogenesis was proposed by Aaron Antonovsky (1979, 1987) to provide a model that showed how people could deal effectively with life’s stressors. The term Generalised and Specific Resistance Resources (GRR’s and SRR’s)) can be applied to any resources which, if present, can be used to mitigate the harmful tension, associated with effects of stress, that may have otherwise resulted. The absence of resource(s) can be seen as a deficit and Antonovsky called these Generalised Resistance Deficits (GRD’s). Antonovsky further proposed that both GRR’s and SRR’s together with life’s experiences contribute to a concept called Sense of Coherence (SOC), which is central to salutogenic theory. SOC is defined an orientation to life, that involves an inclination people have to manage stressors with a combined use of available resources, both GRR’s and SRR’s.

Appropriate and available resources were said to strengthen the three components that were central to SOC, that is, comprehensibility, manageability and meaningfulness. The presence of these three main components contributed to a life orientation that enabled people to see their life as having a manageable structure, and with sufficient meaning and purpose, despite the challenges that could be expected (Antonovsky, 1979, 1987).

The comments made by ALSWH participants born 1921-26 were identified as a rich data source to further our understanding of ageing, guided by the theory of salutogenesis. The first goal, from using these data, was to understand why some women had a more positive report of their life, particularly living as a widow, and why others reported more negative or disappointing stories. The second goal was to identify what resources may have strengthened older women to cope with stressors as they aged. And third, was to develop a deeper understanding from their perspective, of the process of ageing, and what aspects were considered positive and acceptable.

The significance of this work relates to the identification of the major events, experiences and resources that have affected the perceived quality of life for older Australian women, both married and widowed. Their experiences can include significant stressors of ageing, bereavement (including spousal loss for widows) and many other life events, as a source of challenge over many years. The group of women who form part of the older population in Australia (≥65 years) have a unique story. Their lives have been shaped by periods of enormous challenge and significant change. These have included two worldwide conflicts, the
Great Depression, the advent of rapid advances in technology and changes in the social fabric of their family and community. Access to further education, beyond bare minimum standards of approximately 14 years of age, was not common for women born in the 1920’s, yet they have lived to see 53% of young people, the age of their grandchildren, being enrolled in universities by 2011 (ABS, 2011).

For the large proportion of older women who are widowed, they process the grief surrounding the bereavement of spousal loss, and move forward to establishing their new life without the support of a partner. These women have been reported as managing stress related to their health, their finances and their need for positive social support, inclusion and value (Byles, Feldman, & Mishra, 1999; Feldman, Byles, & Beaumont, 2000). Few studies have explored the strategies that women use to cope and adjust to the challenges that bereavement brings (Digiacomo, Davidson, Byles, & Nolan, 2013). In addition, much of the literature on ageing in general still carries the assumption that, for both widowed and married women, old age is marked by lack of independence, growing frailty, a sense of being a burden on families and a drain on society. This research will add knowledge to the literature where there is little awareness of the immense value older people add to families, communities and the economy as a whole, by way of their contribution through caring roles and volunteer groups. These roles often go unnoticed and are frequently unpaid. However, they are important in assisting those widowed develop a sense of mastery, belonging and usefulness, and are subsequently effective resources for coping (Edgar, 2014).

In addition, there has not been a great deal of work done that takes a long term view of widows, and that is inclusive of the broad range of issues that affect widowed women in the broader context of ageing (Digiacomo, Lewis, et al., 2013). The understanding of these issues needs to be extended beyond bio-medical measures, to include psycho-social and behavioural elements (Browning & Thomas, 2013; Cosco, Prina, Perales, Stephan, & Brayne, 2013). For appropriate policy planning it is important that an understanding is developed that reflects the issues paramount to women who are widowed and potentially ageing alone. By studying the lived experience of a large number of women who describe the ways they have made adjustments to change, these results will offer depth to the current body of literature.
1.3 Personal reflections

The researcher is a physiotherapist with 40 years of clinical experience. During the last 10 years the work has been more specialised within the older community, particularly among widowed women. The women who were referred for assessment wished to continue living independently in their home. The aim of the involvement of a physiotherapist was to ensure patients received appropriate education and supervised instruction in ways to maintain strength, balance and safety. The best outcome from this form of intervention was to help women to live in in their own home for as long as it was safe for them to do so. Where possible they were encouraged to maintain interests both in and out of their home, and to be socially engaged in ways that suited their values and abilities. It was during this later period of work a patient repeated a saying she had read: “For people to succeed in life they need: Something to do; someone to love and something to hope for”. The researcher drew on years of face to face contact with many patients, of whom so many were older women, to feel that this saying resonated with what experience had shown.

The memories of so many people from this lengthy period of work as a clinician remain etched in the mind of the researcher as a priceless reminder of the value of the ‘individual’ experience, which was shaped by the interactions with the ‘many’. To do justice to the individual, there needed to be acknowledgment of the community; however, equally the community was made up of many individuals who all offered a unique perspective, many of whom made a worthy contribution. Older women, and women who are widowed and often living alone, were frequently forthcoming if given the time, to share the perception they had of their life as they looked back. When consideration was given to the extraordinary depth of experiences women described, it reinforced the merit of listening to their contribution, as they had opportunity to process and recount the events that had formed the fabric of their life.

In the researcher’s role as a physiotherapist, women who had access to physiotherapy services were frequently covered by governmental assistance, such as that offered by the Department of Veterans’ Affairs (DVA), or under the Enhanced Priority Care (EPC) system offered to holders of a Medicare Australia card. These benefits assisted in reducing the financial stress that others in the broader community may experience when trying to access a broad range of medical services. As such, this support may have influenced the interpretations these women may have had about ageing, compared to women who did not receive similar assistance.
The research sought to deepen the years of clinical experience with better understanding of the theories that have been proposed about the process of ageing, including accompanying physical and emotional challenges. Value was placed on the individual story of each woman, combined with an awareness of how the individual stories were placed within the narratives of the group.

1.4 Research aims

The aim of this research was to understand the main issues that are reported to be important to older Australian women, and how they cope with the challenges of ageing, including changes in marital status if they are widowed. In addition, the aims included to identify evidence of a SOC, as described in the theory of salutogenesis, particularly seen in the experience of women who describe that they are ageing well. The specific objectives were:

1. To identify if the main themes described in earlier research concerning the experiences of older Australian women persist over time (Chapter 4/Paper 1).
2. To identify the main stressors, and the reactions of stress, that women describe over time as they age, according to marital status (Chapter 5).
3. To identify the main resources that help women contend with, and minimise the negative effects of stressors (Chapter 6).
4. To assess if the resources alter over time as the women age, and according to marital status (Chapter 6).
5. To identify the concepts that women deem to be important to them in relation to their assessment of well-being, independence and social engagement and overall, their process of ageing well (Chapter 7).
6. To identify if SOC and GRR’s and SRR’s are seen as useful to counteract and manage stressors and stress. (Chapter 7).
7. To identify if SOC and GRR’s and SRR’s alter over time and with respect to differing marital status (Chapter 7).

1.5 Thesis Overview

This introductory chapter provides some background information about ageing and older Australian women, alongside the significance and aims of the research. Chapter 2 introduces the main concepts related to the research. These include the concept of health (particularly
with respect to older women), spousal loss and subsequent widowhood, and the stressors and resources that may be described by women as being part of their experience as they aged, and how this may be seen in the context of salutogenic theory.

The literature review also examined the current understanding of the term ageing well as distinct from other terms that are similar although not synonymous. Antonovsky’s theory of salutogenesis was used as the theoretical framework. The literature review includes a summary of current knowledge, along with gaps that were evident in other research findings, and how the current research will address these gaps.

Chapter 3 presents the salutogenic approach to understanding health. This represents a divergence from the approach that had been the primary focus of health research until the late 20th century, that is a pathogenic paradigm. The potential for better understanding the way people describe the events in their lives, including the inevitability of stress, is described, presenting the salutogenic concept that health is best viewed as a continuum not as a dichotomy.

Chapter 4 describes the methodological stance of the research, commencing with the theoretical assumptions on which the research is based. This includes a subjective epistemology, which allowed for the individual opinions of all participants to be represented, and for value and importance to be attached to each unique interpretation that was deemed to be true for each woman. The theoretical standpoint was chosen to be interpretive, which fitted well with the subjectivist approach. Reality could be constructed according to social interpretation, and each woman could contribute her perception of what, for her, was considered the truth for her experience. Thematic analysis of the comments was chosen as the method to analyse the qualitative data. This method allowed the ‘how’ and ‘why’ of the women’s experiences to be added to the ‘what’ and ‘when’ that are commonly seen in quantitative methods. In so doing, the subtle nuances of individual perspective could be better understood.

Chapter 4 also covers the data source and methods of the study. It outlines the ALSWH, and the connection between the source of data and the conduct of analysis. A comparative analysis was made between comments from women in the oldest cohort of the study, over 15 years, and from the perspective of different marital groups within this cohort. The chapter also details the description of research procedures, treatment of data, the process of coding and
how the themes could be identified within, and interpreted from, the data. The position of the researcher and possible effects on the research are acknowledged.

Ethics approval is covered in chapter 4 along with how potential bias in sampling was addressed. The issues of trustworthiness of the qualitative research method are introduced. This covers the areas of credibility, transferability, dependability and confirmability, all of which are fully revisited later in the thesis in Chapter 7. After the presentation of the findings of the study, the trustworthiness of the study was reviewed in order to demonstrate that the suggested methods of checking for quality in qualitative research were upheld.

Chapter 4 continues with an overview of the participant groups. This includes details of criteria and key characteristics of the three main groups studied: early widows, late widows and those women who remain married. It also includes steps taken for individual studies and for those taken across all studies. The chapter continues with a paper that was peer reviewed and published, with the title: “Beyond widowhood: Do prior discovered themes that describe the experiences of older Australian widowed women persist over time?” The paper explored the comparisons between the major themes, concerning ageing and being widowed, that women had reported in a previous cross sectional study and assessed whether the themes persisted over the 15 years of available data. The findings from the study concluded that the main themes did persist over time, although changes in emphasis and nuances of meaning were seen.

A conceptual model is then presented which was then applied to the subsequent studies following the first study that was published. The way that the model was applied to the data taken from the next three groups of women is described, concluding chapter 4.

The three findings chapters follow (Chapters 5, 6 and 7). They are presented in a way that follows the relationships between concepts proposed in the conceptual model. Chapter 5 focuses on the presentation of findings about stressors and stress reactions described by older women that were experienced by them as they aged. The purpose was to consider various concepts that had been considered would contribute to the main themes of stressors and stress.

Chapter 6 presents the findings about SOC and the resources that contribute to a salutogenic orientation to life. How women use certain resources to cope with the stress of ageing was investigated. Women who knew they had resources to help them, and could make appropriate
use of them, were found to report a better experience of their ageing process than women who did not know of resources, or how to utilise them effectively.

Chapter 7 presents the findings about ageing well. The focus was on the experiences that added depth to the understanding of how women described ageing from their own perspective. As with each of the findings chapters, consideration was given as to how the experiences were different according to whether the women were married or widowed, and with changes that occurred over time.

The final chapter, Chapter 8, brings together the findings from the studies and considers the relationships of the three key areas: the stressors women identified; how the resultant stress was managed by access to and the use of available resources; and how these can all work together effectively to enable many women to describe that they interpret their situation as ageing well.

1.6 Conclusion

As is true for most of the countries in the world, Australia has an ageing population and one in which women, and indeed widowed women, form a significant proportion of the older group (ABS, 2012b). Despite this, there remains little analysis of longitudinal qualitative data about how they describe their experiences of ageing. In Australia, there is also a large number of older women who will, particularly as they move through their 70’s and later years, age without a spouse. The issues that are important to both married and widowed women need to be better understood. Society needs to pay heed to the potential needs older women may have in terms of accessing services and care. In addition, there is a need to deepen the understanding of ageing, from their perspective. This study will provide an opportunity for women who were born between 1921-26 to describe their process of ageing, and how they create an experience of ageing well. It is the aim of the thesis to examine the data that will give an ‘insider’s view’ of older Australian women and how they describe their experience of ageing.

1.7 The next chapter

The next chapter situates the current study within the body of literature. The background to health and ageing research is presented, along with the theories that had been developed to support knowledge about ageing.
1.8 References


Australian Bureau of Statistics. (2007). *Lifetime marriage and divorce trends (Cat. no. 4102.0)*. Canberra: ABS.


Australian Bureau of Statistics. (2012a). *Australian demographic statistics (Cat. no. 3101.0)*. Canberra: ABS.


Australian Bureau of Statistics. (2014). *Deaths Australia, 2014 (Cat. no. 3302.0)*. Canberra: ABS.


2 Literature Review and Theoretical Framework

2.1 Introduction

This chapter presents a literature review of issues relating to ageing and older women in particular. The review situates the research presented in this thesis against theories of ageing and how a salutogenic approach can be taken to ageing well. First, there is an examination of background information on ageing in general, and some of the challenges that surrounded theories proposed to explain and define health. The strategy of ‘adding life to years’ not just ‘years to life’ is presented, with due consideration that a greater life expectancy is likely for many people. Following, there is a focus on literature about older women and their perceptions of the process of ageing and Health Related Quality Of Life (HRQOL).

The chapter concludes with a presentation of the paradigms of health and ageing that have shaped the development of understanding of the process of ageing.

2.2 Literature search strategies

2.2.1 Methods

2.2.1.1 Sources

A search was conducted using electronic databases: Cinahl, Cochrane Library, Embase, Medline, PsycINFO and Scopus, accessed through the University of Newcastle. Searches focused on primary words in the titles and abstracts. Relevant sources, other than peer reviewed journal articles included in the search were: books, government and special interest groups’ reports, and conference proceedings. These included World Health Organisation reports (WHO), publications by the Australian Bureau of Statistics, Productivity Commission, Centre of Excellence in Population Ageing, National Seniors Organisation, National Ageing Research Institute, and those of University Departments who had an interest in ageing research, government agencies and ageing groups. These reports are frequently published outside of academic journals. A full list of key words searched is included in Table 2-1.
**Table 2-1 Literature search procedure and results**

<table>
<thead>
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<th>Records identified</th>
<th>Records after de-duplication</th>
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* Key words search: Widow; widowed women; widowhood; death of spouse, husband or partner; aged and ageing; ageing well; life course; caring; bereavement; transition; adjustment; coping and coping behaviour; resilience; theory of salutogenesis; salutogenic; stress; generalised resistance deficits; generalised resistance resources; specified resistance resources; health; social support; social engagement; positive disposition; subjective well-being; quality of life; family and friends; socio-economic roles; finances; financial structures;

** Combination phrases used: (widow* or death) within 3 words (spous* or partner* or husband); Widow* and (aging or aged) and women; Women and age*and longitudinal; Women and age* and Australia*

### 2.2.1.2 Inclusion criteria

Studies included in the initial search were limited to English language during the period 1999-2016. Earlier texts and articles were included if considered seminal works in the field and/or have been cited by other authors in the related area of research. Other inclusion criteria included studies on older women, reference to marital status, and the use of longitudinal data. ‘Older’ was defined as being 65 years of age or older. Articles that addressed ageing, widowhood, bereavement, transition and adjustment across the life course or among older adult populations were also included in the review.

### 2.2.1.1 Exclusion criteria

Articles were excluded if the population being addressed was not ‘human’, did not include older adults and if they focused on hospital or aged care facility dwelling participants only.
Exclusion criteria also included book reviews, newspaper articles, and abstracts where full-text was not available from any other sources, whether online or library collections.

2.2.1.2 Search process
The literature search produced a total of 4203 papers. All articles were downloaded to EndNote (EN) (version X7) bibliographic software that was chosen for referencing purposes. These searches were done using Ovid, a web-based searching software. In addition, manual searches were done using the databases identified below from the University of Newcastle (UON) to source work published by authors who had been cited in relevant literature. If published material was not available through UON database, it was retrieved from other sources using the ‘Get It’ service offered by the UON Library. Duplicates were excluded first.

Then, all the items in the EN library were screened for suitability first using the titles. The next stage involved reading all the abstracts, noting key words, types of analyses and findings, to continue screening and assessing for quality and for relevance to the study that was planned.

2.3 Issues that concern older women

In Chapter 1 (section 1.1) the ageing of the Australian population was described. In addition to an overall increased number of people over 65 years of age, it was noted that there are greater numbers of older women than men, and greater numbers of widowed women than married. This was seen to be increasingly true for women aged 85 years and above (ABS, 2012). To date, there has been a lack of attention to the unique experiences and needs of this age group of older women, particularly in relation to spousal loss, and the health and social impacts that follow (Digiaccomo, Lewis, Nolan, Phillips, & Davidson, 2013a). For women to live into their older years (80-90 years of age or older), and to have a desired level of enjoyment and contribution, their health has to sustain them to at least a functional capacity.

Understanding that, over time, there are more Australian widowed women than married, it is possible a woman may be living as a widow, and living alone, for a period that could represent up to 15-20% of her lifetime (ABS, 2007). Not only is the length of time significant but it is during this time that she will live out her oldest years. Moreover, for many women, this change will come after a prolonged period as their husband’s carer, with the associated carer burden, anticipatory grief, post-loss mourning and other stressors (Carr, Wortman, & Nesse, 2005; Hahn, Cichy, Small, & Almeida, 2013; McIntyre & Howie, 2002). While the loss of a spouse is still considered to be one of the most difficult experiences in life, it has been suggested that
research needs to be encouraged to move beyond merely identifying areas of change to well-being in the time surrounding the period of care, and the time of the bereavement itself. More understanding is required as to how spousal loss affects subsequent ageing and how the position and experience of women in families and society is altered by that loss (Lee, 2013). During both periods of caring and bereavement, women have to find a balance in managing increasing issues relating to psychological and physical health, housing needs, altered financial resources and demands, and being able to interact with, and be mobile within the broader community (Holtslander, Bally, & Steeves, 2011; Rosenwax, Malajczuk, & Ciccarelli, 2014).

2.3.1 Caring for spouse

Historically, women have been the associated with roles involving nurturing and caregiving. To date, women are still the most likely caregivers for an ageing spouse. Although more research has been suggested in order to better understand potential differences in the way men and women cope with caring, the body of evidence still supports the finding that women do suffer more negative consequences as a result of caregiving (Digiacomo, Lewis, Nolan, Phillips, & Davidson, 2013b; Herbert & Schulz, 2006; Sharma, Chakrabarti, & Grover, 2016).

The role of caring can be associated with care-giver burden, psychological distress and physical challenges (Schulz & Sherwood, 2008). It has been seen in both the USA and Australia that women who commence caregiving in their mid-60’s, are far more likely to live in poverty than those who were not caregivers (Casey, 2013; Wakabayashi & Donato, 2005). Over time, as women care for their husband, perhaps until the time of his death, their feelings towards the caregiving role can change (Riley & Fenton, 2007). Women can feel overwhelmed with medical information that can be associated with dealing with an illness, they can feel conflicted about how to deal with the ‘patient’ who is also their spouse and they can feel emotionally and physically exhausted. However, it can also true that many women experience caregiving as an opportunity to show kindness in ways of practical and emotional support, and draw comfort from this opportunity (Kang et al., 2013; Litwin, Stoeckel, & Roll, 2014; Roth, Fredman, & Haley, 2015).

The effect of the length of time of care-giving could also influence the experience, with evidence suggesting that with increased periods of care, greater than six months, also came a positive effect from feeling useful. In addition, more time is given to express appreciation and to say things that surround a meaningful farewell. These aspects were seen to assist in preparing the care-giver for an eventual separation, and even for the grieving process to begin
before death, although the effectiveness of anticipatory grief has not been firmly established as being of positive benefit (Burton et al., 2008; Keene & Prokos, 2008; Nielsen, Neergaard, Jensen, Bro, & Guldin, 2016).

Prior to the death of a spouse women report a wide range of negative impacts on their health as a result of providing care (Penning & Wu, 2015; Schulz & Sherwood, 2008). These include stress, anxiety and even thoughts of self-harm. The negative effects of stress on emotional and physical health, and the potential for ‘wear and tear’ injuries to the women such as injuries to the neck, back and shoulders, have been seen to influence the experiences of the care-giving period (Digiacomo, Lewis, et al., 2013b; Keene & Prokos, 2008). The impacts of chronic health conditions and diseases experienced by a woman while caring for a spouse has been also reported to affect well-being in the subsequent bereavement phase (Brodaty & Donkin, 2009; Digiacomo, Lewis, et al., 2013b; Penning & Wu, 2015).

In Australia, it is not common for older couples to co-reside with their children (Abdulrahim, Ajrouch, & Antonucci, 2014) and adult children may be reluctant to provide care for an ageing parent (Silverstein & Giarrusso, 2010). Emotional cohesion has been seen to decline between older parents and their adult children, and there can be ambivalence as to the support the children feel they offer compared to the assessment of the older couple themselves regarding the support they need and/or receive (Silverstein & Giarrusso, 2010). If an older married Australian woman experiences difficulties caring for a spouse, without family support, she may have to consider placing the husband into a formal facility that offers professional assistance. This has been identified as a source of stress for older people, who do not want to be separated in their later years, and may also not want to leave their familiar neighbourhood environments (Mackenzie, Currier, & Byles, 2015). Compared to men, women carers are less likely to place the husband in care (Brodaty & Donkin, 2009). Once the crisis of the death occurred, many women reported being able to resume what formerly had been normal activities for them (Byles, Feldman, & Dobson, 2007). In fact, if the stresses of caring had contributed to decreased marital quality it was found in some studies that mental health may also have actually improved (Das, 2013).

2.3.2 Loss of spouse: Bereavement, transition and adjustment

A recent systematic review endorsed the position that women face many disadvantages following the death of their spouse, including chronic health conditions and financial difficulty (Digiacomo, Davidson, Byles, & Nolan, 2013). Over time as the social networks of older people
become smaller, the spousal relationship can become even more important. Older women with a long marriage partnership, not only suffer the loss of a close connection after their spouse dies, but also have a greater likelihood to remain unmarried (Boerner, Wortman, & Bonanno, 2005).

The effects of spousal bereavement cannot be reduced to a prescribed and sequential process, with respect to the degree, types and length of grief responses (Bennett & Soulsby, 2012; Byles, Feldman, & Mishra, 1999; Carnelley, Wortman, Bolger, & Burke, 2006). Indeed, some women have felt it inappropriate to talk about ‘recovering from’ spousal loss, noting however, that over varied periods of time, a phase of re-building and adjustment was usually possible (Bennett & Bennett, 2001). Research suggests that there is an early phase of more acute response to the process of grief following spousal bereavement, which may range from 6 months to 2-3 years (Bennett & Soulsby, 2012; Digiacomo, Lewis, et al., 2013a; Sasson & Umberson, 2014; Stroebe, Schut, & Stroebe, 2007; van der Houwen, Stroebe, Stroebe, Schut, & Meij, 2010). During this acute post-bereavement period there was an excess risk of mortality, depression and a higher rate of chronic conditions and health events, most commonly for women who were suffering socio-economic disadvantage (Digiacomo, Lewis, et al., 2013a; Pruchno, Cartwright, & Wilson-Genderson, 2009; Stroebe et al., 2007; Sullivan & Fenelon, 2014; Williams, 2005). It was suggested that during this period of acute loss that women may be disrupted from caring for their own needs and this may contribute to negative impacts on their health.

A recent literature review concerning changes associated with spousal bereavement suggested that daily activities are frequently disrupted, especially in the early grief period, which can lead to increased loneliness and health concerns (Naef, Ward, Mahrer-Imhof, & Grande, 2013). Some women found that as they transition to living alone, their health behaviours change with perhaps fewer reminders to maintain healthy behaviours (e.g. to exercise, eat regular and balanced meals and to have regular health check-ups), to take medication in a timely and regular pattern and less assistance being received around the home (Digiacomo, Lewis, et al., 2013a; Williams, 2004). Research also found that although altered health related patterns of behaviour were seen for a short period, it was thought that the bereaved spouse was usually starting to adjust to their new situation from around 2 years, unless there were issues to be considered of complicated grief (Jin & Chrisatakis, 2009; Zisook & Shear, 2009).
The process of bereavement whereby women come to terms with spousal loss, and make the transition to their new life past the initial 2-3 year period is complex and subject to wide variability, according to past experiences, current resources, the state of health at the time of loss and the woman's own life expectancy, changes brought about from living alone and managing a household and finances with no spousal assistance (Digiacomo, Davidson, et al., 2013; Keene & Prokos, 2008; Williams, 2004). As women participate in the process of transition to life without a spouse, they need to make adjustments to fit with their changing roles and circumstances (Bennett, Hughes, & Smith, 2005). Widowhood is not a prolongation of the stage of grief, mourning the loss of the spouse, but a period of new life following adjustment to their situation as a single older woman. This period represents a further developmental phase (Digiacomo, Davidson, et al., 2013). In Australia, with women living longer than men, combined with the social norm for an older woman to have married a man older than herself, 77% of women over 85 years will be widowed (Australian Institute of Health and Welfare, 2015).

Women seem can have many different experiences during this life stage. In one study, poorer coping was reported where women adhered to a traditional gender role, compared to when a more modern flexible role was taken (Garcia, Evans, & Reshaw, 2004; Sasson & Umberson, 2014). In this study, older women’s traditional role was linked with economic dependence on their husband, and with career and interests being more centred on the home, family and domestic related hobbies than was seen in women in younger age-groups. The woman who is older will face a challenge to make role adjustments personally and societally, in addition to managing the ongoing changes of advancing age. Although there were periods of difficulty associated with the loss of their spouse, adjustment to widowhood, and other changes associated with ageing, many express an ongoing optimism and faith that they can cope, adjust and find purpose and meaning in their older age (Byles & Dobson, 2011; Byles et al., 2007; Feldman, Byles, & Beaumont, 2000).

Early work in the United Kingdom (UK) by Bennett (1997) looked at overlapping effects of adjusting to being a widow with negotiating changes that may accompany the ageing process. The 8-year longitudinal quantitative study evaluated relative changes in mental health and morale compared to physical health and social participation. The findings were that the negative changes in mental health and morale were more persistent than the changes in physical and social variables. However, when ageing was factored in as well, the decrease in
morale and social engagement appeared to be mediated by age-associated decreases in physical abilities. Subsequent research followed up on these findings by investigating the ways older women reconstruct their sense of identity following the death of their husband (Bennett, 2010). Many women spoke of their struggle to establish their independence in their new role, and to resist perceived pressures to conform to a position that may be deemed appropriate to their society. However, women who were highly dependent on their spouse prior to his death were found to reap positive psychological benefits in their lives if they developed skills that allowed them to manage with relative independence, and to redefine their lives within the altered social circumstances that they are now found (Angel, Jiménez, & Angel, 2007; Bennett, Stenhoff, Pattinson, & Woods, 2010; Carr, 2004; Digiacomo, Lewis, et al., 2013a).

2.3.3 Social support for older women

Social support forms an important part in the process of adjusting to widowhood with a strong sense of well-being, and is a broad term that originally came from research on the role of social involvement with preventing suicide (Cohen, Underwood, & Gottlieb, 2000). Social support has also been proposed to be a key psychological factor that functions to protect people against the effect that stress may have on health (Heaney & Israel, 2008), and takes on aspects of relationships, networks, engagement and volunteering. Discussion between the involved parties may be helpful to identify what types of support are best suited to the needs of the recipient, and are acceptable and realistic for those who will be offering the support (Ahmadi, 2016).

Social support is not a static concept. The perceived need for support can fluctuate, both from the recipient’s view and from the side of the person(s) offering support. It is possible that widowed women experience an over-reliance on support early in the bereavement process, which may be withdrawn, leaving them feeling isolated and lonely (Stroebe, Folkman, Hansson, & Schut, 2006). Positive feelings in women about social engagement and family interactions can increase following the death of their spouse. Sixteen years of data from 1,266 participants in the Australian Longitudinal Study of Ageing (ALSA) demonstrated a positive correlation between high levels of social engagement and success in overcoming the challenges of bereavement (Isherwood, King, & Luszcz, 2012). However, relationships within families can have an aspect of being obligatory, whereas friendships and activities outside the family are based on choice, and as such can be enjoyed with less feeling of restriction or judgement (Feldman et al., 2000; Nguyen, Chatters, Taylor, & Mouzon, 2016; Singh & Misra,
It has also been found that when women contributed to social interaction, it had even more positive impact on them, than when they were merely the receivers of assistance (Bennett, Smith, & Hughes, 2005).

Over time, as needs alter, social support can be expressed in many ways. It may involve women receiving emotional support (e.g. phone calls, families providing company, physical contact such as hugs) and/or instrumental support (e.g. help with home maintenance and chores) from family and friends. The support may be focused on the older women and their own needs, or it may aim to limit a sense of isolation and extend help towards them particularly if the women are still providing assistance to the spouse (Caetano, Silva, & Vettore, 2013; Melchiorre et al., 2013; Thekkedath & Joseph, 2009). In addition, social support incorporates the benefits older women report receiving when they engage in activities outside their homes external to family activities, by volunteering and contributing to community organisations and religious groups (Byles et al., 2007; Donnelly & Hinterlong, 2010; Hahn, Cichy, Almeida, & Haley, 2011; Kumar, Calvo, Avendano, Sivaramakrishnan, & Berkman, 2012; Tang, Choi, & Morrow-Howell, 2010; Utz, Carr, Nesse, & Wortman, 2002).

While it was acknowledged that the relative hierarchy of support needed from family and friends can alter over time, and between varying ethnic or religious groups, the importance of social support in the lives of women continued to be of benefit (Li, Ji, & Chen, 2014). For older women, particularly widows, being outwardly focused was reported to be a positive way to use the time that had previously been taken with care-giving, thereby easing the sense of being alone, and help to give purpose and meaning (Anderson et al., 2014; Principi et al., 2016; van Ingen & Wilson, 2016).

In studies of disruption following spousal loss, being able to maintain social support from family, friends and neighbours was seen to be important. One longitudinal study, conducted over 12 years, analysed data from the British Household Panel Survey (Glaser, Tomassini, Racioppi, & Stuchbury, 2006). The study investigated the relationship between the loss of spouse and the potential risk of reduced perceived social support and actual frequency of social contact. The receiving of a phone call, at least weekly, from a non-family member was considered the basic measure of social contact. They found that as people aged, the frequency of receiving a phone call external to those from family members, actually decreased. However, as the use of external care services increased over time, the interaction with people involved in providing various types of care increased.
As time passed, and women adjusted to life without a spouse, research went beyond the concept that women benefitted from receiving support. There was evidence that social engagement and volunteering were increasingly important to their well-being. Understanding of this area was furthered in a study that used data from 228 participants in the America’s Changing Lives Study (ACLS) (Donnelly & Hinterlong, 2010). Analysis from three waves of data, collected over an 8-year period, found that women who had lost their partner experienced positive effect from volunteering whether it was the formal type within an organisation or club, or in an informal setting such as helping family and friends with their children. These findings concurred with others that also reported that established patterns of volunteering had positive associations with later life well-being (Li, 2007; Tabassum, Mohan, & Smith, 2016; van Ingen & Wilson, 2016). However, it was also noted that the older widowed women became, the greater their reliance on other sources of social support that was offered to them. For example, they became more likely to be recipients of help, (maybe requiring help with personal care and/or in managing the house itself), rather than being able to be a contributor.

A case study from Scandinavia also showed interesting results when the researchers looked at the importance of women being engaged and involved outside their roles at home (McIntyre & Howie, 2002). It was found that the participants in meaningful activities also reported a more fulfilling, vital life. As a result, it was recommended that more research should be done to explore the importance of maintaining positive social engagement. It was also recommended that community based health workers should be educated as to how best to assist older women to maintain external activities, in addition to their responsibilities and roles at home.

Women have been found to be resilient in the way they re-define their social roles following spousal loss. There was a trend for women to be less socially isolated by taking initiative to develop relationships, embracing new identities and as a result, experiencing less loneliness (Bennett et al., 2010; Digiacomo, Davidson, et al., 2013; Utz et al., 2002). A common assumption held in the Australian community with respect to older widows is that social support is helpful and that isolation has negative effects (Ha & Ingersoll-Dayton, 2011). However, living alone is not necessarily to be equated to being lonely, although the findings in the literature remain divided as to how support is perceived, desired and preferred at any given period of time (Trivedi, Sareen, & Dhyani, 2009). In addition, women seek to achieve a balance between their desire to be seen as competent and independently responsible, against
the need to ask for help when feeling vulnerable (Moss & Moss, 2014), making adjustments to support seeking behaviour as their needs change (Feldman et al., 2000).

Not all social support was considered positive and helpful by widows, and it is possible that it may even cause increased distress rather than relieve it. Some research found that widowed women reported they felt that if they did not follow advice offered by family, further support in the future may be removed (Lincoln, Taylor, & Chatters, 2003; Scott et al., 2007), leaving the women feeling bound to accept the support offered. Timely and appropriate social support has been found to ameliorate the distress and grief of spousal loss (Digiacomo, Lewis, et al., 2013a; Ha, 2010). However, it is possible that social support does not always positively affect adjustment. A meta-analysis of 19 previous studies was conducted to investigate if social support positively impacted adjustment following spousal loss. It was found that this effect was not strong, and recommended that future research should be of a more qualitative design to allow the widows to actually give voice to their opinions (Miller, Smerglia, & Bouchet, 2004).

2.4 Defining ‘health’

The constitution of the WHO declared that there are nine principles that are basic to the happiness, harmonious relations and security for all people, and the first of the nine is health. In the preamble to the constitution, formulated in 1948, health was defined as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 1948). This definition has elicited great differences in opinion over the many years since it was originally framed. There is wide acceptance that the goal to create a workable definition in the critical area of health was appropriate and commendable. The main aspect of the definition that has drawn criticism has been regarding use of the word ‘complete’ (Huber et al., 2011).

The idea of ‘complete’ health is considered by many researchers and health professionals to be an unrealistic expectation that leaves most people in some state of ‘dis/ease’ all of the time (‘dis/ease’ relating to a breakdown of some kind within a person’s life, leading to poorer health rather than a specific diagnosis) (Smith, 2008; Tinetti & Fried, 2004). The ideals expressed by the WHO, starting with its first constitution, were the result of a new hope being born. The hopes and dreams that emerged after the second World War (WWII) included that good health and health care could be achieved with concerted world wide effort and should be available for all in a way not achieved before that time (WHO, 2009). However, the arbitrary and often
empirical definitions of health have often been thought to be counterproductive to guiding health care research in an appropriate direction due to the absolute and unachievable goals that had been envisaged (Godlee, 2011; Huber et al., 2011; Parslow, Lewis, & Nay, 2011).

To this day, the concept of health and the understanding of its various domains remains a point of contention (Smith, 2008). This thesis does not have as its aim to try to address reaching a consensus regarding the meaning of health. However, it is acknowledged that the lack of agreement regarding even the variables that should be associated with a definition of health diminishes the opportunities for greater agreement about its meaning (Huber et al., 2011). Without a more generally accepted definition as to what health means, it remains difficult to both measure (subjectively and objectively) and manage such an important concept. Potentially, future developments in research can work towards identifying health in terms that go beyond the opinions of professional people whose work is in the area of medicine, and who contribute to the management of disease, disability and survival (Cosco, Prina, Perales, Stephan, & Brayne, 2013b). This research addresses the areas of health with respect to the view of the ‘insider’, in this case, older women. It includes their assessment of health, well-being and ageing, and incorporates their opinions regarding social engagement, capability of managing their circumstances and their use of available resources.

The concept of health, within a framework of diversity in meaning, was not a new concept in the 20th century. Even as far back as the writings of Hippocrates, translated in later literature, there has been awareness that it is important to minimise and manage the negative impacts of disease (Hippocrates, 1953). It was known that for good health to exist there was a need for a good diet, for a person to maintain physical activity, to have sufficient sleep and to have interests that kept the mind active. Additionally, it was known that if processes became out of balance disease or illness could occur (Berryman, 2010; Tipton, 2014). The efforts of the WHO, since its inception, have been to promote control of diseases, and to encourage both individuals and countries to take a greater interest in better health management. As a result, more people are being encouraged to be engaged in, and to exercise greater control over, their health. A longer life-span is one possible outcome, along with a greater sense of well-being over the added years.

In terms of salutogenic theory health is defined as being far more than the presence or absence of one, or even multiple, specific diseases. It moves beyond risk factors that tend to move people towards sickness and eventual death. And most importantly health is to be
considered as a continuum not a dichotomy, whereby people at all stages of life can move towards health/ease (a building up) or dis/ease (a breaking down). This understanding of health is a key differentiating point from most other prior considerations of health that have had their origins from a pathogenic standpoint. Salutogenic theory promotes a different approach to the thought that we should all be well, and only occasionally become sick, a situation that should be righted as quickly as possible, and hopefully prevented from re-occurring. A salutogenic understanding of health supports finding out what makes people healthy rather than what makes people sick, regardless of the presence of disease (Antonovsky, 1990). It views the person as a whole being not a person with ‘disease A’ or a combination of diseases categories. The orientation with which a person views their life enables them to bring to bear on their situation resources which avoid, minimise or manage stressors so that they have a minimal effect of moving that person towards the dis/ease end of the continuum (Mittelmark et al., 2016).

2.5 Ageing and Health Related Quality of Life

2.5.1 Health related quality of life (HRQOL)

HRQOL is a broad concept that involves factors relating to overall quality of life, such as general life satisfaction, good health, safe housing and environments, and education, that are shown to affect both physical and mental health, over time (Kaplan & Ries, 2007) (Centers for Disease Control and Prevention, 2016; Gandek, Sinclair, Kosinski, & Ware, 2004). As a concept, HRQOL has evolved, including early work by Lawton (1991) which proposed the importance of considering that quality of life can apply to people across different states of health. It was thought that a focus should be kept on the individual’s perception of their own quality of life, with due consideration of the many contributory factors including personal, social and time related dimensions (Lawton, 1991).

HRQOL is seen on both individual and community levels. For the individual, it is inclusive of their perceptions of health that relate to energy levels and mood, and other factors such as health risk factors, social support and socio-economic status. For the community, it includes resources that are seen to affect the standard of services delivered, or the way policies and practices can be implemented that affect the general population (Bowling, Hankins, Windle, Bilotta, & Grant, 2013). There is a growing recognition of the importance of including the
dimensions described by those people who are experiencing the ageing process, as to what contributes to HRQOL. This is thought to be preferable to relying on technical and specific medically based criteria, previously tendered by researchers and clinicians. In addition, it includes subjective assessments of the abilities to maintain activities and to reach goals that are important to the individual (Asadi-Lari, Tamburini, & Gray, 2004; Browning & Thomas, 2013; Polinder, Haagsma, van Klaveren, Steyerberg, & van Beeck, 2015).

Self-assessed health status is considered a reliable means to demonstrate the impact of health on HRQOL, going beyond the results that have been gained from empirical studies (DeSalvo, Bloser, Reynolds, He, & Muntner, 2006). Given that there are more older women (≥ 65 years) than men in Australia, and more widowed women than married, there is a great importance to be placed on investigating how older widowed women report their perceived quality of life (ABS, 2012, 2013). This includes an awareness of how the stressors of ageing may impact upon HRQOL.

Comparison was made between the results from two cross-sectional surveys, conducted nearly ten years apart, the earlier one being from a study in The Netherlands (Brouwer & van Exel, 2005) and the later one with participants from Hungary (Pentek et al., 2014). The findings from both studies showed that while men and women were found to have been fairly accurate when predicting their life expectancy, women had underestimated their future quality of health. While preventive care, early medical interventions and positive health behaviours affect biomedical health outcomes, the findings of a longitudinal study by Bowling and Iliffe (2011), conducted over a 7-8 year period, supported the idea that psychological approach to quality of life has emerged as being one of the most important predictors of how people will rate their ageing process.

This is a key area to be considered for future research, as the concept of quality of life should be framed in more than conventional biomedical terms, and to include psychological approaches such as self-efficacy and optimism (Bowling & Iliffe, 2011). Behavioural and psychosocial factors are also affected by both current circumstances and events that have occurred over a lifetime (Browning & Thomas, 2013). Positive attitudes that people may show towards the ageing process have been associated with improved mental and physical health, over time, and a greater life expectancy. However, some people may still express concern about anticipated challenges that may be faced with worsening of health and a diminished degree of respect that may be encountered (Demakakos, Gjonca, & Nazroo, 2007).
2.5.2 Adding life to years

There is an awareness that some degree of physical decline is one sign of ageing (Lopez-Otin, Blasco, Partridge, Serrano, & Kroemer, 2013; Morrison & Newell, 2012). Age related deterioration is a major risk factor for chronic diseases such as cancer, diabetes and cardiovascular disease. Due to the potential increased burden of age related diseases, there is a need to better understand how the greater number of years that are added to later life can be spent in better health, with a greater sense of enjoyment, value and contribution (Jin, Simpkins, Ji, Leis, & Stambler, 2015). Recent findings have pointed to key impacts on the process of ageing and associated quality of life including the combined perceptions of other people towards the ageing person, along with their own perceptions of themselves (Levy, Zonderman, Slade, & Ferrucci, 2009; Sargent-Cox, Anstey, & Luszcz, 2012). The numbers of years of healthy living are also significantly affected by the components of physical, social functioning and emotional functioning (Woods et al., 2012). Older people report that despite the fact that they are not entirely free of disease or disability, by adapting to the challenges that they face, they can maintain many areas of function that they deem to be important to their quality of life in their later years. Some examples of concepts that have been found to be important to older people are maintaining cognitive function, a sense of optimism, social engagement and life satisfaction (Jeste, Depp, & Vahia, 2010).

2.6 Paradigms of health and ageing

Combining a definition of good health, with understanding of how the process of ageing varies, across culture, across generations and between men and women, is open to interpretation (Westerhof, Whitbourne, & Freeman, 2012). Although it is acknowledged that some losses, in numerous domains, are almost inevitable with ageing, a sense of well-being and satisfaction with life is identified by many older people. (Kunzman, Little, & Smith, 2000). There is an ongoing search for a better understanding of this process of adjustment to change, and how a balance can be achieved between the losses and gains that may be experienced while ageing.

Research into understanding ageing within the broader field of gerontology has grown in the years since WWII (Schroots, 1996). Early proponents of paradigms and models for ageing included research using case studies on 533 older men and women, conducted by Pressey and Simco (1950). This research investigated the experiences of those who had reported problems with ageing compared to those who had less difficulty. The key concepts they discovered to be
essential for a more successful outcome were varied interests and a feeling of being able to contribute in a meaningful way to others (Pressey & Simcoe, 1950). The term most commonly used by contributors to this area of research was ‘successful ageing’. Even in the early stages of developing an understanding of what constituted a good outcome with respect to ageing, there was ongoing disagreement to the domains and dimensions that could apply.

2.6.1 Successful ageing

One of the key early contributors to the placement of successful ageing as central to the discipline of gerontology was Havighurst (1961). He believed that a definition of successful ageing would be necessary in order to provide a basis for measuring the degree to which people fitted into the construct. Even at this stage, there was an acknowledgement that this step would be difficult due to the differing orientations people have when attempting to operationalise the term ‘successful ageing’ (Havighurst, 1961).

At the time Havighurst was writing about successful ageing, there were two contrasting paradigms in the literature. One was activity theory, which stated that successful ageing entailed the maintenance of activities and attitudes that had characterised mid-life (Havighurst, Neugarten, & Tobin, 1963). The other was disengagement theory, which proposed that over time, as people age, they would prefer to disengage from an active life (Cumming & Henry, 1961).

In an effort to move forward from some of the initial definitions of successful ageing, such as maintenance of mid-life activities and experiencing a way of life that was socially acceptable to the group, the Life Satisfaction Index was proposed by Havighurst and his colleagues (Havighurst et al., 1963). Over a five-year study period, with healthy, middle class men and women from Kansas City, they used an attitude scale of 20 items to identify concepts that were representative of five components of successful ageing. The five components were zest for life, as opposed to apathy; resolution and fortitude versus resignation; congruence between desired and achieved goals; high physical, social and psychological self-concept; and optimistic mood tone (Adams, 1969; Havighurst et al., 1963). Overall, the prevailing strongest notions associated with the early work on ageing was that ageing was almost universally associated with losses and declining function and quality of life (Fries, 2012). In addition, there was an associated emphasis in the research done prior to the 1980’s on the physiological aspects of disease and disability (Rowe & Kahn, 1998).
The Duke Longitudinal Study on Ageing (Busse, 1993; Rossman, 1986), based in the south-east of the USA, was a significant research project. It was conducted using two separate studies, over a 25-year period (1955-1980) that began with an investigation into what was considered normal ageing. The first study (1955-1976) involved 270 community dwelling residents who were aged 60-90 years. The second study (1968-1976) involved 502 participants, 46-70 years of age. A key outcome of the study was the development of the ‘Longevity Quotient’ that evaluated an individual’s rate of ageing. Another study, called the Baltimore Longitudinal study commenced in 1958 with men only participants, however women were included in the study from 1978. The aim of the study was to examine the ‘natural’ course of human ageing, by studying healthy independent people at regular intervals over a long period of time (Shock et al., 1984).

Key findings from these studies were critical in the emergence of the fundamental thinking of gerontology of that time. Firstly, health and physical function was found to decline over time, and that the rate of decline varied. Second, not everyone declines, therefore, no absolute rule was ascertained. Third, unless illness impairs function in older people, psychosocial function does not decline. And finally, general patterns do not predict the results for every individual. This finding reinforced the understanding of ageing as a heterogeneous process which was confirmed again in later work (Blazer, 2004; Lowsky, Olshansky, Bhattacharya, & Goldman, 2014; Manton & Stallard, 1981; Sabharwal, Wilson, Reilly, & Gupte, 2015).

It was into this stage of understanding of ageing that the influential Macarthur Study was launched. In 1984, Rowe and Kahn led the study which aimed to develop understanding of the factors associated with successful ageing. There were over 4,000 men and women, aged between 70-79 years, who were identified as functioning in the top one-third of their age group. They were recruited from three communities in north-eastern USA. In 1987 Rowe and Kahn (1987) published results of their studies which for the first time, within the category of ‘normal’ ageing, made the distinction between ‘successful’ and ‘usual’ ageing. They proposed that people who aged successfully would show little to no age-related decline in physiological function. Those who were said to be ageing usually would show evidence of this type of decline, and these would be frequently attributed inherently to the process of ageing (Rowe & Kahn, 1987).

It was a landmark change in the direction of the discipline of ageing research. The emphasis was changed from anticipated loss and decline, to considering potential for growth and a
greater awareness of the heterogeneity of the ageing experience, rather than an explicit
distinction between ‘normal’ and ‘diseased’ (Rowe & Kahn, 1987). Three main distinctions
were made to help identify successful ageing versus usual. First, the avoidance of disease and
disease related disability, for example, by adopting healthier lifestyle choices. Second, the
maintenance of high cognitive and physical functional abilities, which if achieved, gave
foundation to the third, and last distinction, which was the maintenance of active engagement
with life (Rowe & Kahn, 1997).

Rowe and Kahn (1997) went further, to argue against one result of the Duke Studies (Palmore,
Nowlin, Busse, Siegler, & Maddox, 1985), which had been to emphasize the division of the
population into diseased versus normal, and to divide the findings about ageing into disease
related and age determined. Rowe and Kahn saw three limitations with these divisions. The
first and most important was the potential of ignoring the heterogeneity of older people
within the ‘normal’ group. The differences related to the individual’s experience and also
involved cultural differences, and how these could affect the concept of expectations
surrounding the ageing experience. Second was the possibility that ‘normal’ could be seen as
low risk, and helpful steps to take up positive health behaviours could be dismissed as being
unnecessary. The last limitation was that ‘normal’ ageing could be equated with natural and
acceptance of changes attributed to ageing. This acceptance could lessen the perceived
benefits of modifying the outcomes through further research or encouragement for people to
take up personal responsibility to improve their lifestyle choices (Rowe & Kahn, 1987).

Over time there has been an increased awareness that personality is also a critical factor that
could predict if people would age successfully (Neugarten, 1972; Srivastava & Das, 2013).
Personality was considered to encompass concepts such as coping styles and the ability to
adapt to expectations of life, as well as income, health and other social interactions. The
contribution made by Ryff (1989) added weight to the aspect that well-being and successful
ageing are constructs that are peculiar to any one individual and as such must allow diverse
and at times competing definitions (Ryff, 1989). Further, Ryff (1989) concluded that a
discussion about subjective constructs that were inherently value based could never be
entirely resolved by scientific argument. Ryff (1989) proposed a more theoretically based
representation of the stable and positive aspects than had been previously documented in
successful ageing research in the form of six dimensions of positive functioning. These
included: (1) Self-acceptance was proposed as a key point of convergence of previous work; (2)
Positive relations with others, which embraced concepts of warmth, trust, affection and love; (3) Autonomy, whereby people could be seen to resist external and cultural pressures to conform to accepted social norms, and was reflected in greater independence and internal regulation of behaviour; (4) Environmental mastery whereby people are seen to manage, balance and direct multiple complex activities within home, work and social environments; (5) Purpose in life, as being central to a sense of well-being; (6) Continue participation in growth to expand as an individual, in order to cope with changes in the world, which in turn necessitated personal change (Ryff, 1989).

There has been ongoing debate about distinctions made with the successful ageing paradigm. One key issue that has characterized much of the findings of research since the Macarthur Studies (Rowe & Kahn, 1987) has been a consistent discomfort, and even stronger sense of disagreement, with the use of the word ‘successful’. The implied associations of ‘failure’ around the experiences of those deemed to be ageing ‘unsuccessfully’ has consistently featured in subsequent work which has struggled to agree on the meaning of successful ageing. Along with these issues, there has been disagreement regarding the appropriateness of the way the main criteria proposed by Rowe and Kahn (1987) operate to make the distinction between those who are said to be, or not to be, ageing successfully (Bowling & Dieppe, 2005; Cosco et al., 2013b; Jeste et al., 2010; Ouwehand, de Ridder, & Bensing, 2007; Strawbridge, Wallhagen, & Cohen, 2002).

There are major criticisms that surround this direction of understanding the ageing process. First, there is the emphasis that has been placed on the opinion of professional people, both clinicians and research based professionals, as to what is thought to be successful, rather than on the opinions of the people who are ageing (Cosco, Prina, Perales, Stephan, & Brayne, 2014). It has been consistently found that lay people rate their opinion of their well-being and health as significantly better, using more subjective measures of process than would a professional clinician or researcher in their assessment (Hung, Kempen, & De Vries, 2010). As many as 50% of the older people have been reported to consider themselves as ageing successfully whereas by a traditional bio-medical model, less than 20% would achieve this rating (Bowling & Dieppe, 2005; Bowling & Iliffe, 2011).

This research also contends that the pathological view of ageing can over-estimate the degree to which chronic conditions can contribute to the effects of ageing. In addition, it highlights a potentially considerable difference between what researchers find to have most impact on
outcomes that measure criteria of successful ageing when compared to what the insider’s perspective reveals. Cosco et al (2014) have found that professional researchers tend to utilise quantitative methods, with objective concepts such as those proposed by Rowe and Kahn (1987). Similar studies, identifying the means by which outcomes of ageing are assessed, also tend to exclude the perspectives of the people who are living this experience (Cosco, Prina, Perales, Stephan, & Brayne, 2013a).

The criticism of the ‘successful ageing’ paradigm centres on the arbitrariness of the largely biomedical based criteria, which by defining cut-off points, consign many more people to the group termed ‘usual’ than they would rate themselves, if given the opportunity. In addition, by implication of the use of the term ‘successful’, there is an associated negative association with being relegated to a group who are seemingly seen to be assessed to be ‘unsuccessful’ when it comes to ageing (Cosco et al., 2013b). Different classes and cultures view what is deemed successful to be different. Not all people even have the possibility of making choices towards better health behaviour, even if they are informed of the same (Holstein & Minkler, 2003).

A review of literature that focused on successful ageing research has reported a shift that now encompasses holistic perspectives into the more traditional physical, social and cognitive concepts. This is thought to be more truly reflective of older persons’ views compared, rather than considering that of academic researchers only (Hung et al., 2010). In addition, there is a lack of research about the way cultural and spiritual beliefs in non-western cultures may affect the way older people regard their health. Groups from non-Western cultures may reflect views that are not in alignment with those that have been considered normative to date, which have been more generally in line with Western culture (Garroutte, Sarkisian, Arguelles, Goldberg, & Buchwald, 2006; Hung et al., 2010; Moberg, 2005).

A second major criticism has been directed to the multiplicity of definitions that have been used to operationalise successful ageing. Even within the same research there can be confusion as to the use of many terms such as healthy, active and productive ageing. For example, Depp and Jeste (2006) conducted a review of the literature concerning criteria, components and definitions of successful ageing. Of the 14 components mentioned in literature describing successful ageing, physical function and freedom from disability were the only two components that were common to all of the studies. No other component was present in any more than 50% of the studies that were reviewed. Further, adding to the variation in meaning was the fact that in this same literature review, of the 28 studies that met
the criteria for inclusion (sample size more than 100 participants; English language publications and adults to be over 60 years of age), there were 29 different definitions used for successful ageing, given that one article provided two definitions (Depp & Jeste, 2006; Jeste et al., 2010).

There is ongoing difficulty, and unresolved tension, between being able to combine the inclusion of biomedical perspectives of ageing with psychosocial perspectives in defining successful ageing (Cosco et al., 2013a). For example, some researchers with a biomedical approach, suggest that the subjective nature of psychosocial factors could be potentially misleading indicators of successful ageing (Baltes & Mayer, 2012). Other researchers, who are primarily psychosocial in their approach, contend that the possibility of avoiding disease and maintaining high physical function can be unrealistic for some (Bowling & Dieppe, 2005), and restricting measures to a biomedical focus delays advances in policy and research (Glass, 2003).

Around the time of MacArthur studies, Baltes and Baltes (1990) offered a lifespan model that utilised a more qualitative and psychosocial approach for the study of successful ageing than previous research had used. Their approach acknowledged a heterogeneous process of balancing aging-related losses in the physical and psychosocial domains with an individual's actualisation of the remaining strengths. The model was advanced by further work (Baltes, 1997; Freund & Baltes, 2002), which focused on changing balances within the domains of gains and losses. The model was based on the premise of three major components: selection, optimization and compensation. It was thought that success in the ageing process would be more likely if older people could ‘select’ and prioritize goals that were deemed to be important. They then could ‘optimise’ the resources they perceived were available in order to succeed with gains in numerous domains, and continue development, throughout older age. Finally in the process, they may have had to ‘compensate’ for losses to allow them to adapt to altered circumstances (Baltes & Baltes, 1990).

The ‘selection, optimisation with compensation’ model can be expressed in conscious or unconscious ways, with active or passive expression. The model is thought to be universally applicable, while yet allowing for individual expression (Baltes, Staudinger, & Lindenberger, 1999). Goals will vary over the life course and will be appropriate to the culture of the individual (Baltes & Carstensen, 1996; Cosco et al., 2013b). Importantly selection, optimisation with compensation accommodates individual expression, separated from a strict adherence to normative values that may usually be attributed to successful processes over time. Irrespective
of the disagreement that has surrounded successful ageing, it was considered by the researcher imperative to describe in depth the hallmark early stages of the research that helped direct pioneering research into the process of ageing. Other concepts that relate to ageing have been studied since these efforts in the middle part of the 20th century, as understanding of ageing has developed. Some of these concepts which have had some degree of adherence are included in the following sections.

2.6.2 Active ageing

Active ageing is a concept that has been a growing element to policy frameworks; one that can guide future directions that best suit support and care for an ageing population. The rationale for active ageing stems from the goal that, for an increasing number of people, the experience of a longer life should be positive, not merely longer. Policies should therefore stimulate the development of environments and systems that enable older members of the population to be ‘active’ contributors to their communities. In addition, they can remain engaged in both interdependent and intergenerational activities of life. The process of active ageing supports the vision whereby opportunities for health, participation and security are maximised, and the quality of life in older age is enhanced (WHO, 2002). Active ageing provides an important policy framework to support older people contributing to society and feeling valued.

The three key pillars of active ageing (participation, health and security), are said to be important in enabling older people to remain active and independent over time (WHO, 2002). Concepts included in participation are ongoing learning over the life course, and include the possibility of work, whether paid or unpaid. The health concept considers both achieving and maintaining good physical and mental health. The pillar of security encompasses the rights of older people to feel safe socially, financially and physically, whilst preserving their dignity. These three key concepts are thought to be inter-connected, and taken cumulatively, they add quality to the experience of ageing, across cultures, yet also respect the values of the individual.

While the UN and WHO were beginning to encourage countries to support an active ageing policy, the International Council on Active Ageing (ICAA)1 consolidated knowledge and goals from different groups. The ICAA created a model, seen in the Nine Principles of Active Ageing, to guide governments who seek help to lessen the challenges, and increase the opportunities,

1 www.icaa.cc
that are associated with an ageing population (Milner, 2013). Of the nine principles, some relate more to the direction of industry and staffing directions. Others specifically address personal issues pertinent to this thesis, for example, where active ageing can also be seen to act as a foil to ageism.

Ageism was a term first coined by Butler (1969). It refers to discrimination of people because of their age. Ageist views, which may stem from lack of knowledge, preconceived discriminatory opinions, and/or fears, can form a barrier to societies being inclusive of older people. A review, conducted of early 21st century literature on the prevalence of stereotyping of older people, found that myths of ageing remained part of popular perception (Ory, Hoffman, Hawkins, Sanner, & Mockenhaupt, 2003). Ageist stereotyping can be harmful, and the associated negative connotations can potentially lead to older people themselves adopting a negative attitude towards their own ageing. This attitude may have a detrimental effect on their self-confidence, physical function and even longevity (Levy & Myers, 2004).

Despite the awareness of the need to support active ageing and reduce ageism in communities, a recent literature review by Lai, Chan and Chin (2014) found that there had been little research done to investigate the salience of key determinants of the concept. To address this gap in knowledge, they conducted a Randomised Control Trial (RCT) on 238 community dwelling residents in Hong Kong. They concluded that active, healthy ageing people report fewer diseases, have better mental health evaluation, greater life satisfaction and higher self-esteem.

Additionally, findings from a British study of participants aged ≥65 years, concurred that psychological well-being is associated with active ageing, and stressed the importance of maintaining an active and engaged lifestyle to help protect mental health (McFarquhar & Bowling, 2009). Activities of interest and/or importance to older people have been found to prevent decline in psychological well-being (Hao, 2008). For some, paid work, whether full-time or part-time, is an important part of ongoing activity, and may be continued well into later years. The choice can be based on economic and/or social reasons. Undertaking multiple activities, such as those that may be involved in regular volunteering in the community, is also thought to protect psychological well-being, through possibilities of social contact and support, and cognitive stimulation.

In addition to maintaining meaningful activity, environmental issues are key to wellness and contribute to active ageing. This is observed where there is provision of safe housing and
accessible community designs. The research conducted by the Health and Independent Living (HAIL) Study, used interviews with 202 community dwelling Australians aged 70-79 years, to better understand the needs and experiences of older people regarding their expectations of future housing. Findings supported the importance of safe and accessible home and neighbourhood environments to encourage independence at home and engagement with society (Mackenzie et al., 2015).

Finding meaning and purpose in life, in line with personal values, is yet another key dimension of wellness, and supported by the work of the Australian Active Ageing Taskforce (AAT), an initiative of the government of Western Australia (Bull, Bellew, Schöppe, & Bauman, 2004). The AAT suggested that within the three main pillars of active ageing, social participation should be main the central concept, supporting the other two pillars, health and security. Despite suggesting this difference from the original pillars proposed in the WHO report (2002), active ageing framework has been widely embraced as a policy directive within Australia (National Seniors Productive Ageing Centre, 2005; Western Australia. Office for Seniors Interests and Volunteering, 2006).

The Australian Active Ageing Study utilised the AAT framework, with participation as a central pillar, not health, to investigate predictors of active ageing (Buys & Miller, 2006). The method used for the study was a postal survey sent to 5,800 Australian residents, aged above 50 years, who were all members of the National Seniors organisation. The researchers sought to better understand what being actively engaged in life meant to the participants. It was found that the three pillars of active ageing proposed by the WHO were found to be an accurate representation of the expectations of older Australians. A key part of Buys and Miller’s (2006) findings, was the strong element of inter-connectedness between the pillars, which corroborated their earlier findings that efforts to understand ageing terms must embrace a multi-faceted reality of the process of ageing.

From this earlier research, it has become apparent that a holistic approach is required, to ensure that medical, psychological, social and financial perspectives are included in the quest for understanding ageing. This is particularly true given that the medical model is still dominant in how ageing in conceptualised (Bowling & Dieppe, 2005). Clinicians and policy makers alike will need to gain a greater understanding of how ageing can be considered in all its dimensions (including psychosocial needs and community engagement) if the care of the older population is to be considered to be truly effective (Walker & Maltby, 2012).
2.6.3 Healthy ageing

While it is true that the model of successful ageing was prominent in literature for nearly half a century, there have been other terms that have since captured other aspects of the process of ageing, and which differ to the criteria implicit in successful ageing research. Healthy ageing is described as a lifelong process whereby opportunities are optimised for health to be improved and preserved, in order for an active and functional life to be maintained for as long as possible. In addition, physical and psychological wellness can be preserved, along with high QOL, healthy life expectancy, healthy life years and physical and economic independence (Hansen-Kyle, 2005; Kendig & Browning, 2011; WHO, 2012; 2015).

The pathway to encouraging healthy ageing is supported by a life course approach and an understanding that healthy ageing is strongly subjective, and will be seen differently across individuals and cultures (Jeste, 2005; Lamb, 2014). Most of the research about healthy ageing as a concept has been conducted in countries that are considered ‘aged’. The United Nations (UN) defines countries as aged where at least 7% of a population has aged more than 65 years, and where people’s life expectancy at birth is over 70 years (United Nations. Department of Economic and Social Affairs. Population Division, 2013). As most of the countries that can be so categorised are in the Western world, the domains considered as contributing to healthy ageing will have come from a Western cultural basis, with national differences also evident. In addition to cultural differences, the definitions of healthy aging to date have largely reflected the academic viewpoint, not that of the older people themselves (Naaldenberg, Vaandrager, Koelen, & Leeuwis, 2012). These two considerations together have a two-fold effect. First, older people may choose more subjective perceptions to conceptualise the reality of their ageing experience, although this has also been found to vary across cultures. Second, and by way of contrast, the view of the academic contributor may emphasise objective measures, has been which has been seen to be more stable across cultures (Hung et al., 2010; Lowsky et al., 2014).

There is a wide range of approaches to studying healthy ageing and still no agreement on the definition of that process (Fuchs et al., 2013). Some of the literature about healthy ageing agree that there is a relationship between healthy behaviours such as not smoking, maintaining good levels of physical exercise, optimal body weight and moderate (or lower) consumption of alcohol, and positive health outcomes, for example, absence of disability, good mental health and independence in activities of daily living (Depp & Jeste, 2006; McLaughlin,
Jette, & Connell, 2012; Peel, Bartlett, & McClure, 2004). A review into numerous studies of people older than 65 years, indicated a wide range of health benefits could be achieved through regular exercise, including both aerobic and resistance training (Taylor, 2014). The WHO has published recommendations on specific guidelines regarding appropriate levels of physical activity for older people. The importance of these guidelines cannot be underestimated considering that 3.2 million deaths per year are attributed world-wide to inactivity (WHO, 2013).

Healthy ageing is also described as a multi-dimensional process. It is thought to extend far beyond criteria that link anticipated outcomes with chronological age. It has been suggested that there is a strong link between social and biological factors that occurred early in life and a process of healthy ageing, and these need to be conceptualised using a life course approach (Kuh, Karunanananthan, Bergman, & Cooper, 2014). One approach that was taken to better understand the variation in the awareness and perception of the health of the individual, was seen in a nationally representative cross sectional study, completed in the Mid-life in the United States Study (MIDUS) (Brim, Ryff, & Kessler, 2004). Although the focus for this American based study was mid-life, one of its findings was that a 75 year old could report feeling 15 years younger than their chronological age, when related to better subjective well-being and mental health, and better physical function (Westerhof et al., 2012).

How people anticipate and prepare for their older years is also important to understand. A cross-sectional survey of American’s over 65 years of age found that people with a low expectation of ageing participated less in health promoting behaviours, particularly physical exercise, when contrasted against people who have a higher expectation and perception of their ageing process and health measures (Sarkisian, Prohaska, Wong, Hirsch, & Mangione, 2005). In addition, older people who exhibited a more fatalistic approach to ageing also had higher expectations that ageing and health problems were inextricably linked. However, earlier research had largely neglected the factors that can influence ageing and HRQOL of older people (Mollenkopf & Walker, 2007). The approach to managing HRQOL can alter the outcomes. One approach takes into account the degree to which age related changes could be considered as being a ‘normal’ function of the ageing process, and as such can be expected to occur and require management as they occur. Another approach could emphasise the importance of people participating in positive health behaviours and exerting control on their expected outcome. With this approach, people who participate in healthy life style choices,
may well maximise their well-being and minimise the onset of chronic diseases (Strawbridge et al., 2002).

The ALSA has been an influential population based study that has collected data for over 22 years, and has provided insights into the way many Australians, both men and women, are experiencing a positive process of healthy ageing. The study commenced with over 2,087 residents (both community and residential care dwelling) of South Australia, aged 65 years and more, in 1992, and the final wave of data was collected in 2014 (Luszcz et al., 2014). The overarching aim of the study was develop a better understanding of how social, bio-medical, behavioural, economic and environmental factors affect ageing. At the outset, it was anticipated that knowledge gained from the study would help track how changes in health and function alter over time. In addition, it was felt that the study would help identify risk factors for major chronic conditions and would assess how disease process and lifestyle choices may affect the need for long term aged care services. A key finding from the study was that many of the factors that promoted healthy ageing and quality of life were indeed seen to be lifestyle related and were therefore amenable to change, particularly if people were supported by programmes and social networks that encouraged activity in the community, physical activity and a positive state of mind. The findings from the study have also added weight to the knowledge that many factors that promote longevity and quality of life are behavioural aspects that are amenable to change (Luszcz et al., 2014). A combination of early screening, educational programmes and social networks that support health choices have been seen to have the potential to improve physical and emotional well-being thereby enhancing quality of life.

The Melbourne Longitudinal Studies on Healthy Ageing (MELSHA) has been studying community dwelling older people, aged ≥65 years at baseline, since 1994 (Browning & Kendig, 2010). An important feature of this study is that it has adopted a different approach to understanding healthy ageing. The MELSHA has aimed to uncover predictors and consequences of healthy ageing of the participants, based on their self-reported participation in behaviours that promoted health. The emphasis has been placed on the opinion of the participants rather than on meanings largely derived from academic and professional conceptualisations of illness and disease constructs such as mortality, morbidity and the prevalence of health problems and dysfunction (Kendig, Browning, Thomas, & Wells, 2014; Lowsky et al., 2014). This study has helped Australian research move beyond the service needs
and dependency of older people, to consider the ways that health and healthy behaviours can be understood and brought to the fore. In addition, it has promoted the need to consider positive dimensions of ageing rather than concentrating on potential negative outcomes (Kendig & Browning, 2010).

Using data from The Health and Retirement Study (HRS) and the Medical Expenditure Panel Survey (MEPS), a study in the USA examined the proportion of older people (51-85 years and above) who remained healthy and active as they aged, and how much variation existed in HRQOL outcomes (Lowsky et al., 2014). The markers of HRQOL were self-reported health; the amount of help needed with Activities of Daily Living (ADL); the amount of limitation in ability to work at home or in a job, due to physical or mental health problems; not being diagnosed with any of the five leading chronic non-communicable disease (cancer, diabetes, heart or lung disease, stroke); and a perfect score on EuroQol five dimensions questionnaire (EQ-5D), a standardised measurement instrument for measuring health outcomes (Schrag, Selai, Jahanshahi, & Quinn, 2000). The findings showed that age does not necessarily equate with illness. For example, 28% of those aged 85 years and older rated that they had an excellent, or very good, self-reported health status. Conversely, they also found that 89% of people aged 51-54 years had significant health based limitations in work or at home. The presence of a healthy proportion of the older population is important because, associated with more people with better health, is lower social costs, greater engagement in the community, both in paid and voluntary capacities, and enormous gain socially to extended family networks (Lowsky et al., 2014).

These findings have strengthened the link between the knowledge of health behaviours and their impact on the process of ageing, especially in much older years, including the late 80’s, 90’s, and even in the growing number of centenarians (Peel et al., 2004). Peel and colleagues (2005) conducted a systematic literature review on eight longitudinal studies that were published between 1989 and 2003. They found that there was a strong link between the combination of positive health behaviours (such as not smoking and good diet) and high levels of physical activity, with healthy ageing outcomes (such as maintain the ability to function with independence in physical and mental domains). The link between healthy behaviours and better outcomes is significant within the global context as it supports the benefits of healthy ageing policies and early intervention in lifestyle choices.
From the research, it appears interventions that address healthy ageing include the need to educate people about the benefits of not smoking, adequate exercise and good nutrition. Early uptake of positive life style choices supports healthy ageing process in later life. It also supports the summary by Morley and Flaherty (2002) that many aspects of behavioural modifications and a healthy lifestyle have been found to be effective in postponing and even reducing morbidity in older people, and in fact, it is ‘never too late’ to make positive choices regarding health behaviours (Morley & Flaherty, 2002). There is ongoing work being done by organisations such as the European Innovation Partnership to propose the use of appropriate and reliable instruments that will help construct conceptual frameworks that can then be used for comparison purposes between the findings of studies in the area of healthy ageing (Bousquet et al., 2015; Bousquet et al., 2014).

2.6.4 Productive ageing

The concept of productive ageing was introduced in an effort to counter the idea that older age was generally a time of loss, of vulnerability and dependence, and lacking the opportunity for contribution. Butler and Gleeson (1985) were pioneers of the concept that a ‘productive potential’ could be accessed as older people participated in areas of paid work and/or voluntary interests and commitment. Defined as “any activity by an older individual that produces goods or services, or develops the capacity to produce them, whether they are to be paid for or not” (Bass, Caro, & Chen, 1993, p. 6), this concept has been constrained by the implied meaning of ‘productive’ as it related to ageing. This implication has led to an assumption that money needs to be exchanged, or that people must be seen to be making some official and measured contribution to an organisation or economy. In addition, there are difficulties associated with measuring what are often less obvious contributions within the family network, particularly in the area of grandparents who assist with child care (Sands, Goldberg-Glen, & Thornton, 2005).

The contribution that grandparents make to the area of child care is substantial although there is almost no mention of this contribution within governmental productivity reports (Australian Government Productivity Commission, 2013; National Seniors Organisation, 2015b). The National Seniors Organisation in Australia has extensively researched the contribution of the older population, and has reported that the total contribution assessed in monetary terms of older Australians in building a more productive nation is estimated at $65.7 million. This
estimate includes the economic and social contributions, and extends to estimates of formal and informal care opportunities (National Seniors Organisation, 2015a).

Productive ageing in the 21st century reflects that older people live longer, and are frequently in a state of health that allows them to maintain an ability to contribute socially and economically, from which they may derive benefit. The years lived have often added opportunity to gain wisdom from experiences that can be invaluable to pass on to others in their families and communities, although it can be seen as a less tangible resource. One study analysed data, drawn over a two-year period, from two postal surveys of older people who were volunteering in various programmes. It was found that the volunteers reported personal benefits in the form of better psychosocial and mental health, if they received organisational support to help promote and encourage their involvement (Tang et al., 2010). These findings were also supported by findings from three waves of data from the ACLS which revealed that older people who engaged in moderate levels of volunteer work also reported higher levels of well-being (Morrow-Howell, Hinterlong, Rozario, & Tang, 2003).

The assumptions of productive ageing reflect today’s reality that older people are repositories of wisdom and experience and are important assets for society; relatively healthy, with the potential for maintaining that condition until late in life; in need of purposeful and meaningful roles and activities in life; and capable of making economic and social contributions that benefit themselves, their families, and their communities. Productive ageing emphasises involvement in paid work, volunteerism, education, fitness and exercise, leisure and travel, advocacy and political action, and consumerism.

2.7 Summary of literature and research gaps

The literature review has covered issues surrounding an ageing population. It has sought to understand the development in the literature of ageing, its process and its key concepts. The change in emphasis from the pathogenic model compared to the salutogenic model was explored. The way in which SOC relates to how older women in particular, cope with stressors of ageing, the resources they may use to help adjust and cope was also considered. In addition, literature about a strong SOC being associated with positive outcomes of ageing has been reported. There is a strength in the literature regarding many aspects of ageing, and some of the more common theoretical approaches have been described. This thesis takes the
opportunity to focus on the views and voices of the insiders of the ageing experience: older Australian women, both married and widowed.

To date, there has not been a great deal of research done in a way that uses longitudinal qualitative data, along with a sufficiently large number of participants who could be considered representative of the total national demographic of older women in Australia. There is also a gap in the area of examining widowhood using the salutogenic theory particularly from an Australian perspective, despite the utility of SOC as a construct for examining how people manage stressors, across different cultures and across the life course. There has been a call for more studies to examine reactions to grief (Carnelley et al., 2006), creating wellness into older age (McMahon & Fleury, 2012), and how people can adjust over time to significant life events such as spousal loss (Allender, Hutchinson, & Foster, 2008).

The current research provides a valuable opportunity to utilise the method of retrospective thematic analysis of free-text comments collected over a 15-year period to improve our understanding of the lived experience of older women as they age. This research, by using longitudinal data, and qualitative analysis allows for an exploration of what older women themselves say about their experiences of ageing. The data also enables a better understanding of what widowed women write well beyond the initial period of change following spousal loss. These experiences can then be contrasted against those of women who remained married, throughout the period of the current study.

### 2.8 The next chapter

The theory of salutogenesis is described, presenting the concepts of stress, resources and SOC, and how this direction of health research demonstrates a departure from the traditional pathogenic direction of much past research. The central concept of salutogenesis, the SOC is also described, to provide insight as to how people may be able to identify and use their own resources to move towards better health and well-being, rather than concentrating on disease and risk minimisation.

### 2.9 References


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3 A salutogenic approach to health and ageing

3.1 Introduction

Pathogenesis (the origin of disease) is a model that has dominated Western health management. The aim of pathogenic study is to find out the mechanisms of disease, its origin, transmission and management. In general, pathogenesis assumes stressors to be a problem that require management, and where possible, eradication (Antonovsky, 1987). By contrast, salutogenesis (the origin of health) acknowledges that although stressors are an inevitable occurrence, it is possible that not all stressors are harmful, rather people can turn their existence into an advantage (Strümpfer, 1995). Salutogenesis seeks to explore the origins of health and well-being, with a focus on how the individual contributes to the outcomes using inherent and developed potential and resources (Wiesmann & Hannich, 2014).

There appears to be a paradox in studies of well-being, that older people consistently report positive experiences throughout their older years despite evidence of declining physical health and function and the presence of multiple co morbidities (Carmel, Raveis, O’Rourke, & Tovel, 2016; Hansen & Slagsvold, 2012; Siedlecki, Tucker-Drob, Oishi, & Salthouse, 2008). The shift in thinking towards a salutogenic paradigm, where people were motivated to promote their health and enhance their well-being, was significant (Tan, Chan, Wang, & Vehvilainen-Julkunen, 2016; Wiesmann & Hannich, 2010). This shift aligned with a positive self-care approach that focused on health not as not being a dichotomy. Instead, health can be viewed as a continuum, with room for movement back towards better health despite an intervening period(s) of ill-health (Wennerberg, Eriksson, Danielson, & Lundgren, 2016). Additionally, the salutogenic paradigm promoted that health and HRQOL were not best rated as success or failure, rather, that with the focus on the use of available resources, the movement back towards health could be encouraged and supported (Lindstrom & Eriksson, 2005).

3.2 Concepts of salutogenesis

The history of the theory of salutogenesis developed from 1979, when the American born, Israeli sociologist, Antonovsky (1979) introduced his theory in his book ‘Health, Stress and Coping’. Antonovsky (1979) proposed that stress was ubiquitous, and that some type of stress
would almost inevitably occur within people’s lives whether it was in their personal, social and/or medical spheres. The more accepted view prior to his work was the pathogenic paradigm, which asserted that there was a normal or correct way in which things should function. Further, in a pathogenic model, when malfunctions occur, they should be investigated, and righted if at all possible, and future recurrences should be minimised (Antonovsky, 1979). An important implication of a salutogenic model is that it rejects the dichotomy that is inherent in the pathogenic model, whereby people are designated as being sick or healthy. Rather it was proposed that all people occupy a place on a continuum of health, that has extreme poles. Movement is always possible between the two extreme positions of health at any given time (Antonovsky, 1993a).

3.2.1 Salutogenesis and stress

Antonovsky (1979) developed the model of salutogenesis from his sociological studies of menopausal women. Concurrent to his work on the effect of menopause on mid-aged women, he observed that many of the women participants in his study had also experienced the enormous stress of having lived through the holocaust of WWII. Subsequently, he found that many people can maintain health and well-being even during periods of extreme stress and difficulty. He observed that the occurrence of stress should be expected and should not be considered necessarily negative and problematic. Although Antonovsky recognized that risk factors were important to consider, and could contribute to moving people towards disability and even death, he posed the question, and sought answers to the same, about what factors help people move towards health (Antonovsky, 1993a).

Salutogenic theory proposes that it is important to maintain a focus on the resources people have to create health, even in the midst of stressors (Antonovsky, 1979, 1987). Even when stressors are extreme, many people have the ability to mobilise their resources and thereby contend with the tension that such challenges can place on their lives (Lindstrom & Eriksson, 2005). According to salutogenic theory, and concurring with other research, not all stressors are harmful or exceed a degree of routine stimulus (Antonovsky, 1979, 1987) (Lindstrom & Eriksson, 2006; Salleh, 2008; Schneiderman, Ironson, & Siegel, 2005). It may be difficult to ascertain when the demand of a stressor unduly taxes the resources that are available to the person involved (Antonovsky, 1979). Women as they age will experience multiple stressors in their lives. The nature of each stressor will vary for the individual, as will the degree to which they occur, and the length of time over which they may be felt.
3.2.1.1 Understanding stress

The term ‘stress’ was used by Selye (1956) to denote and distinguish the response of an individual to a stimulus, a perceived or real threat, called a ‘stressor’. Selye also noted that a prolonged or extreme state of stress could lead to damage, deterioration and/or disease (Selye, 1956). When a demand is placed on an individual, a response is required, and their pattern of behaviour has to be adjusted in some way. If stressors are heightened, prolonged and/or accumulate over time, the physical and psychological system of the person feeling the negative impact of the stress response can overtax resources. Breakdown of systems within the body and/or feelings of disorder can follow (Orzechowska, Zajączkowska, Talarowska, & Galecki, 2013).

Not all stress is negative, although negative events form the basis for most of the research on stress (Phillips, Carroll, & Der, 2015; Schwarzer & Schulz, 2003). Selye (1956), identified the nature of stressors and the stress response, and developed his ideas to include two key areas that are related to the salutogenic paradigm. First, was the idea that stress was not inherently ‘what happened’ to the person, but how that person ‘reacted to’ a stressor (Selye, 1974). Second, was the concept of eustress, which distinguished whether the response of stress was caused by negative events or emotions, or by positive events and emotions (Selye, 1974).

The notion of eustress is particularly relevant to developing an understanding of ageing well. Although older women will experience negative events, such as deaths within their close networks, illness and/or financial challenges, they will also experience family weddings, births of grandchildren and graduations from school and university of various members of subsequent generations. Short-term stress tends to boost the immune system, and also forces adaptation to occur. In assessing various types of stress it was seen that styles of coping may affect the outcomes (Podolska, Majkowicz, Sipak-Szmigiel, & Ronin-Walknowska, 2009). For some people, chronic stress can lead to increased disease, including cardiovascular and respiratory conditions (Salleh, 2008). Characteristics of the stressors should be considered, for example, the intensity, duration and controllability, as the nature of the events will have a bearing on the way it is perceived by the person/people involved (Schwarzer & Schulz, 2003).

3.2.1.2 Types of stress

Another consideration of stressors and how people respond to stress, is developing a better understanding regarding the types of stress that have typically been categorised as life events, chronic strains and daily hassles (Thoits, 1995). For older Australian women, research has
shown that the distinction between types of stressors is significant. Major life events are acute changes such as spousal loss and bereavement, a pressing need to change housing and major financial losses, all of which have been reported as potential sources of stress (Feldman, Byles, & Beaumont, 2000).

Chronic strains, such as caring for a spouse, especially in the final days, managing a home, especially if little assistance is available, and managing health conditions, have been seen to be stressful, over a period of time. Following the death of a spouse, there are many aspects of stress that impact women’s lives, particularly as they have to make many changes once living alone. These include having to deal with informing financial and government institutions about a husband’s death, potential decreased income, changing needs regarding social interaction and support, and difficulty knowing how and when to best communicate these needs to others who may be able to offer help in some way. As a result of the stress they felt, they frequently reported decreased physical and mental health (Digiacomo, Lewis, Nolan, Phillips, & Davidson, 2013; Digiacomo, Lewis, Phillips, Nolan, & Davidson, 2015).

Stress can and does occur on a daily basis. Daily ‘hassles’ are classified as the more minor interruptions that can occur, such as decisions about roles, about tasks to be done at home, or being late for appointments. These more minor challenges may only require slight adjustments each time they occur. However, it has been found that even insignificant hassles can be a cause of stress. When women described making frequent role changes within a day, for example, between being a caregiver, a grandparent, and helping other friends or family, they reported higher levels of stress. The American Time Use Survey, with 7,662 participants, used a time-diary to examine the stress reaction reported when people changed roles in various social roles and settings, throughout the day. The findings reported that women found multiple switching of roles to be more stressful compared to men (Cornwell, 2013).

3.2.1.3 Balancing stressors through resilience

Resilience is considered by many to be the ability seen in some people to positively adapt to adverse life circumstances, and to respond in a way that is not that harmful to health and well-being (Southwick, Bonanno, Masten, Panter-Brick, & Yehuda, 2014). Resilience is yet to be well defined, as to whether it is a trait, a process or an outcome. However, it is suggested that it would be best viewed on a continuum that may be present in varying degrees in many domains of life. It is potentially subject to change according to the individual’s development and their interactions with the environment (Kim-Cohen & Turkewitz, 2012; Pietrzak &
Southwick, 2011). In some ways the process of resilience could be considered part of a pathway that arrives at a good outcome by way of personality hardiness. Hardiness in this sense emphasizes commitment, control and challenge, all of which are concepts that align well with the resources that are so central to salutogenic theory (Bonanno, 2004).

Resilience differentiates those who manage stress effectively, and those impacted negatively by stress. There are similarities to be seen between resilience and salutogenic theories. They both emphasize resources as key to understanding how the concepts can be developed, and they both see the development process as being a continuum not a dichotomy (Eriksson & Lindstrom, 2011). One of the key differences, however, is that resilience as a theoretical concept is usually associated with heightened risk factors and potential negative outcomes (O’Dougherty Wright, Masten, & Narayan, 2013). Resilience was first identified in studies of children who, despite the adversity of their early years were found to have developed into successfully functioning adults (Masten, 2001). One of the most commonly accepted aspects of the concept of resilience found in literature is that, if it has been deemed to be present, those who suffer severe hardship and adversity, show a pattern of positive adaptation. They had exhibited an ability to ‘bounce back’ from a period of grief, loss and physical and emotional stress; to show flexibility in the face of pressure, and to recover from disruptive events and misfortune (Bonanno, Boerner, & Wortman, 2008; Bonanno, Westphal, & Mancini, 2011; Maddi, 2005). In addition, according to commonly used scales, resilience has also proved harder to measure consistently, whereas the central concepts of salutogenesis have been found to be valid across multiple population groups (Eriksson & Lindstrom, 2011; Lindstrom & Eriksson, 2005).

3.2.2 Salutogenesis, Sense of Coherence and Generalised Resistance Resources

In order to cope and adapt to stressors, people were reported to utilise a SOC. This was defined as the inclination people have to cope using available resources which enable the events in their life to be seen as being comprehensible, to be manageable and to have meaning (Antonovsky, 1979, 1987). Antonovsky (1979) called these GRR’s and suggested financial resources, strength of ego and social support networks, healthy behaviours, commitment, and view of life as examples (Lindstrom & Eriksson, 2006). As an additional concept SRR’s, were also included, whereby people incorporate the use of resources that are more specific to particular situations (Antonovsky, 1979). For example, a woman caring for a
husband with a neurological condition may choose to get support from the group that has been set up to assist with knowledge and skills appropriate to helping patients and friends with that disease. Access to, and the use of appropriate resources, can be effective means whereby people can at times withstand prolonged physical, emotional and social trauma and disruption, and still function without significant impairment.

Coping is defined as behavioural and cognitive efforts to deal with perceived demands on the individual (Hefferon & Boniwell, 2011). The current understanding remains in line with significant early work by Lazarus and Folkman (1984) which defined coping as a process based on the decisions individuals make to manage internal and/or external stressors. In order to manage the stressors, it is proposed that people can exercise one form of coping ability, which is their SOC. The field of coping theory is broad and to adequately cover this topic in depth is outside of the aims and scope for this thesis. Although coping and salutogenic theories have inter-related and overlapping constructs within them, they are not synonymous. It is noted that Antonovsky (Antonovsky, 1993a, 1993b) identified a key difference between SOC and coping. Antonovsky felt that SOC was better seen as a flexible orientation to life, rather than being a mechanism, such as coping, which subscribed to more defined and prescribed adherence to a set of strategies. For this current study the term ‘coping’ will be covered by the way women identify and make use of various resources, to best manage the stressors they experience, over time, as they age.

Eriksson et al (2006) conducted a systematic analysis of the knowledge of salutogenic theory. The main finding was that SOC is related strongly to perceptions of health, particularly mental health. This finding was found to hold to be true across multiple populations, age groups, gender and research design. The scales that measure the SOC have continued to prove to be psychometrically sound (Eriksson & Lindstrom, 2005). In addition, there is evidence from a review investigating the relationship between QOL and SOC, that a high SOC seems to be able to predict health and QOL (Eriksson & Lindström, 2007). The possibility of the orientation of SOC as a health resource is of great interest as it offers the positive benefit of helping people to develop better perceptions about their health (Eriksson & Lindstrom, 2008).

3.2.3 SOC and a supportive environment

The power of a supportive environment to enhance a person’s ability to develop a stronger SOC has potential to provide a framework for enhancing and promoting better health opportunities. Continued study of SOC has found that that this concept seems to offer an
explanation of a resource that has assisted participants to manage tension and stress and yet maintain good levels of self-rated health (Eriksson & Lindstrom, 2006; Lindstrom & Eriksson, 2006).

The same authors developed the concept further in cross sectional research, using data from 1500 residents in Aland, Finland. In this community the registered levels of stress were reported to be lower, life expectancy was higher by 2-3 years and employment rate was low, being assessed as 2% compared to 9% in the rest of Finland (Eriksson, Lindstrom, & Lilja, 2007). From their results, they posed the possibility that the concept of individual application of a high SOC could be widened to include many groups within a given society (Eriksson et al., 2007). This was seen by them to have importance if communities could implement strategies that could help achieve the important objectives of good public health along with health promotion. In the study of residents of Aland, an environment that encouraged people to develop and exercise their SOC, also saw greater social involvement of the residents, more efficient uptake of physical activity options and improved quality of life.

3.2.4 Ageing well

Prescriptive criteria that surround other paradigms of ageing described previously (successful, active, healthy, productive), cannot fully encompass the subjective expressions of well-being that older people have offered. Despite challenges in life older people can describe a positive process of ageing (Edgar, 2014). In this thesis, it is argued that these positive processes involve SOC and the use of GRR and SRR to adapt to the many stressors faced by people as they age.

There is no one accepted definition of ageing well. However, the key factor that is present in most attempts to define the concept is inclusion of a subjective evaluation of the ‘insider opinion’, that is, the opinion of people who are themselves describing what matters most to them about ageing. (Fernandez-Ballesteros, Schettini, Santacreu, & Molina, 2012; Futurage, 2011). The key concepts which have been found to be consistently represented are: having family and emotional support, experiencing mastery over circumstances, life satisfaction, interests and goals, mental activity, and being able to compensate for losses and autonomy (Hsu, 2007). While it is true that with age, decline and difficulties inevitably occur, many people continue to describe achievements alongside setbacks, and happiness despite losses (Vincent & Velkoff, 2010). It is proposed that ageing well has similarities with other for other technical terms (such as successful, active and healthy ageing), however it captures the
positive attributes of ageing that are contributed by the older persons themselves (Fernandez-Ballesteros et al., 2012).

Some of the most well-known studies on ageing well are the research projects that have used data from the Harvard Grant Study, a study that has run for more than 75 years, and is itself part of the Study of Adult Development (Vaillant, 2002). More than 700 men have been studied well into their old age (one group numbering 268 were Harvard college students in their 2nd year of study, and the 2nd group were 456 Boston school boys from the inner city). The focus of the study was the characteristics of healthy people, 70’s and older. Understanding was sought regarding the contribution of uncontrollable early life events, particularly negative situations involving abuse or poverty. One key finding was that positive experiences in early life were a better predictor of future well-being than negative experiences. The results of the study concurred with current understanding, that healthy lifestyle choices (such as not smoking, a moderate alcohol intake, along with good levels of physical exercise) are important contributors to good health in older age. In addition, other factors such as social engagement and inclusion whereby an older person feels as much a contributor, as a taker, are considered to be exceptionally valuable. Findings that were also of significance were that marriages can be a great source of contentment, particularly after 70 years of age. Additionally, in older people (over 80 years of age) hereditary factors had less impact on physical ageing than did healthy habits that were formed prior to reaching 50 years of age (Vaillant, 2012).

Ageing well has been studied in the Women’s Health Initiative (WHI), using data from a cohort of more than 25,000 American women, aged over 80 years of age (Woods et al., 2016). In that study, the findings about ageing well were presented as three main constructs: Successful ageing was evaluated using data related to absence of disease, risk factors and functional role performance; Effective ageing considered how women managed life’s challenges; Optimal ageing was denoted by measures of well-being. Despite a diversity in findings, one key area of convergence was that many women rated themselves as having good health or better, despite the presence of some reported disability. Many women felt that they had high levels of resilience and control, and there was a high level of emotional well-being across the cohort.

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2 It is noted here that the term ‘effective ageing’ was not in common use in literature searched and as such has not been described up to this point. However, it is included here as an accurate representation of the WHI findings, with the attached definition that this study took for the term.

3 The same comment is made about ‘optimal ageing’ as was made about ‘effective ageing’.
Additionally, Australian research through the MELSHA programme, has reported findings on predictors of ageing well over a 12 year period, which focused on socio-economic, health, gender and lifestyle influences (Kendig, Browning, Thomas, & Wells, 2014). One of the key findings was that many of these predictors can be modified over a lifetime. The possibility that positive choices to alter behaviour can be enhanced by early intervention and education is an important reason to further research and understanding of the benefits of ageing well, to the individual and to wider society (Kendig & Browning, 2011). Furthermore, older people have defined their ageing well process in terms of keeping active, and having a positive disposition encouraging them to see brighter possibilities in their future, rather than bleak. Other terms that have been used include: a good level of physical and social activity, choosing healthy activities and healthy diets, which in turn allows them to remain independent and socially engaged (Kendig & Browning, 2011).

Another contribution from Australian research was that although older people valued their good health and their ability to function well physically, these factors were not the ultimate goal of their ongoing uptake of healthy behaviours and their use of appropriate medical interventions when necessary. Rather, they reported that good health and function allowed them to remain engaged with life, rather than being considered as objective goals in and of themselves (Kendig & Browning, 2011; Kendig et al., 2014; Miller, 2009). By way of contrast, other terms that have been used to describe ageing, such as successful and active, have concentrated on the achievement, or not, of prescribed criteria.

There has been some research into the positive experiences of ageing well, examining psychosocial and biological aspects in contrast to the earlier methods that focused on disease management and reduction of degeneration (Kendig et al., 2014). This was heralded by the WHO active Ageing Policy Framework (WHO, 2002), and has since been supported and developed by other ageing policy initiatives, for example within Australia, USA and UK (Australian Government Productivity Commission, 2013; Marshall & Altpeter, 2005; Mayhew, 2005). As ageing is a process, it is best considered over time and longitudinal studies are recommended to capture the ‘whole of life’ approach. In addition, a focus on people who are ageing well, rather than emphasizing negative aspects, such as disability and morbidity could help ease the confusion as to what ageing well is perceived to be by those who are experiencing it (Peel, Bartlett, & McClure, 2004).
Despite potential differences that could arise from the perceptions of ageing within various population groups, considerable consistency has been found regarding people’s opinions on ageing well (Fernandez-Ballesteros et al., 2010). The opinions of older people regarding concepts most important to themselves as they aged included remaining in good health until death, being able to take care of themselves, having the support of family and friends, and feeling good about themselves. The concepts that had been offered for consideration for older people in numerous studies, yet received the lowest amounts of agreement, were living a very long time, and, working beyond normal retirement age (Fernandez-Ballesteros et al., 2010).

Findings from studies into the meaning of ageing well, for those in Latin America, Europe, USA and Japan concurred with the major opinions found to be held by older Australians (Miller, 2009). Research concerning the opinions of Australian older people has found that central issues of importance to them are social engagement, life participation, meaningful roles and community involvement to their perception of ageing well. The use of terms such as having a ‘reason to get up’ and ‘life would be empty without social interactions’ give added depth to their opinions about how the concepts are life-related and practical in their day to day experience (Miller, 2009).

Developing these ideas further were descriptions offered about the added components of mental and emotional health. Older people described that having a clear direction in life, with purpose, control and confidence were important components that gave further insight into their assessment of ageing well. As distinct from purely evaluating health as a stand-alone concept, the idea of ageing well incorporates the opinion of the individual as to the quality of their life. This can be achieved through living out the values deemed to be most important to the individual, along with a general assessment on many levels of ‘being well’ (McMahon & Fleury, 2012).

Further understanding of ageing well can build on past findings and identify more information from older people themselves, about their values, and what factors are identified by them to be of most importance in supporting their experience of ageing well. The concept of ageing well, with its emphasis on heeding the opinions of those who are ageing, is linked strongly with key concepts of salutogenic theory.
3.2.5 Sense of Coherence and ageing well

Antonovsky (1987) proposed that SOC evolved during childhood and adolescence and was most probably established by early adulthood, possibly around the third decade. A more recent review of literature has shown that it appears that SOC, although a relatively stable orientation, has been seen to increase with age, and the older the age of the sample studied, the higher the SOC score (Eriksson & Lindstrom, 2005). A large cross sectional study, where participants were aged 18-85 years, was conducted across five Swedish counties, suggested that SOC could increase over a lifetime, until the mid-70’s (Nilsson, Leppert, Simonsson, & Starrin, 2010). Although this study could not confirm the exact timing of maximum SOC, findings appeared to concur with others who also proposed that older people can continue to access resources to maintain health, well-being and QOL in their later years (Tan, Vehvilainen-Julkunen, & Chan, 2014).

The resources that people access to strengthen their SOC can be drawn from within the person (self-esteem, identity), and can also be drawn from external community resources (support of health care professionals, help from family and/or friends to maintain hobbies and interests). A recent study has added greater understanding of how SOC changes over time (Silverstein & Heap, 2015). This longitudinal study was conducted with Swedish adults, aged 55-101 years, using five survey time points between 1991 and 2010/11. Decline in health and social resources negatively impacted SOC, however, once those factors were controlled, SOC strengthened even over the latter years of life. This adds further weight to the findings that older people should continue to be supported and encouraged as they age, with positive outcomes on their health and well-being being possible (Drageset et al., 2008; Tan et al., 2014). The utilisation of as many resources as are available can optimize the benefit of their use, and can reduce the burden on health care services.

It was thought that the experience of SOC may differ for people who live in their own home compared to residents of aged care facilities (Soderhamn & Soderhamn, 2010). In this cross-sectional study, 146 home-dwelling participants were recruited to answer questionnaires, along with 144 people who lived in an aged care facility. The sample group was matched so that there were even numbers of home dwelling people compared to those who living a care facility. The total number in the study group was 1,602, about 56% being women, and with a mean age of 74.2 years. In Antonovsky’s (1979) early research, he did not have the intention to use the three components of SOC separately (that is, comprehensibility, manageability and
meaningfulness). However, in a Swedish study, separation of the three concepts proved useful to elicit more specific findings (Antonovsky, 1979; Eriksson & Lindstrom, 2005). The findings included that meaningfulness was found to be a greater predictor of health for facility dwelling participants, compared to comprehensibility being found to be the greater predictor for home dwelling participants (Soderhamn & Soderhamn, 2010).

### 3.3 The next chapter

The next chapter will address the methodology, the data sources and the methods used, that will underpin and guide the study, in response to the perceived gaps in current literature. A conceptual model (Figure 4-12) that was developed from the literature and from early analysis from the first study is then introduced to provide a structure to drive ongoing studies, and the subsequent analyses of findings.

### 3.4 References


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4 Methodology, Data Sources and Methods

4.1 Introduction

The thesis focuses on the experiences of ageing, as described by women born in the period 1921-26, in comments provided on the back page of up to six ALSWH surveys from 1996 to 2011 (S1-S6). By following a large cohort of women through their later years, the ALSWH provides an opportunity to examine the changes in women’s experiences as they age and in relation to the death of their spouse. The study is particularly rich in providing demographic, epidemiological and psychometric data, and also in collecting qualitative comments on the back page of the survey in response to the question: “Have we missed anything? Is there anything else you would like to tell us?”

This chapter describes the methodological reasoning that guided the research and the methods adopted, including the analysis of qualitative data to capture an ‘insider’s view’ of the women’s experiences and attitudes, the theoretical approach, and the methodological viewpoint. The research described in this dissertation is founded on appreciation of the value of the individual experience, which can be explored through such qualitative data. Further, by using a contrasting group design, this research also allows for patterns of behaviour across varying groups to be explored.

Two studies were conducted, using data from three subgroups within the oldest (1921-26) cohort of the ALSWH, with the key objective being to uncover experiences of women as they aged, and with respect to differing marital status. The first study in the thesis used qualitative thematic content analysis of the comments provided by the women, to provide an understanding of the context and experiences of the women who were already widowed at the start of the study, and to examine how these had changed over time.

The theory of salutogenesis was then used to guide subsequent analyses conducted in the second study. In line with the salutogenic paradigm discussed in Chapter 3 (section 3.2), these analyses were undertaken in three parts. The first analysis looked at the comments for information about stressors that were experienced by women as they age. The second analysis concentrated on comments that deepened an understanding of the resources women used to
counteract the stressors. The third analysis, concentrated on how the women described *ageing well*.

### 4.2 Epistemology

In order to value the individual experience of older women, interpretivism was taken as the methodological ideology, in keeping with the Interpretivist approach to narrative research described separately by both Riessman (2008) and Speedy (2008). The interpretivist approach accepts that reality is only constructed through social constructions such as language and shared meanings. The researcher acknowledges their potential influence over the research process. Responsibility is accepted by the researcher whereby the use of this approach requires that differences of meaning that are held by participants must be subjected to thorough evaluation and interpretation. Accordingly, the aim of the analysis was to interpret as accurately as possible, the possible intent and meaning of the free-text comments contributed by women in the ALSWH.

Many women in ALSWH provided free-text comments, resulting in unsolicited feedback on a number of topics. In turn these comments deepened our understanding of how they see their world. This included how they may take control of events where possible, and how they made adjustments to behaviours as required. It was also thought that women had taken the opportunity to reflect on their health and on any other areas that they felt were important. The opportunity to add comment addressed potential concern women may have had that perhaps the survey had not included some areas as adequately as they may have liked.

Applying an interpretivist ideology, the analysis also used a subjective standpoint. This was done by taking note of the key events that had shaped the lives of the women in the study. In addition, effort was made during the analysis to uncover meaning constructed by women in the oldest cohort of the ALSWH, about their experiences, with consideration given to marital status, whether married or widowed. A subjective standpoint was considered compatible with the belief that women would describe their experiences of ageing in numerous ways and they would construct their own representation of reality.

The aim of the analyses was to go beyond descriptive recording of the comments, to compare differences in potential meaning, and to question significance in relationships between key issues and events that they mentioned in the comments. The stories of each participant were
synthesized together to develop an insight regarding events and experiences that have been described (Bazeley, 2009). The analysis aimed to identify key themes within the comments that are deeply embedded in the understanding of how women age. In addition, the relationships between life events, such as spousal loss, and the responses of each individual were compared and contrasted with others in the cohort. The analysis helped to identify the links between the description of experiences that the women contributed, their use of resources and how the process of ageing was reported across a large cohort of women within Australia.

The research being undertaken was context-specific to Australian women, participating in the oldest cohort of ALSWH. It was driven by the goal of better understanding how older women negotiate transition and adjustment across the later stages of their life. The perspectives of older Australian women were discovered within the setting of life and ageing that was their reality. This approach allowed for flexibility as exploration of the comments can yield nuances of meaning previously undetected in quantitative studies.

As described by Patton (2002), past knowledge, experience, personal values and the belief system of the researcher could potentially influence the interpretation of the data. Some personal reflections were outlined in Chapter 1 (section 1.3) of the thesis. In analysing the data, the researcher was reflective as to her position of influence in the research process, and this position was acknowledged throughout the thesis. Past experiences and beliefs cannot be removed entirely as the researcher cannot be removed from being an instrument in the research. As suggested by Daly et al. (2007), to strengthen the potential contribution of this current study, time has been given to establishing a strong evidence base that supported the design of the study. Thorough processes also extended to choice of data selected, and the subsequent analyses and reporting of findings.

4.3 Theoretical framework

A salutogenic framework was chosen to guide this study. The theory of salutogenesis, first described by Antonovsky (1979, 1987) was outlined in Chapter 3. The theory stemmed from research on older Israeli women, in which Antonovsky (1979) found that despite the immense stressors they had experienced in the concentration camps of WWII many women had managed to stay well. Up until this time, the pathogenic approach towards maximising health was more common, with a preoccupation with risk minimisation and disease elimination.
In a departure from this approach, Antonovsky’s theory of salutogenesis focused on the use of resources to counter stressors and maximise health (Eriksson & Lindstrom, 2008; Lindstrom & Eriksson, 2005, 2010). These resources were called GRR’s and Antonovsky (1979) proposed that their use would enable people to make sense of, and manage events in their lives. Where people showed a repeated pattern of accessing and using resources in a successful way, it was further thought that they developed an orientation to life, which was a resource for managing health and well-being. This orientation Antonovsky termed SOC (Antonovsky, 1979).

SOC was central to salutogenic theory, as it provided the basis for understanding how stress can be managed in order for people to maintain good health and effective function. The presence of a strong SOC was proposed to be a way that the presence of stressors would not be harmful to health. As described by Antonovsky (1987), the presence of three main components of SOC contribute to better health outcomes. The cognitive component is that a person perceives the events in their life to be reasonably structured, predictable and explicable. The instrumental component is that people feel they have sufficient resources to meet the demands posed by stressors. The motivational component is expressed in that a person feels that the demands they experience in life are meaningful and worthy of the investment (Lindstrom & Eriksson, 2006).

The application of salutogenic theory as a framework for analysing the data was taken as an appropriate way to examine the stressors that the older women in the ALSWH had described, along with resources they had described as being available and helpful to manage their reactions to the potential challenges of ageing. In addition, the meaning that was ascribed to the events in the women’s lives was examined.

In relation to the specific aims of this study, it is proposed that by analysing the free-text comments that the women write over time, evidence would be seen of a SOC as they coped with the ageing process. In particular, changes described by women who were widowed were sought.

4.4 Longitudinal qualitative analysis

This research focused on qualitative data provided by women on the back of the ALSWH surveys. Qualitative data can delineate the smaller details of experience as expressed by individuals within various groups that form a larger community (Guest, MacQueen, & Namey,
Studies which ask questions where people have opportunity to add their opinions (such as providing information about ‘why’ and ‘how’) regarding their experiences, provide a worthwhile addition to other quantitative research that tends to focus more on specific questions (such as ‘what’ and ‘when’). In this way, the meanings are sought in the text instead of the numbers (Petty, Thomson, & Stew, 2012). Qualitative research inquiry aims to develop further understanding of the views and stories captured in the qualitative data, and can derive information on intentions, perspectives and process that may be involved with social change and interactions as described by Agee (2009) and Sandelowski (2010).

The application of a longitudinal qualitative analysis, examining each woman’s comments over time, provided a further dimension to this study, and was a particular strength. The experiences of ageing can be best understood when information is available over a time course. Analysis of cross-sectional data does not allow the researcher the opportunity to compare the changes in experiences of the individual over time, neither can comparisons be made between people (Gallacher & Hofer, 2011). Longitudinal research is considered to be critical when developing an evidence base for assessing ageing related changes (Logie, Hogan, & Peut, 2004). A focus on the data collected over the latter part of life when major health problems and other significant life events may occur can deepen the understanding of how challenges, both significant and those seemingly less daunting, although perhaps persistent, can affect how ageing is experienced (Stanziano, Whitehurst, Graham, & Roos, 2010).

4.5 Thematic Analysis

Thematic Analysis (TA) was chosen as the analytic tool for the women’s free-text comments, with an aim to generate patterns in the data. On reflection and by using repeated comparison and re-sorting of groups and categories, the meaning behind what is being said can be emphasised rather than merely how it is said (Braun & Clarke, 2006; Fereday & Muir-Cochrane, 2006; Ryan & Bernard, 2003). It is a descriptive approach that is well suited to answering questions about, and gaining insight into people’s experiences, perceptions and personal opinions. TA was applied to the longitudinal data to identify commonly occurring accounts. The researcher was also mindful of the presence of the less common experiences, or opposing opinions, expressed by women regarding their experiences of ageing, whether as widowed or married women.
TA is a flexible research tool that focuses on identifying, analysing and reporting patterns of meaning and recurring themes. The approach for the study was guided by the work of Braun and Clarke (2006). TA provides a way of systematically analysing large amounts of data, helping to present data in an organised way (Cresswell, 2007). Just as in other forms of qualitative research, there can be a lack of clarity about the assumptions made and the research could be flawed through non or under analysis of the data (Braun & Clarke, 2006). It is acknowledged that there are potential problems, for example, with only a description of the data being offered, lacking insufficient analysis (Frith & Gleeson, 2004). There could be inadvertent bias in the way the data are presented. Quotes could be taken in isolation, or out of context, which would not lead to a genuine interpretation of the participants’ words (Fereday & Muir-Cochrane, 2006). In addition, the researcher may not take into account multiple interpretations that could be possible. In this thesis, careful attention was given to ensuring and maintaining that the research was conducted in a trustworthy manner. This was achieved by applying specific criteria to the analysis (sections 4.10 and 8.9), with a clear audit trail established and allowing the intricacies of meaning within the data to be captured.

4.6 Role of the Researcher

To ensure the quality and rigour of qualitative research of this type, appropriate steps need to be taken, due process must be followed and documented, and the stance of the researcher declared early in the study. In reading the data, the researcher was immersed in reading hundreds of comments, and reading them multiple times, to consider as many aspects as possible that were related to the aims of the study. The women were not just ‘unnamed participants with an ID alias’, they came to life as ‘real women’. While it was true that all data were anonymous, the details contained in the comments were so rich and descriptive, the process became far more biographical over time. With repeated readings, it was possible to follow the stories of the individual women, their families, their friends and their wider circles of influence. Due respect was paid to the concept of ‘familiarity’. This could be engendered through a long exposure to the data, and through the researcher’s professional life associations with similar women and repeated stories. As a result of the process of being immersed in the data over a long period, there was the possibility that the researcher could become almost an ‘insider’ to the participant group. Care was taken to minimise such external intrusions into the process of writing a ‘trustworthy’ contribution to research. It was the aim of
the researcher that all the hallmark steps of creating an extensive audit trail were taken in order to preserve ‘quality’ in the qualitative study.

4.7 Data sources

4.7.1 The Australian Longitudinal Study on Women’s Health

4.7.1.1 Background

Since 1996, the ALSWH has been surveying three cohorts of women, born 1921-26, 1941-45 and 1973-78. The specific goals of the study are to identify factors which promote or reduce the good health of women, alongside how these factors affect their use of health services (Brown et al., 1996). The longitudinal design of the study allows the trajectories of ageing to be documented thereby helping to identify risk factors and to understand the impact of key life events and changes as they evolve over the life course. The study has proved to be of great significance, both in the local and worldwide context.

The ALSWH was one of the first studies of women to utilise a data base that was representative of the whole nation, not just from sub-groups, such as those based on geography or occupation (Brown et al., 1996). The origins of the ALSWH were related to the first Australian National Women’s Health Policy which was launched in 1989, and as a response to lobbying by women’s health organisations for the Australia’s Federal Government to establish a study to focus on women’s health and well-being, across the life course. Initial funding was received for the ALSWH in 1995 and there is provision for ongoing funding until at least 2017.

4.7.1.2 Cohorts

Three cohorts made up the first participants of the ALSWH. They were randomly selected from the Medicare database, representing women born 1921-26 (aged 70-75 at baseline), 1946-51 (aged 45-50) and 1973-78 (aged 18-24). Cohort selection was based on the likelihood of major life events and transitions occurring during the follow-up period between surveys, for women at those ages. For example, the youngest cohort could be entering child-bearing years; the mid cohort would be going through menopausal phases; and the oldest cohort could experience retirement and spousal loss. The women were first surveyed in 1996 with 106,000 baseline surveys mailed to women in three birth cohorts. Survey response rates were 41-42% in the youngest cohort, 53-56% in the mid-cohort, and 37-40% in the oldest cohort (Lee et al., 2005). No financial incentives were provided by the ALSWH to encourage participants to either join,
or remain in, the study (Young, Powers, & Bell, 2006). In 1996, more than 40,000 women were initially recruited.

4.7.1.3 Surveys
Table 4-1 shows the survey schedule for the three ALSWH cohorts. With regard to the 1921-26 cohort, this current research explores their life experiences from 1996 (Survey 1 (S1)) through to 2011 (Survey 6 (S6)). The oldest cohort included 12,432 women at baseline with following surveys conducted on a 3-year rolling basis, starting with the 1946-51 cohort in 1998, the 1921-26 cohort in 1999 and the 1973-78 cohort in 2000.

Table 4-1 Schedule of Surveys for the ALSWH

<table>
<thead>
<tr>
<th>Year Range</th>
<th>Survey 1</th>
<th>Survey 2</th>
<th>Survey 3</th>
<th>Survey 4</th>
<th>Survey 5</th>
<th>Survey 6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18-23 yrs</td>
<td>22-27 yrs</td>
<td>25-30 yrs</td>
<td>28-33 yrs</td>
<td>34-39 yrs</td>
<td>37-42 yrs</td>
</tr>
<tr>
<td></td>
<td>45-50 yrs</td>
<td>47-52 yrs</td>
<td>50-55 yrs</td>
<td>56-61 yrs</td>
<td>59-84 yrs</td>
<td>62-67 yrs</td>
</tr>
<tr>
<td></td>
<td>70-75 yrs</td>
<td>73-78 yrs</td>
<td>76-81 yrs</td>
<td>79-84 yrs</td>
<td>82-87 yrs</td>
<td>85-90 yrs</td>
</tr>
</tbody>
</table>

Adapted from: Trends in women’s health: Results from the ALSWH-priority conditions, risk factors and behaviours report (Brown et al., 2006)

4.7.1.4 Participants
Comparison of characteristics of women in the 1921-26 cohort and women in the 1996 Australian Census indicates women who returned an ALSWH baseline survey were roughly representative of women of the same age in the Australian population. Married women were slightly over-represented with 55.5% of respondents indicating they were partnered compared with 49.2% expected from the Census, and there was a slight bias towards women with university, college or trade qualifications. A minority of women identified as Aboriginal or Torres Strait Islander descent (0.4%), proportional to the Australian population, however overseas born women from non-English speaking countries were well represented (12.2% of participants) (Brown et al., 1999; Young et al., 2006).

4.7.1.5 Retention
Retention of participants is an important matter, and one that the ALSWH has prioritised and monitored in order to minimise attrition and to assess its effects. Attrition rates for the 1921-26 cohort have been relatively small, apart from loss due to death or being too ill to continue completing surveys (Young et al., 2006). Reasons for ill health include strokes, dementia, Parkinson’s disease and general frailty. Other reasons for attrition include participants moving
home and not leaving forwarding information, or they can lose interest in being ongoing contributors to research (Powers & Loxton, 2010). Table 3-2 shows the attrition rates for the 1921-26 cohort.

**Table 4-2 Participation and Retention of Women (1921-26 cohort) aged 70-75 years at Survey 1 in 1996**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age in years</td>
<td>70-75</td>
<td>73-78</td>
<td>76-81</td>
<td>79-84</td>
<td>82-87</td>
<td>85-90</td>
</tr>
<tr>
<td>Deceased</td>
<td></td>
<td>551</td>
<td>1238</td>
<td>2286</td>
<td>3626</td>
<td>5279</td>
</tr>
<tr>
<td>Frailty (e.g. dementia, stroke)</td>
<td></td>
<td>98</td>
<td>302</td>
<td>523</td>
<td>597</td>
<td>790</td>
</tr>
<tr>
<td>Withdrawn from further surveys</td>
<td></td>
<td>562</td>
<td>1088</td>
<td>1360</td>
<td>1371</td>
<td>1347</td>
</tr>
<tr>
<td>Total ineligible</td>
<td>1208</td>
<td>2628</td>
<td>4169</td>
<td>5594</td>
<td>7416</td>
<td></td>
</tr>
<tr>
<td>Contacted but did not return survey</td>
<td>481</td>
<td>862</td>
<td>596</td>
<td>640</td>
<td>870</td>
<td></td>
</tr>
<tr>
<td>Unable to contact participant</td>
<td>309</td>
<td>295</td>
<td>509</td>
<td>637</td>
<td>91</td>
<td></td>
</tr>
<tr>
<td>Total non-respondents</td>
<td>790</td>
<td>1157</td>
<td>1105</td>
<td>1278</td>
<td>961</td>
<td></td>
</tr>
<tr>
<td>Respondents completed survey</td>
<td>12,432</td>
<td>10,434</td>
<td>8,647</td>
<td>7,158</td>
<td>5,560</td>
<td>4,055</td>
</tr>
<tr>
<td>Eligible at current survey</td>
<td>11,224</td>
<td>9,804</td>
<td>8,263</td>
<td>6,838</td>
<td>5,016</td>
<td></td>
</tr>
<tr>
<td>Retention rate as % eligible</td>
<td>93%</td>
<td>88.2%</td>
<td>86.6%</td>
<td>81.3%</td>
<td>80.8%</td>
<td></td>
</tr>
</tbody>
</table>

Adapted from: Table 4: Participants and retention of 12,432 women in the 1921-26 cohort. Data known as at 22 March 2016⁴

⁴Retention rate as % eligible implies the percentage of women who completed the survey of the total number of women left in the study minus those deceased, frail or having withdrawn (eligible sample).

More details can be found on the ALSWH website: www.alswh.org.au/about/sample
At the sixth survey (S6), in 2011, a total of 4,055 women returned the survey, representing 80.8% of eligible participants. The remaining participants do represent a slightly biased group in comparison with the original participants and the national population. However, it was considered that any bias was insufficient to negate the importance and relevance of the findings of such a lengthy and inclusive longitudinal study. The results of the study are largely generalisable to Australian women in these age ranges. Compared to the general population, women in the 1921-26 cohort have had a relative survival advantage of 9.5% (95% confidence interval, 8.3–10.7%), mainly due to baseline differences in demographic characteristics and health behaviours (Lucke, Tooth, Hockey, & Dobson, 2006). Over the course of the study, underrepresentation of non-English-speaking country of birth increased from 3.9% to 7.2%, and underrepresentation of underweight BMI increased from 1.3% to 3.8%. Such small biases are unlikely to affect measures of association or the comparisons being made within this study (Brilleman, Pachana, & Dobson, 2010).

4.7.1.6 ALSWH survey content

ALSWH has collected information on the health of women, including the social, behavioural and economic determinants of health and use of health-related services. Also collected are general demographic characteristics, area of residence (classified using National Key Centre for Social Applications of Geographic Information Systems Categories of Australia (GISCA)) and categorised according to Accessibility/Remoteness Index of Australia (ARIA+ scoring) (Department of Health and Aged Care, 2001), social support measures, whether the women provide care for someone else, and their levels of physical activity and information about symptoms and diagnoses of conditions. Standard measures are included in all ALSWH surveys meaning that trends across generations and over time can be assessed (Mishra & Schofield, 1998).

The ALSWH also includes an adapted version of the Medical Outcomes Study 36-item short-form multi-dimensional measure of health (SF-36) at each survey time-point (Mishra & Schofield, 1998; Ware & Sherbourne, 1992). The SF-36 provides an indication of how women rate their overall functional health and well-being. Items pool into eight sub-scales of health status: vitality, physical functioning, bodily pain, general health perceptions, physical role functioning, emotional role functioning, social role functioning and mental health. These then cluster together to represent physical and mental health scores. A single item also asks women “in general, would you say our health is...”, and can identify perceived change in health over
time. Scores for the SF-36 over time, are presented in Figures 4.7-4.10 (section 4.7.2.7 and 4.7.2.8) for women of the 1921-26 cohort.

In addition to the closed-option quantitative items, at the end of each ALSWH survey is a space left for women to record qualitative comments, in response to the question “Have we missed anything? Is there anything else you would like to tell us?” The comments represent voluntary responses drawn from the whole cohort, of issues that the women feel strongly about sharing. The qualitative comments provide a rich source of information that helps capture the essence of opinions, values and experiences of the participants, and provides better understanding of the effects of these on the choices people make about their health behaviours (Tavener, Chojenta, & Loxton, 2016). Since 1996, more than 52,000 free-text comments were contributed by more than 23,000 participants from the three original cohorts in the ALSWH. The women have taken the opportunity to write on the surveys about a wide range of topics, not only their health concerns. Broadly, they have included comments about experiences with health service providers, disability, social networks, finances, experiences of violence both distant and recent, emotional well-being and recent life events.

More specifically, ALSWH qualitative data has been used to help understand certain phenomena, such as day-to-day expenses relating to medicines and healthcare (ALSWH, 2013) and postnatal depression (Chojenta, Lucke, Forder, & Loxton, 2016). Comparisons can be made across cohorts, such as work by Lee (2001) into experiences of women who take on care giving roles, both for the older cohort and also the mid-aged cohort (Lee & Porteous, 2002). Within a longitudinal context, the free-text comments have revealed how women experience living through drought (Rich, Wright, & Loxton, 2012). They have also been used to investigate the language decline that can occur with ageing (Spencer, Craig, Ferguson, & Colyvas, 2012). Overall, the selection of stories the women chose to share reflect the relative level of importance of that particular information to them, and their need to share that part of their experience.
4.7.2 A summary of women in the 1921-26 cohort

The following section provides a broad overview of women in the 1921-26 cohort, by way of adding background information to the participants in this thesis.

4.7.2.1 Marital status

In 1996 when the women were aged 70-75 years, around 35% of the women surveyed were widowed. This figure rose to about 75% by Survey 6 when the women were 85-90 years of age. Figure 4-1 indicates the marital status (expressed as a percentage) of women in the cohort. There is a steady increase in the proportion who are widowed over 15 years, with approximately one-third of women reporting their marital status as widow at baseline survey in 1996, rising to over two-thirds at the 2011 survey. The women in this cohort mostly did not re-partner after the loss of their spouse. Other research about the experiences of widowed women and the effects on their health (section 2.3) raised the importance of understanding more about the experiences of these women over time and as they aged (Figure 4-1).

Figure 4-1 Marital status from Survey 1 (1996) to 4th six monthly follow-up (2013).

Sourced from (ALSWH, 2014)

5 In addition to Survey 1 to Survey 6 results, the graphs and figures in this thesis may show results from 6-monthly surveys that the older women have received since 2011, after their final 3-yearly survey (Survey 6).
4.7.2.2 Caring

There was an increase in the percentage of women who reported that they ‘regularly provide care or assistance to any other person because of their long term illness, disability or frailty’ from 17% at 70-75 years of age to 26% at age 79 to 84 years. This then decreased to 13% of women by age 85 to 90 years when the women were less likely to be able to provide care, and were more likely to require it themselves (Figure 4-2).

Many women have cared for more than one person with some form of disability across their lifetime, where that was their own parents, siblings, friends as well as their spouse. The group who care for their spouse were shown to be least likely of all primary carers to seek additional help and this can negatively impact their own health and well-being (Hales, 2007). For the women who are living with the spouse for whom they care, it was seen that they also had more negative outcomes with respect to mental health, sleep and stress levels. As a result of these difficulties they also were seen to be higher users of health care services (Lucke et al., 2006) (Figure 4-2).

Figure 4-2 Percentage of women who reported caring for another person from Survey 1 to 4th six monthly follow-up (2013).

Source from (ALSWH, 2014)
4.7.2.3 Requiring help with daily tasks

The increase in the percentage of women who reported needing ‘help with daily tasks because of long-term illness, disability or frailty’ rose from 8% at age 70 to 75 to 26% at 85-90 years. There was also more evidence of women reporting that they required assistance with activities of daily living, which included dressing and matters of personal hygiene. They also reported needing more help with instrumental activities such as cooking and driving (Figure 4-3).

*Figure 4-3 Percentage of women requiring help with daily tasks because of long term illness, disability or frailty from Survey 1 to the 4th six monthly follow-up.*

Difficulty managing on income

In general, women in the 1921-26 cohort reported some limitations on their financial situation. Difficulty managing on income was reported more frequently on earlier surveys (when the women were younger), which then appears to decrease over time. With respect to finding it ‘impossible’ or ‘difficult always’ to manage on available income, at Survey 1, 27% indicated that they had difficulty, and this number fell to 20% by Survey 6 (Figure 4-4).

*Sourced from (ALSWH, 2014)*
**4.7.2.5 Housing**

At the outset of the survey 75% of women in the cohort lived in a house. This number declined to 58% over the ensuing 15 years. During the same period the number of women living in a retirement village, or assisted living facility (e.g. one that offered help with changing linen, home maintenance needs), doubled from 10% to 20% (Figure 4-5).

**Figure 4-5 Housing from Survey 1 to 4th six monthly follow-up**

Sourced from (ALSWH, 2014)
4.7.2.6 Self-rated health
Women were asked ‘in general, would you say your health is...?’ At age 70 to 75 years, 33% of women rated their health as ‘excellent’ or ‘very good’. By 85 to 90 years, this proportion had declined to less than 20%. Conversely, the percentage of women with ‘fair’ or ‘poor’ self-rated health increased from 28% to 42% over the same period (Figure 4-6).

![Figure 4-6 Self-rated health from survey 1 to 4th six monthly follow-up.](image)

### Sourced from (ALSWH, 2014)

4.7.2.7 Physical functioning and mental health
Scores from the SF-36 are used to measure eight sub-scales. The main two sub-scales being physical functioning and mental health. The physical functioning questions relate to activities the women might do during a typical day and if their health limited them, such as vigorous work (for example, vacuuming, mopping, digging in garden), moderate leisure activities (for example, recreational swimming and dancing), and activities needed to get from place to place (for example, climbing stairs and walking distances between 100 metres to one kilometer). It appeared that there was a steady decline in physical functioning over the years as the women aged. The mean score at Survey 1 was 64 out of a possible 100, and by Survey 6, the mean score for physical functioning decreased to 42 (Figure 4-7).
Figure 4-7 Mean physical functioning score from Survey 1 to 4th Six Monthly Follow-up.

The SF-36 mental health questions relate to whether the women felt nervous, down in the dumps, calm and peaceful, felt down or had been happy. The mean scores started, and remained, much higher than for physical functioning. There was only a slight decline over the study period with scores remaining in the range of 75-78 out of a possible 100 (Figure 4-8).

Some of the reasons proposed for declined in mental health in later life include psychosocial stressors, multiple losses, frailty and illness. In addition, if social networks are more limited, and coping mechanisms become less robust, it is possible that these also contribute to a lower mental health score in later life (Leigh, Byles, Chojenta, & Pachana, 2016; McLaughlin, Vagenas, Pachana, Begum, & Dobson, 2010) (Figure 4-8).

Sourced from (ALSWH, 2014)
4.7.2.8 Change in SF-36 physical function and mental health (marital status)

These findings present information derived from 8 SF-36 sub scales which can be collapsed into two component scores: Physical Health Component Score (PCS) and Mental Health Component Score (MCS). In 2003, the ALSWH compared the PCS and MCS for women according to their marital status at each survey (Survey 1 - Survey 3). As shown in Figure 4-9, PCS declined as the women aged comparing Surveys 1, 2 and 3, for married (M), divorced/separated (D), widowed (W) and single/never married (S).

Figure 4-9 PCS for older cohort for most commonly occurring marital status patterns from 1996-2002.

Sourced from (Brown et al., 2006)
An exception in the ‘MWW’ group (i.e. married, widowed, widowed) was noted, whereby scores were maintained during the first ‘W’ (i.e. widow) period, and then dropped sharply. MSC appeared highest for those women who never married (i.e. ‘SSS’, single, single, single). Of relevance to the current study is the decrease in mental health scores for women who reported a marital status change to widow (i.e. ‘MMW’ and ‘MWW’). For women in the ‘MWW’ category however (i.e. married, widowed, widowed), their score improved from the first ‘W’ to the next, three years later (Figure 4-10).

Figure 4-10 MCS for older cohort for most commonly occurring marital status patterns from 1996-2002.

Sourced from (Brown et al., 2006)

In both Figure 4-9 and 4-10, the changes that are seen are not due to less healthy women dropping out of the study, or dying, as these data were only for women who participated in every survey.

4.7.2.9 Chronic disease

A recent report on the findings from the ALSWH about the prevalence and impact of chronic conditions has provided an overview of chronic conditions affecting the 1921-26 cohort (Byles et al., 2015). Arthritis is one of the most commonly reported conditions by older women in the ALSWH, with 70% of women in the oldest cohort being affected by the condition by the time they were 85-90 years of age.

Cardiovascular conditions (for example, heart and stroke conditions) placed a burden on morbidity and mortality for these older women. These conditions affect how mobile and independent women can be as they age and, in addition, they are linked with increased use of
health services, which is of economic importance within the area of health provider services. The incidence of diabetes increased with age and by the time the women were in their 80’s 15% of them reported having this condition.

Osteoporosis and asthma were less commonly reported. However, they were still considered common contributors to morbidity in older women. Good levels of activity, along with timely medical management were considered to be essential to prevent the conditions occurring if possible, or at least minimise the impact these conditions have on later life. The emphasis of health promotion need to be not only to minimise the impact of any chronic conditions. It would be preferable if from early in life there was awareness of the need to prevent the onset of such conditions that compromise strength, mobility and independence in the later years.

A limitation of the ALSWH is that it does not provide good data on cognitive decline. However, recent analysis of linked administrative health data analysis indicates that around 20-28% of women in the cohort developed dementia by 2011. These women are less likely to continue to participate in the surveys, and are under-represented in the ALSWH data (Byles et al., 2015).

4.7.2.10 Major causes of death
From 1996 to 2011, 5,279 out of 12,432 participants in the oldest cohort had died, and by 2013, 6,543 (53%) of women had died (Byles et al., 2015). The most common causes of death were coronary heart disease, cerebrovascular disease, dementia, chronic obstructive pulmonary disease and diabetes (Byles et al., 2015). It had been seen at Survey 1, in 1996 that the women who reported lower self-rated health were actually at a greater risk of dying. However, despite the fact that women have been found to have a higher disease burden than men, the majority (69%) of Australian women aged 65 years and older considered themselves to be in good, very good or excellent health (ABS, 2006). In most cases, more than one disease contributes to death. The condition that most directly contributes to the death is called the underlying cause of death. Other factors that are can be considered to help offer insights in all the possible disease processes that may be present at end of life are called associated and multiple causes of death. Although these factors are not the primary cause of the death, knowledge of their presence and their potential contribution to mortality can be useful in guiding research and enhancing estimations regarding the burden of disease (Australian Institute of Health and Welfare, 2013). Women with lower or higher than recommended Body Mass Index (BMI) had a higher risk of mortality, as were women who smoked, when compared to ex-smokers, or those who had never smoked (Byles et al., 2010).
4.8 Methods

4.8.1 Sampling frame and sample size

In order to allow three groups for comparison (early widows, late widows, and married women), three stratified samples of women were drawn from the ALSWH database. Figure 4-11 shows the process and inclusion criteria used to draw the samples for each group.

Figure 4-11 Sampling frame

In Group 1, participants were all women who reported their marital status as ‘widow’ in 1996 at ALSWH Survey 1, wrote free-text comments at Survey 1 and at least one other survey time point, and who had been widowed less than five years at Survey 1. These women were initially included in Study 1, with the aim to analyse longitudinal data for the same group of women.
who had contributed cross sectional data in an earlier study by Feldman and colleagues (2000). In order for reasonable comparison to be made between data from the same women, with the additional benefit of data available from a further six surveys over 15 years, data from all eligible women was analysed. This also ensured that the full breadth of data was considered early in the thesis to become acquainted with the type of information that could be contained in the comments, and to give good background to the wide experiences that could potentially be described by women.

In Group 2a, participants were women who reported a marital status change to ‘widow’ in 2005 at ALSWH Survey 4, who wrote a comment at S1 and at least at S4, which was the same time as their marital status changed to widow. In Group 2b, the participants were women who reported a marital status change to ‘widow’ in 2008 at ALSWH Survey 5, who wrote a comment at Survey 1 and at least at Survey 5, which was the same time as their marital status changed to widow.

In Group 3, participants were women who reported their marital status as ‘married’ at each ALSWH survey time point from 1996, remained in the ALSWH until at least Survey 4, and who wrote free-text comments at Survey 1 and on at least one survey time point from Survey 4 onwards. Consideration was given to the sample size for Groups 2a, 2b and 3. The large amount of data available from the entire group of participants who fulfilled the criteria and needed to be addressed was a barrier that limited the feasibility of one researcher being able to undertake these sized analyses, multiple times, and in the time frame allowed for this thesis. Therefore, in order to select an appropriate sample size for analysis, 50 women from each of these groups were sampled (with an option to sample more women if data saturation was not achieved).

The sample size estimation was based on research that had considered this decision process as well, and evaluation of suggestions that had been made regarding data size (Bowen, 2008; Mason, 2010; Onwuegbuzie & Leech, 2005). Two of the most important factors to consider in qualitative research are that there is sufficient depth in the data analysed and that there is maximum opportunity for transferability of findings (Anney, 2014). The first study in the current research (Group 1/Early widows) had used a larger number of participants (N=162). It was considered that this gave an appreciation of the depth and variety of data that was likely to be gained from free-text comments from other marital groups that would form Groups 2 and 3. The findings from other research also confirmed that smaller numbers of data would
most likely be adequate to gain the breadth of information that was sufficient to generate meaningful findings for these subsequent groups. In addition, supporting a smaller sample size was the suggestion that larger amounts of data did not necessarily provide more information (Al-Busaidi, 2008; Ritchie, Lewis, Nicholls, & Ormston, 2014). This idea, termed data saturation was also addressed in other research which indicated that, particularly in qualitative research, an adequate sample size is achieved when there are no surprising findings being seen and no more patterns or themes are seen to be emerging (Guest, 2006; Strauss & Corbin, 1998). It was proposed that although it is always possible to add detail, with individual descriptions being seen, there comes a point at which the new information is not considered to be adding depth to the explanation. It is at this point that saturation is considered to be achieved.

After examining literature that had investigated appropriate sample sizes for qualitative studies, it was agreed between the research team that a random sample of 50 women in each group, 2a, 2b and 3, would be sufficient. This size was considered large enough to obtain a wide range of women’s experiences and opinions, and a second random sample could be arranged if saturation of information was not achieved. The size was also in keeping with earlier suggestions by Morse (1994) and took into consideration the time and resources available for this thesis.

4.8.2 Sample Group 1: Early widows

At Survey 1, 4,335 (34.8%) of the women in the 1921-26 cohort of the ALSWH defined their marital status as widowed. There were 718 women who had made a comment at Survey 1 and on at least one other survey. An additional criterion for inclusion was for women to have been widowed for less than 5 years when first surveyed in 1996 (N=165 eligible women, who wrote 631 comments). The five year criteria related to the fact that specific effects on health and well-being related to spousal loss are thought to be significant for a limited period, as discussed in Chapter 2, particularly in relation to the work of Bennett and Soulsby (2012).

The expectation for these women was that they have been widowed for a sufficient length of time for some adjustment to have been made, if possible, after an initial phase of more acute grief and change that may have followed the loss of a spouse. These women also experienced the loss of their partner when they were in their late 60’s and early 70’s, when they possibly had more resources to use in adapting to their new life circumstances than the women widowed in later life referred to in this thesis.
An early analysis of the Survey 1 comments of widowed women showed women experienced significant challenges in the areas of their health, social relationships and support, and in financial areas following the loss of their spouse (Feldman et al., 2000). One of the aims of this thesis was to conduct a follow-up analysis of the comments made by these women at subsequent surveys to determine if these themes were still prevalent in the women’s data. A second, and more substantive, aim was to examine the women’s comments for evidence of salutogenesis, in the way in which they adapted to life as an older widowed woman and other stressors as they aged, and to compare these approaches with the experiences of women widowed later in life and women who remained married well into their later years.

### 4.8.3 Sample Group 2a and 2b: Late widows

By Survey 5, 63% of the women remaining in the oldest cohort self-reported that they had been widowed. To capture the experience of women who were widowed later in life, women who first indicated marital status as widow at Survey 4 or Survey 5 were selected for further study. The sample groups included 109 women (who wrote 465 comments) who were eligible to be included in the analyses as they had first indicated ‘widowed’ as their marital status at Survey 4, and made comments on Survey 1 and on at least Survey 4; and then a second group of another 82 women (who wrote 390 comments) who had first indicated ‘widow’ as their marital status at Survey 5 and contributed a comment at Survey 1 and on at least Survey 5.

The women in these two groups were older at the point of significant change that spousal loss entails compared to the first group of younger widows. During the period leading up to the death of their spouse they have possibly been the main carer. This period of care has been seen to be associated with lower physical and mental health scores. These tended to decrease further after the spouse’s death, for a period of time, as described in earlier parts of the thesis (Chapter 2 section 2.3.1-2.3.2). It had been seen that many women move forward, and make adjustments to a new life, once widowed. Consideration was given to the effects on the later widows of their age at the time of spousal loss. These women were already at least 79 years of age. They may have found it more difficult than women widowed earlier to transition to a new life without the support and companionship of their husband. At an older age, women from within the later widowed group may have to make significant decisions, for example, about housing and financial matters. These types of decisions are challenging at any life stage yet perhaps even could be more difficult at later ages. Subsequently, a random sample of 50 was chosen from the total number of women who fulfilled the criteria. For Group 2a (widowed at
S4), this meant 211 comments were available for analysis, and for Group 2b (widowed at S5) there were 225 comments available for analysis.

4.8.4 Sample Group 3: Married women

The sample group for this group included 364 women (who wrote 1541 comments) who fulfilled the criteria, of remaining married for the length of time they remained in the ALSWH up to Survey 6 in 2011. The additional criteria were that they had contributed comment at Survey 1, and on at least one other survey from Survey 4 onward, in order for the later part of their journey to be captured.

This group of women were living with their husbands, in a partnership that by later surveys, had existed for at least 60, to possibly more than 70 years. This was such a significant feature to consider, given the changes they had experienced together, across society, in their professional lives and within their family and friendship networks. Many from within this population group in Australia may have managed to live in the same house for a long period. The neighbourhood would also have changed as the families who grew up together in one location moved on to create their own family units. It was also possible that the average age, and even cultural composition, of a suburb or region may have completely changed during the time the couple have lived in their marital home (Mackenzie, Currryer, & Byles, 2015).

The likelihood that one of the couple would need to function as a carer also increased over time. At later surveys the pressures of caring could be compounded by the additional challenges of the ageing process in the older years. The longer the couple stayed together in their marriage, the less likely they were to rely on outside friendship networks. They may try to maintain joint activities where both partners could be involved. For example, both partners may try to participate in visits to family, or to maintain activities such as church meetings or professional groups, rather than either developing, or trying to invest energy into the maintenance of, external friendships. More time may be needed to manage the health needs of two people.

Over time, there may have been attendant challenges regarding transport to appointments, and assistance when at appointments. This could be that assistance may have been needed to access buildings, for example, the use of ramps, stairs and elevators. Another person may have been required to be present to help understand and explain the management of complex medical conditions, with the medical professionals at times using scientific or disease specific
language not familiar especially to an older person, not associated with a medical profession. Of the total sample of 364 women who fulfilled the criteria, a random sample of 50 was chosen (who wrote 217 comments for analysis).

4.8.5 Research procedures and data treatment

4.8.5.1 Data preparation
Data were entered into an Access Database by the ALSWH team, and initial screening processes for de-identification were conducted. Comments for selected groups of women were extracted by the ALSWH Data Manager and provided to the researcher as separate Microsoft Access files, in accordance with ALSWH study procedures. The qualitative processing protocol document is located in Appendix 1 of this thesis. The first step in the analysis was to read all of the data. All comments were initially re-screened by the researcher to ensure data were completely de-identified, once again in accordance with ALSWH processing protocols for de-identifying qualitative data. At this point, three women were excluded from the dataset of the early widows, as their comments were too specific to preserve their anonymity. This then reduced the number of women from 165 to 162, and the number of comments available for analysis for this group from 631 to 614.

4.8.5.2 Initial thematic analysis of Group 1: Early Widows
By the process of becoming immersed in the data, the researcher became familiar with the content. Initial thoughts about potential grouping of segments of data into codes were recorded by hand, and kept along with early notes, that served as a reminder of the impressions received at that time of first reading.

The next step was to create a codebook to record all decisions regarding coding. The data were re-read, and codes were allocated to the text. Codes were meaningful groupings of words, expressions and terms that captured a particular aspect of the information. The codes were derived deductively, to determine whether the original themes identified within the analysis by Feldman and colleagues (2000) were still evident. Inductive coding was also carried out, to ensure any additional codes should be considered that had not been seen in the earlier research by Feldman (2000) that had provided the basis for comparison. The Microsoft Access programme was used to provide assistance with data handling, allowing comments to be highlighted and grouped together for storage and effective review procedures throughout the entire analysis process. The programme was most useful to assist in handling large amounts of data. It provided a means to compare the data contributed from the same woman at various
time points and also to compare comments made by all the women at any one-time point. In addition, the Access programme allowed for a review of all comments that had been coded into a category during any point of analyses which meant changes to coding could be considered at all times if the researcher felt this to be an appropriate step. However, it is essential to note that inherent in a qualitative study that has as the comments that women have made over time are the data used, no automated procedure surpasses the need to read all comments, with due respect and intensity, and to remain involved in the process of evaluation and coding at all times. This process generally followed the procedures recommended by Fereday and colleagues (2006) and Ritchie and colleagues (2014) for coding qualitative data for thematic content analysis.

Coded segments of text were kept in context in order to add additional transparency and rigour to the findings. At the conclusion of coding each theme, a reflective piece was written to capture the salience of the comments without time passing, when the reactions to the comments could have diminished. Comments that contained key ideas, that used phrases that seemed to encapsulate an opinion, and/or that shed light on poignant moments in the women’s lives were noted, always within the context in which they were written. A handwritten memo sheet was also kept, where additional thoughts and responses were noted immediately, so as to capture the saliency of reflective comments that resonated with the researcher, during the process of coding.

This first study, with Group 1 women, was a comparison between earlier cross-sectional research concerning early widows (Feldman et al., 2000), with findings that had become available after 15 years of data had been collected. Three main issues had been identified by Feldman and colleagues (2000), that of health, social relationships and support and financial and structural issues. These had been identified where present in the longitudinal data.

Words and phrases that conveyed possible time related changes were a key feature of the analysis. For example, it was possible that women reported changes as to how they managed a disease process and may reference more surgeries, medications and other interventions. They may have reflected on the fact that now they were widowed, they had more time to be able to get out and mix with friends for social support. Other women may have reported that over the years most of their good friends and siblings may had already died, leaving them to express a sense of being more alone. It was also possible that this research would find expressions of confidence or fear regarding the stability and efficacy of their financial situation. The results of
this study were published in Women and Health Journal in January 2016 and appears at the end of the chapter (see 4.11).

4.8.5.3 Inductive and deductive comparative analysis of Group 1: Early Widows, Group 2a, 2b: Late Widows and Group 3: Married women

For this second stage of analysis, the theory of salutogenesis was applied to the women’s comments to see if elements of the SOC were a resource for women as they managed the transition and adjustment to widowhood, and also changes that the later years of ageing bring. The key aim of this study was to explore the possible use of salutogenic factors by women, and to compare these between the three groups of women, using their comments contributed over a possible 15-year time period.

To commence this analysis, operationalised definitions were taken for the codes that would be applied. The analysis was both deductive and inductive. The findings from earlier research that were presented throughout Chapter 2 yielded a large depth of information from which to develop further knowledge about possible areas that women found important and relevant to their experience. In addition, as has been referred to in sections 1.3 and 4.6 that the researcher brought extensive experience to bear on the understanding of how older women in Australia had described ageing to her over a 40-year period of time in her professional capacity. In addition, importantly, the findings from the first study had been published by the time this second analysis was being conducted. Therefore, the comments from subsequent groups of women were read with a depth of prior understanding. However, it was always the intention that by a process of intense reflection, by making journal notes after each new category was considered, and by meeting regularly with the supervisory team, that an inductive approach was also considered for all comments read. This enabled new themes to be considered, and/or subtler nuances or changes in emphasis to be considered as comments contributed over 15 years were read.

The comments from all three marital groups were read again, in chronological order to get the broadest possible picture for all the women, at any of the six surveys on which they had offered comments. Following this process, documents were created within the codebook that provided a systematic method for reviewing and organising all the data that were analysed. The decisions about initial codes that were identified deductively were made with due consideration having been given to theories of ageing and the theory of salutogenesis.
Additional concepts that were seen to appear in the comments and were identified inductively were also coded.

The segments of text were kept in context in order to add additional transparency and rigour to the findings. At the conclusion of coding the data against the conceptual model, a reflective piece was written to keep a record of thoughts and relevant opinions at the time of coding. Women’s comments that offered key ideas, that used phrases that seemed to encapsulate an opinion or that shed light on particularly poignant moments in the women’s lives were noted in memos, again within the context in which they were written. These served as reminders of the reactions and opinions early in the analysis process. They were frequently referred to for comparison purposes, as further review of findings occurred during the later stages of the research.

4.8.5.4 Early generation of themes

Generating categories from the initial codes was the next step taken. This was done by sorting codes from all three women’s groups into larger groups (categories) on the basis of relationships between information contained in the codes. Following this, categories were grouped into sub-themes. These groups bore some relationship to each other and also were considered to have some discrete element that justified their consideration as separate identities at the earlier stage of analysis.

These sub-themes were subsequently considered again, and some were further collapsed into the larger overarching themes. The decision process of how to sort and organise the information into themes was iterative, whereby different segments of text that were allocated to themes were continuously compared with each other looking for consistency in the method of reasoning and allocation. The flexible and adaptable approach of thematic analysis means that the process of coding and sorting of themes was neither linear nor prescriptive. Rather, it was iterative and recursive as each phase of analysis could benefit, and even require, movement back and forth between the coding process and the data.

A higher frequency of the occurrence of a theme across the data did not inherently mean it was of greater importance than another that was mentioned less frequently. This decision making process was part of the challenge of the coding. The nature of the theme, the intensity of the data in which it was represented, and the very essence of what it was conveying were all key points that had to be considered at all times. Some themes were divided into separate
sub-themes, while others were collapsed into each other. This decision was based on whether the data had sufficient likeness within it or whether there enough difference within the group to justify making a distinction following the methods of Patton (2014).

Once the process of multiple readings, coding, and reflection had been effectively completed and documented, all themes were reviewed within the codebook and were considered for ‘goodness of fit’. Meetings were held regularly with the supervisory team. Differences in opinions were discussed, if required, regarding alternative interpretations of text. Consensus was not considered a primary goal given the understanding of the subjective approach, whereby multiple meanings were both allowed and expected. Decisions were made regarding the appropriateness of coding on a case by case basis.

4.8.5.5 Ongoing refining of coding and organising of themes
Every re-reading of data and re-arrangement of codes could be considered a greater refinement of the process of coding. However, once each reading was yielding similar results in terms of where data should sit within the themes, the formal coding process was considered completed.

4.8.5.6 Treatment of themes from text
It was noted that segments of comments frequently appeared under multiple codes, which suggested overlapping themes. Keeping the segments within context was an important part of the process so that meaning was not lost in each comment that occurred over time. It also ensured that contextual meaning was preserved during the multiple periods of analysis.

4.9 Ethics process and approval

The ALSWH project has received the required ethics approvals and this research was conducted in accordance with the relevant policies and procedures for data access. The University of Newcastle granted approval under H-076-0795 and the University of Queensland Human Research Ethics Committees granted approval under 2004000224. All participants gave written consent for inclusion in the ALSWH and for the use of their information for research purposes.

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Any proposed studies using the ALSWH data are reviewed by the Publications, Sub-studies and Analyses (PSA) Committee of the ALSWH. Following required procedures, an Expression of Interest (EOI) was put to the committee in the middle of November 2013 to seek permission to obtain and analyse data for study 1 (A489). This secondary analysis of existing qualitative data was approved by the ALSWH PSA in January 2014 and a Memorandum of Understanding was signed by all researchers collaborating on a project providing agreement to abide by the policy and procedure guidelines that govern the access of the ALSWH data. The terms of approval include that analysis of the requested data must be conducted using the method that was specified to the committee, and any subsequent changes to the project must be submitted to the committee using the appropriate variation forms that cover changes to the study compared to an initial submission.

An additional EOI (A587) was put to the committee to seek permission to analyse the contrasting data for groups 1, 2a and b, and 3 and applying the salutogenic framework. Approval was granted in May 2015. Six-monthly project updates are required to be submitted to the ALSWH to ensure permission for ongoing access to the data.

4.10 Trustworthiness and rigour

In order to increase the rigour of the analyses conducted in this research, the analytical methods applied followed the standards suggested by Kitto and colleagues (2008) for assessing the quality of qualitative studies. These standards will be discussed in Chapter 8 when the findings of the study are reviewed, allowing for reflection about the way the issues regarding the trustworthiness of the study were addressed.

4.11 Published paper

Kennaugh, R., Byles, J., & Tavener, M. (2015). Beyond widowhood: Do prior discovered themes that describe the experiences of older Australian widowed women persist over time? Women and Health, 56(7), 827-842

4.11.1 Background

The significance of this study related to the identification of major themes that reportedly affect the perceived quality of life for widows as they process the grief surrounding the bereavement and move forward to establishing their life without the identification with, and
support of a partner. These have been reported as being issues related to their health; how they are coping financially with potential diminished income; and how they perceive the opportunities they have for positive social support, inclusion and value (Byles, Feldman, & Mishra, 1999). There was a minimal number of studies that had explored the strategies that women use to cope and adjust to the alterations bereavement brings to them (Digiacomo, Davidson, Byles, & Nolan, 2013). In addition, there had not been a great deal of work done that took a long term view of widows both within Australia and in the broader context of ageing and more longitudinal studies have been recommended (Bacon et al., 2015; Singh & Misra, 2009). For our society to implement appropriate policy and to provide infrastructure to support a growing sector of the population, it is important that an understanding is developed that reflects the issues that are paramount to women who are widowed and potentially ageing alone. By studying the lived experience of a large number of women who describe the ways they have made adjustments to change, these results will offer depth to the current body of literature.
4.11.2 Publication: Beyond Widowhood

Beyond widowhood: Do prior discovered themes that describe the experiences of older Australian widowed women persist over time?

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ABSTRACT

In previous cross-sectional studies researchers have explored the experiences of widowed women in the 1921–1926 cohort of the Australian Longitudinal Study on Women’s Health and identified three major themes: health, social relationships and support, and financial and structural issues. In the current study the authors examine longitudinal data collected over 15 years to assess whether these themes persisted and/or evolved over time. The sample included 162 widowed women aged 70–90 years. Thematic analysis was used with a constant comparison method. Many women reported good health despite managing comorbidities. Social relationships frequently shifted from friends to family to more formal support. Most financial and structural issues related to managing increasing health costs as women aged. These results confirmed that the three major themes previously reported persisted over time, and underscore the importance of continuing to support women, and their changing needs, well beyond the initial period of bereavement.

Introduction

Research has focused on experiences of widows in terms of stressors associated with the loss of their spouse and on the relations to health and lifestyle, and the process of recovery from this critical life event (Bennett, Hughes, and Smith 2005). The loss of a spouse is a distressing experience (Lee 2013) with critical changes to be managed (Boerner, Wortman, and Bonanno 2005). A widow may experience decreased physical and mental health and signs of stress and depressive symptoms, (DiGiacomo et al. 2013b; Stroebe, Schut, and Stroebe 2007), particularly in a period of up to 2 years post-bereavement. However, experiences of women during this period are not uniform. Keene and Prokos (2008) examined transition from care-giving to widowhood.

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They found that while many women experienced depressive symptoms following the death of their husbands, women who had been care-givers reported improved mental health once they were relieved of the stress of the caring role. They concluded the process of adjustment following spousal loss has not as yet been clearly defined and understood.

Women cope beyond the initial period of grief according to a complex array of factors. These include time that has elapsed since the loss (Boerner, Wortman, and Bonanno 2005), the residual physical and emotional effects of caring for their husband (Digiacomo et al. 2013a), access to social support from family and friends (deVries et al. 2014; Utz et al. 2014), interaction outside the home, opportunities for volunteering, and other social roles.

Throughout this period of change in widowed women’s lives a story unfolds of resilience, coping, and transition to a new way of life. Focusing only on the event of the husband’s death and the immediate period of bereavement fails to recognize the subsequent evolution of women’s lives and fitting widowhood into the later part of their life course (Bennett and Soulsby 2012; Carr, Wortman, and Nesse 2005; Hahn et al. 2011).

Byles, Feldman, and Mishra (1999) analyzed cross-sectional data for women in the oldest cohort of the baseline survey of the Australian Longitudinal Study on Women’s Health (ALSWH), then aged 70–75 years, to compare widowed women’s health and social circumstances with those of other women in the cohort. In that study, women who had lost their husband in the previous 12 months had particular physical and mental health needs, as well as financial and practical needs relating to managing on their income. They had the lowest self-rated health, were most likely to report they were stressed about their health, and had poorer health-related quality of life. In contrast, women who were widowed for longer than 12 months were similar to married women on these measures. Feldman, Byles, and Beaumont (2000) conducted a cross-sectional analysis of free-text comments provided by more than 700 of these widowed women. The authors found three key themes that emerged as being central to the lives of older widowed women: health, social relationships and support, and financial and structural issues.

Feldman, Byles, and Beaumont (2000) reported women’s descriptions of their health, both physical and emotional, and whether it was affected after the loss of their husbands. They reported that women acknowledged that they needed multiple social relationships to improve their quality of life. The financial difficulties for widowed women concentrated on their ability to manage on one income to fund their own housing and health as they aged.

The aim of the current research was to analyze women’s free-text comments over a 15-year period in the ALSWH. By contrasting them against the previous work by Feldman, Byles, and Beaumont (2000) we sought to understand further the experiences of widowed women well beyond the initial period of bereavement. Key themes identified by Feldman, Byles, and
Beaumont (2000) were revisited and cross-checked against free-text comments made by women who reported marital status as widow in 1996 to see if the same themes persisted over time. In addition, the women’s modes of transition and adjustment were reviewed over time.

**Methods**

**Participants**

The ALSWH is a large national longitudinal study on women’s health and health services. Since 1996, the study has surveyed cohorts of women born during the period 1921–1926 who were randomly selected from the Medicare Australia database, which includes all people in Australia who are eligible for universal health insurance. Consent rates for the original cohort were estimated at 37%–40% (Brown et al. 1999). The women who participated were similar to other women of the same age in the Australian Census, with some over-representation of married women and under-representation of women born overseas.

This current secondary analysis of existing data was approved by the ethics committees of two universities. All participants provided signed, written and informed consent to participate in ALSWH. The longitudinal design of the study allows effects of aging and key life events to be assessed, with each cohort surveyed on a three-year rolling basis. In addition to quantitative questions, at the end of each survey women are provided with space to write free-text comments under the heading “Have we missed anything? If there is anything else you would like to tell us, please write in the space below.” The comments are not prompted by specific questions, allowing the women to volunteer anonymously their experiences of any aspect of their health and well-being. Proximity of questions preceding the free-text field was carefully considered by the ALSWH research team so as not to “prime” the women to write on a particular topic. The two questions before the free-text area were “Did someone help you fill in this survey?” and “What is your date of birth?”

Participants for the current study were drawn from among 12,432 women in the oldest cohort of ALSWH, born 1921–1926, and aged 70–75 years at baseline in 1996. For their data to be included in the current study women had:

- self-identified marital status as widowed at baseline ($N = 4,224$);
- written a free-text comment at baseline and at least at one of the next five surveys, conducted between 1999 and 2011 ($N = 718$); and
- been widowed five years or less in 1996 ($N = 165$).
The criteria for women to be widowed for 5 years or less related to current understanding that personal effects of spousal bereavement are considered to be significant for a limited period (Bennett and Soulsby 2012). Widowhood, however, is an ongoing state that carries potential for both personal and social transition and adjustment. The impact of these changes alters over time (Lund et al. 2010). The decision, therefore, was made to choose participants who, at baseline, were in the earlier phase of adjustment to changes associated with death of their husbands.

Data preparation

Free-text comments were entered and stored in Microsoft Access. All comments from 165 women were screened first by two of the authors to ensure data were completely de-identified in accordance with ALSWH processing protocols for qualitative data. At this point, three women were excluded from the dataset as their comments were too specific to preserve their anonymity, leaving 162 women.

Analysis

Thematic analysis

Thematic Analysis (TA) can be used within different frameworks and allows for patterns of meaning to be identified. This method was suitable for secondary analysis of existing data and was also in keeping with methods used by Feldman, Byles, and Beaumont (2000). TA can accommodate a diverse range of issues, and it allowed the current authors to code both deductively and inductively. Working definitions of the three original key themes from Feldman et al. (2000) were developed and agreed upon by all authors before coding began: this formed the basis of a code book maintained by first author. Analysis was recursive; hand-written memos were kept during the coding process to assist with review and naming of themes. The process of coding and theme development were primarily deductive (a-priori), looking for persistence of the three key themes from Feldman, Byles, and Beaumont (2000) that concerned health, social relationships and support, and financial and structural issues, then inductive, identification of emergent themes.

Coding the data

One author was responsible for coding all of the women’s comments and identifying themes. A second author read comments from a random sample of 20% of the women (N = 32 women, 123 comments). A third author, who had been part of the initial 1996 research read comments by a random sample of 10% of the women (N = 16 women, 71 comments) to ascertain if coding was in
accordance with principles of the earlier work. Working definitions of the three a-priori themes and the code book guided the coding and review process during meetings between authors. The first two authors discussed their review of women’s comments and resulting codes with primary reference made to the original themes by Feldman, Byles, and Beaumont (2000). The third author discussed her coding against the full code book, when coding and theme identification was complete. Reconciliation of differences was discussed on a case-by-case basis, with each author providing a rationale for their coding differences, and final decisions based on the strongest meaning (i.e., message) held in the segment of text.

Guided by the three a-priori themes of Feldman, Byles, and Beaumont (2000) the segments of text were initially coded under fifty-two categories, with each category label representing the key message interpreted from the women’s comments. The categories were grouped into twenty-one sub-themes, representing similar subjects and ultimately these were cross-checked against the three assigned a-priori themes. Incorporating both a deductive model based on the three themes already established in 1996, in combination with a data-driven inductive approach, allowed the original themes to be re-examined while also allowing for contrasting, emergent themes to be identified. Free-text comments were also arranged into a “wide” format, containing each woman’s ID number, and segments of text according to each category and theme, in order for the temporality of experiences to be explored.

Results

The 162 eligible women made a total of 614 comments over six ALSWH surveys. Women could choose to comment on any of the surveys from 1996 onward. All women had made a comment at Survey 1 (S1), as per eligibility criteria for the present analyses, and most women commented on S2 (1999), S3 (2002), and S4 (2005). Fewer women commented at S5 (2008) and S6 (2011) (see Table 1). From the 162 women, 60% reported their health as being good, very good, or excellent; 36% reported school or intermediate certificate as their highest educational qualification; 10% had experienced a major personal illness in the preceding 12 months, and 10% of the women said they lived with other people.

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Each of the main themes identified are described firstly in terms of three *a-priori* themes described by Feldman, Byles, and Beaumont (2000), re-examined as part of this work, and then changes in the women’s comments over the 15-year period are described.

**Health**

“Health” was the most coded theme, with women writing of a wide range of experiences they perceived as related to their health. The findings were very similar to those of Feldman, Byles, and Beaumont (2000), with women describing details of their husband’s death, effects on their physical and emotional health, and changes to their health over time as they aged. However, being able to analyze women’s stories from 1996 up to 2011 emphasized the strength of “health” as an enduring narrative. On earlier surveys, the women described being stressed and feeling down following the death of their husband. Some found “living alone now very difficult” (S1, 1996) and would “cry a lot at times” (S2, 1999). Congruent with results reported by Feldman, Byles, and Beaumont (2000), women perceived stress as having an impact on their physical and emotional health. They described a variety of causes, such as missing the family home, being a burden to others, and feeling that they were “not able to cope physically, mentally, or financially” (S2, 1999) on their own. One woman’s comments revealed the seriousness of adjusting to life without a spouse:

> My husband left nothing but debts … and his superannuation had been used up consequently. I can’t afford help in the house cleaning department. That’s what worries me most—trying to do all the housework and the garden, and knowing I can’t do it—even though I’m very healthy for my age. My children all live in other cities the nearest being 3 hours away. So being alone worries me (S1, 1996).

Analyzing the women’s comments over a 15-year period revealed the candidness of their writing and that health issues were prominent in the women’s lives as they aged. One woman described over 11 years that she had “contracted Encephalitis” (S1, 1996); had “three eye operations and haven’t the sight to do too much” (S2, 1999); experienced “bad memory and epilepsy … two cataract operations and the re-sewing back of a retina lining” (S3, 2002); then having to “change doctors and (take new tablets) which made me feel lifeless, put me off food and gave me Lupus” (S4, 2005).

Contrasted against their narratives of illness, women still wrote of remaining active and finding meaning as an older widow, such as “attending the theatre occasionally and being involved with son’s and daughter’s children and their lives” (S1, 1996). One woman wrote that she was “very lucky to be so healthy and to have so much energy … walking and climbing much better and longer than some of the 40–50 year olds. My husband and I were very
close, I miss him terribly and find being busy (that) it’s easier” (S1, 1996). Eight years later when she wrote again, she was “still blessed with good health but (was) starting to slow down a bit” (S5, 2008).

Memory loss was a concern for widowed women in case their family saw it as a negative sign of aging, and it was seen as a further threat to their independence and ability to live on their own. One woman wrote soon after her husband’s death “I also feel that my strong feelings of not being able to make decisions, confusion, and muddled thinking, could be due to this (husband’s death), although I fear the possibility of Alzheimer’s” (S1, 1996). At S4 in 2005, she wrote she was still driving with confidence and that she was able to manage her garden actively, but remained worried about her failing memory. Many women reported feeling their health was further adversely affected when, in addition to adjusting to life without a spouse, they had to deal with deaths of close family and friends, noting that if any of their children died, this event was particularly overwhelming.

Social relationships and support

Findings by Feldman, Byles, and Beaumont (2000) persisted over time, in that few widowed women experienced aging in total isolation without some family or friends to provide support. Women’s commentaries regarding appreciation of the care shown by their family was marked, especially in later surveys. Having family close by brought comfort, as one woman wrote at S3 (2002):

During the last year my married daughter, her husband and two little girls have come to live approx. 2 km from me ... this has made a wonderful difference to me and although I only see them about once a week it’s still nice to know they’re so close.

Having family close also provided a sense of meaning, with women caring for grandchildren, sewing and knitting, and helping with light household tasks as a means of contributing to their family. One woman wrote:

Since moving to be close to my family I have a lot of support from them ... my grandson has custody of his children who are very dear and see very often, they like to have sleepovers and we play many games, I have taught them many things from nursery rhymes to how to knit (S4, 2005).

Also discernible over time was when such experiences began to diminish, as another woman shared from 1999 to 2002:

[She would] knit for new babies in the family, sew, do all my own cooking, make jam, a regular letter writer, phone user, an avid reader ... helping a son and young family in many ways—so, I feel that all of these activities help keeping me alert, healthy, and, I hope sane (S2, 1999).
Then three years later she looked after grandchildren “only occasionally” (S3, 2002).

Some women described that their needs for support had altered over time. Whereas they formerly offered support, they now found they were increasingly on the receiving end, both emotionally and physically. However, not all women felt supported by families. Some described their families as being too busy; others lived far away. Some did not want to be a “burden (to) another family member” (S1, 1996) while others described personal conflicts that kept them apart.

The loss felt after the death of their husband was a key element in the women’s earlier writing, with references to feeling lonely such as: “I had a very close loving relationship with my husband for almost 50 years and as he died suddenly I realize some of my (survey) answers reflect the sadness and aloneness I now feel” (S1, 1996), and “from a happy busy life I have gone to a lonely life … don’t see people at all” (S1, 1996).

In the years following the loss of a spouse many women began to refer to their desire for continued contact with friends and the opportunity to contribute to their community. Sometimes these activities were described as a substitute for their husband’s companionship and shared activities. Many women wrote about driving friends to social gatherings such as lunches but also to community volunteering and interest centers, such as Meals on Wheels, hospital auxiliaries, Red Cross, and war widows groups. One woman said while her health allowed, she would continue with “charity work and … positions of President, Secretary, and Treasurer with local groups” (S2, 1999). However, on later surveys she no longer wrote of such things, focusing instead on her arthritis and incontinence. In later surveys, there were narratives reflecting women’s search for extra (younger) social contact and stimulation, as one woman described, “I have taught high school seniors for so long that I now find empty talk about bingo from ‘us oldies’ tiresome. … I love to be in the company of my 19 and 20-year old grandchildren … more stimulating stuff about now and the future … too many oldies wallow in the past” (S5, 2008).

Over time women reported obtaining more formal means of support. This took the form of assistance with heavier tasks, such as house cleaning, garden maintenance and in doing laundry (particularly bed linen). Community transport was often required while they remained living alone. If women moved to assisted living accommodation they frequently mentioned meals and washing were now done by staff.

Financial and structural

Feldman, Byles, and Beaumont (2000) identified financial insecurity as the third major theme expressed by widowed women. Concerns included
difficulties managing on one income and worry about being able to stay in the family home. In the current study women wrote specifically about difficulties affording health coverage, housing costs, and problems accessing transport and community services. Many women wrote that living as a widow on a single income meant affording private health insurance was a major concern. Commentaries of maintaining, or cancelling, insurance were most present on early surveys, when women first shared experiences of living as a widow. One 70-year-old woman wrote:

ever since private health insurance came into being my family belonged to (a) health fund, but as now I am an old age person I had to give it up as on pension I found it too expensive ... so now have to wait if needing an operation (S1, 1996).

Also, women wrote of “having to make do with things because of the cost of better ones” (S3, 2002), such as hearing aids and deciding how to meet costs, such as “council rates, insurances on unit, as well as contents insurance... I can’t afford to go on trips or holidays as it takes too long to save enough money” (S1, 1996).

Some women wrote of moving closer to family and were grateful they could save money as their family did “much of the work, shopping and cooking, yard fixing, and painting” (S5, 2008). Others wrote that having shared or adjacent properties helped to relieve the financial burden of housing costs. One such example was a woman who said at both S1 in 1996, and 9 years later at S4 in 2005 that she was glad she lived in a granny flat behind her son’s house; not having to pay rent meant she could manage on her single pension. If women moved to assisted accommodation, some expressed concern that most of their income went into paying for this, up to “85% pension plus all rent allowance, which only leaves less than $60 a fortnight and pay phone, electricity, (and) my health fund” (S3, 2002). Others expressed some relief that they “have meal provided, room cleaned, and bed made” (S6, 2011), and that in general “there are pluses and minuses ... but I think the plus side outweighs the minus” (S4, 2005).

In addition to accessing community and medical services, widowed women wrote of the added difficulty of finding transport that was physically accessible, and financially affordable. They now had to ask family members for help or had to try to access taxis or community buses. While this was widely reported, women living in rural areas and regional towns particularly expressed feeling vulnerable if services were removed as options were particularly limited in their environment.

**Change**

Feldman, Byles, and Beaumont (2000) reported that a new way of life was already starting to evolve for widowed women who commented on their survey in 1996. In this current study we observed that over the 15-year period
to 2011, widowed women were "hoping to be better" (S3, 2002); that they would find ways to cope with living alone, and that they would be able to find purpose and value, living as a single woman. Women conceptualized their "success" in adapting to life as a widow as very personal. They wrote in terms of how they "managed to survive" (S1, 1996) on a daily basis, finding strength in familiar, meaningful pursuits. Also, they felt their efforts were ratified when others said they appeared to be "coping very well" (S5, 2008).

Women often told us that "things are so different" (S4, 2005) to when they last wrote, whether that be three years between surveys or longer, or for better or worse. For some women little appeared to change over time, apart from reassuring us that they "keep reasonably well" for their age (S5, 2008), or writing that they did not have much to complain about "except for the birthdays coming around regularly" (S6, 2011). For other women, their simple writing could reveal immense transformation, with one woman writing across the 15-year period: from "my life is much better now" (S1, 1996); to "I feel my health has deteriorated" (S3, 2002); then a final note from a care-giver on the women’s behalf “She rarely leaves her bed . . . her life is now sedentary” (S6, 2011). Critical incidents recounted by the women, such as major surgery or the death of a close sibling, did result in expressions of feeling vulnerable, but were often countered by descriptions of feeling lucky or that their health was still “not too bad” (S4, 2005).

Health featured strongly in the women’s writing at baseline, and continued to represent an important aspect of their identity as they aged, with time appearing to intensify and add credence to earlier minor health problems. Women acknowledged they had to work at finding new friendships and ways to receive support: some even learned to enjoy living alone even though they might miss their husband and felt that “no one will ever take his place” (S2, 1999). Becoming a widow represented a significant difference in the direction of the women’s lives, and ways of coping underwrote many of their stories over time: whether that meant having to manage finances for the first time, leaving the family home, seeking medical advice, relying upon social networks or working with change that was imposed upon them by others.

Discussion

Findings from the present analyses present a rich description of the experience of widowed women as they aged. Our primary aim through this work was to analyze women’s free-text comments made over a 15-year period and contrast them against previous work by Feldman, Byles, and Beaumont (2000). Examination was made of whether Feldman et al.’s major themes (health, social relationships and support, and financial issues) persisted over time and whether changes in priorities occurred and were operationalized by women. In general, women’s longitudinal comments did resonate with the
earlier work of Feldman, Byles, and Beaumont (2000) with the three major themes still evident in women’s comments over 15 years but with some different nuances of meaning. Moreover, these continued to be the dominant themes in women’s comments.

Initially many women conveyed the depth of sadness, loss, and devastation felt after the death of their husband. For many the initial grief was overwhelming, and they wrote of the extent their life changed after they had begun living alone. Not only did they have to cope with spousal bereavement, but over the years, many women wrote about the pain of losing siblings, children, and close friends. Associated with the loss of family and friends, they described their social networks as shrinking and were sad that they had few friends left, and at times, none at all.

Over the 15-year period, women wrote less about the challenges in their life being linked to the bereavement process itself, and wrote of creating a new life for themselves. These findings relate to those of Bellamy et al. (2014) who suggested that the way women perceive their ability to re-create a meaningful life after the loss of their husband shows remarkable resilience and is dependent on the presence of psychological, socio-economic, and family factors. Evaluating the changes women describe as they age, and in the light of their past experiences, can deepen our understanding of how women adjust to being a widow. Van den Hoomaard (2009) published the results of a series of interviews with women aged 53–87 years about how they came to terms with being a widow. Their findings reiterated that the transition from wife to widow is told not only as a story of loss, but also of gain and unexpected accomplishment. Current findings support this contention that many women had been able to adjust by learning new ways of interacting with children and other family members, re-establishing relationships with their community, and finding opportunities for social outings. In addition they had to learn how to manage on decreased income.

Earlier research that looked at the effects of bereavement over much shorter periods of time, from 6 months (Houwen et al. 2010), 12 months (Byles, Feldman, and Mishra 1999; DiGiacomo et al. 2013a), 16 months (Lund et al. 2010), to 3 years (Bennett et al. 2010), all reported that bereavement can affect physical and emotional health of the surviving spouse. The degree of the effect can vary over time. These authors suggested that future longitudinal research should examine widowed women’s experiences of the outcomes of bereavement alongside experiences of aging over a much longer period of time (Bennett, Hughes, and Smith 2005; van der Houwen et al. 2010). Our research, over the longer time frame of 15 years, bears out the expectations that women would adapt to widowhood, within the context of their older years. In fact, the later lives of these women may not have been so different from other women who were not widowed—an investigation beyond the scope of this current study.
A primary theme from Feldman, Byles, and Beaumont (2000) was that of health. The findings of the current study concurred with this. Health is a complex state and women wrote of multiple comorbidities that often increased over time. Some people experiencing grief can neglect their own personal wellbeing (DiGiacomo et al. 2012). However, in the current study many women kept physically active and engaged in productive and valuable social interactions. Some were quite expressive that they had felt free to embrace new opportunities once they were not bound by responsibilities of caring for their husband. DiGiacomo et al (2013a, 2013b) reported that women who had been widowed may have been at risk of neglecting their own health and this may have affected their ability to maintain an active life. The findings of the current study suggested that over time many women managed this risk by maintaining and even improving their physical health and social engagement for many years as they age. Many were prepared to participate in activity in older age even if they suffered from ongoing health issues, not simply descending into inactivity and illness (Byles 2007).

The second of the major themes reported by Feldman, Byles, and Beaumont (2000) was that of social relationships and support. Also strongly evident over time, women in the current study wrote of their ability to find new ways to move forward following the death of their husband. Many felt lucky and fortunate to have found fulfillment and meaning within their families, friends, and communities. Bennett and Soulsby (2012) noted that women talk about changes in friendships following the death of their husband, particularly changing from having married friends to being friends with other widowed women. Although such a finding was not obvious in the current study, the women did place a high value on family and other social networks. It appeared that most women gained positive effects from family support. However, others remained cautious of asking for too much help because people were already busy, and/or did not seem interested in the problems of an aging relative.

Lack of social support is recognized as a risk factor for poor outcomes following bereavement, with mixed results as to whether women experience more difficulty than men in adjusting to life after the loss of their spouse (Caserta et al. 2009). Findings from the “Changing Lives of Older Couples” study indicated higher levels of social contact and support can have a positive effect on the bereavement process. (Ha and Ingersoll-Dayton 2011). It was also found that social participation was a complex factor and the perceived need for various types of support could vary over time. Linked with this finding was that some women may prefer to rely on established networks of friendships and informal support structures (e.g., activity based groups), rather than beginning a new relationship with formal structures (e.g., widow support groups) (Scott et al. 2007). The results of the current study add weight to the knowledge that women have a need for social relationships...
and support over a long period of time but they may adjust the type and amount of each as they grow older.

The third theme reported by Feldman, Byles, and Beaumont (2000) of financial and structural concerns continued to be reported over time by women in the current study, with comments concentrating on having sufficient funds for managing health and paying for private health insurance and housing arrangements. In our findings, women often reported they independently managed their home for many years without significant assistance, which concurs with the findings of Bennett et al. (2010). Women reported worry about the ultimate decision to move, whether that was moving to a smaller dwelling or relocating away from their usual community to be nearer family. These concerns embraced financial and social matters and were often not separable. A recent study by Mackenzie, Curryer, and Byles (2014) supports the notion that homes and neighborhoods can be considered as support mechanisms in themselves, and that changes to an older adult’s living situation can affect their overall aging experience. Many women reported driving until quite a late age, and not having this option available exposed a number of difficulties in terms of transport requirements for medical appointments, shopping, and attending community events considering they had no spouse to assist.

A key commentary across major themes in the current study was that of “coping.” Future work could examine in more detail matters surrounding women’s coping processes and coping resources over time, particularly in older age. Stress and coping as contextually embedded processes would be expected to change over time. Studying the methods women use to identify and make use of coping resources can further our understanding of how women help to craft a more positive aging experience.

**Limitations**

Women in the 1921–1926 cohort of the ALSWH who recorded free-text comments had certain socio-economic characteristics, such as higher education, better physical health, and social functioning (Rich, Chojenta, and Loxton 2013). In the current work the authors analyzed free-text comments from women who had been widowed for 5 years or less; therefore, these facts plus the potential for participation bias in the ALSWH may mean that the comments reported did not fully represent widowed women and the depth of their experience and thus may not be generalizable. Also, because of the use of secondary data, the researcher had no opportunity to direct questions to participants who wrote comments for further clarification. Additionally, the open-ended nature of the question to which written responses were provided did not prompt all women to write responses (Rich, Chojenta, and Loxton 2013) and specifically
may not have prompted women to write about their experiences and changes in their perceptions since becoming widowed. Future exploration of targeted topics via free-text comments could be achieved by adding semi-structured questions to a survey, so that responses would be more “directed.”

**Strengths**

Access to the same group of ALSWH participants as described by Feldman, Byles, and Beaumont (2000) added considerably to earlier findings of how older women experience being a widow. The involvement of one of the original researchers from the earlier study also enabled the authors of the current study to have expert input during qualitative analysis. Thematic analysis facilitated a systematic approach to data analysis, particularly given the diverse subjects written about by the women, and allowed for both deductive and inductive approaches to code development. The sample size available for analysis was sufficiently large to give substantial insights into the lived experience for widowed women aged 70–90 years. Moreover, the element of time was introduced through the analysis of free-text comments, and comparison of categories and themes, over a 15-year period, enabling researchers to make sense of how older women experienced being a widow, together with issues of growing older more generally.

**Summary**

Through this work the authors deepen our understanding of experiences of widowed women through the analysis of narrative provided over a 15-year period. Original themes of health, social relationships and support, and financial and structural issues continue to be dominant issues for widowed women as they age. The experience of being an older widow is not homogeneous, and coping with spousal loss can involve health and relationship transitions and finding strategies for accessing resources and meeting new support needs. Findings from this research can inform stakeholders, service providers, and support networks whose role it is to plan and implement appropriate care and interventions for this large sector of the population. Moreover, best practice literature is scarce, particularly for working with existing written narrative when collected within the context of a longitudinal study. More of such work is required to provide more representative, generalizable insights into the experiences of this growing population.

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**References**


4.11.3 Summary of publication

The publication allowed further understanding to be developed regarding the main issues faced by older Australian widowed women, with the added knowledge gained from data gathered over 15 years. The journey for every woman presented unique aspects along with commonly occurring events and responses. The breadth of experience was reflected in the findings. Not every woman reported the same issues. However, there was a sense of a ‘generational voice’ that could be heard. These women had life experiences over significantly changing times. They were forthcoming as to how three key issues impact their daily lives and associated decisions. Managing their health was the most important issue to them. Despite challenges, there was an overwhelming presence of determination and persistence for women to participate in an active and healthy lifestyle, for as long as possible. They reported they valued the social support from family, friends and the wider community. The way the support was needed, in frequency and intensity, changed over time, according to altered circumstances. Financial concerns were a key issue for many women, particularly regarding health costs and the difficulties associated with paying for private health fund membership. Finally, financial concerns impacted the manner in which they could choose the type, and the location of housing that best suited their needs as they aged.

4.12 Conceptual model for ageing well

The literature presents many models that represent the interactions of concepts that relate to the ageing process. In many ways they are well supported by research, most have a broad frame of reference and they attempt to capture key messages and important criteria. As described earlier in this thesis (section 3.2.4) one of the distinguishing features of the concept of ageing well is that it has a focus on the opinions of those who, over time, are describing their experience of ageing. It is these contributions that this current study is aiming to understand better. In keeping with the aims of this current research the term ageing well was selected as the term that would best represent the findings of the study.

The published paper, presented in section 4.11, followed up on the past findings of three themes that were described as being of particular importance to women as they aged. Although the findings from the following 15 years resonated with the ongoing importance of the three main issues (health, social issues and financial and structural issues), the data from the 162 women was already seen to be rich with many other important areas of relevance to
the women in their experience of ageing. The depth of findings from the first study gave support to the development of the subsequent studies. The knowledge gained from the early analysis strengthened the design and methods that were applied to ongoing research.

Ageing well also seemed to resonate with the past experiences of the researcher when working among older women. The women the researcher had met acknowledged the stressors in their lives. They had spoken of the response of stress they so often felt. They had been forthcoming in describing resources that they knew they had available and sought to use to counter stressors. For many of these women, the result of their response to stressors, and their use of resources was that in their opinion they were ageing well. The women were aware things could be improved if necessary, and were open to learning more about how they could contribute to a better outcome. They spoke with thankfulness and appreciation of the people who supported them. These experiences the researcher had with older women were echoed in some of the studies that have been reviewed in this chapter.

Taking together the findings from the literature, the findings from the first study conducted, that was published (section 4.11) and the researcher’s 40 years of experience working among many women, a conceptual model was developed. The model showed relationships that were thought likely to be seen between stressors, resources and outcomes. The conceptual model included the concepts contained in the salutogenic framework. Consideration was also given to potential contributing concepts to the process of ageing well.

The literature presented findings concerning significant challenges during the later years of life. Examples were given concerning the loss of a spouse, and significant other people within the network of older people, understanding that more women than men would experience the significant disruption of spousal loss. Other examples related to stressors associated with ageing itself, with health, social and financial issues. Along with commonly described challenges, was the description of the benefits of multiple resources, both internal, within the person, and external, involving people and organisations, that offered support to enable the process of ageing to be managed in a positive and health promoting manner. Some examples of commonly described resources were social resources, positive disposition and locus of control. The resources that were identified were thought to contribute in differing ways, and various times, to the three main concepts that support the orientation of a SOC. In turn, the orientation that allows people to view their lives as being comprehensible, manageable and meaningful, is likely to contribute to a process described by people themselves as ageing well.
which is described by women as including element of subjective well-being, quality of life and social engagement.

The conceptual model (Figure 4.12) that was developed portrays potential interactions between key concepts that have been identified in literature, in previous research and from experience working within the ageing community. In addition, the salutogenic framework that was used had been found to be supported by sound theory, and by findings from a wide range of studies. It is acknowledged that just as the group of people experiencing ageing are heterogeneous, so too are their experiences. However, it has been thought that there is also sufficient commonality within these experiences that can be analysed and the findings reported in a meaningful way. As a result, there can be a deepening of the understanding regarding how older women in Australia experience ageing.
4.12.1 Applying the conceptual model to the findings

All the comments available for analysis were contrasted against each of the concepts in the conceptual model. Consideration was given as to the goodness of fit regarding the concepts, and considering the operationalised definitions that had been taken for each concept. Also, thought was given as to how all the concepts may have related to each other, how they were described by individual women, and between women, and how they incorporated change over time. It was anticipated that taken with the results of the literature review, the development and application of the conceptual model would provide a useful structure around which to
build further understanding of how older Australian women may experience ageing. In addition, the model was used as a ‘lens’ through which to structure data analysis. The following section describes the process of considering the analyses with respect to the overarching themes of stress, SOC and resources and ageing well.

**Stress:** There were six concepts identified which contributed to stress: caring, spousal loss and widowhood, bereavement (other than spousal) and other significant life events, ageing, health issues, social issues, and financial and structural issues. In this way, all comments from all women in each sample group were read through in their entirety six times at a minimum, with numerous iterative excursions between the comments of various participants, in order for the process to be conducted thoroughly and systematically. The comments were considered as to how the content, relating to stressful events and forces were reflective of any type of stress reaction.

Salutogenic theory is based on an acknowledgement that challenging events, situations and forces, occur for all people, at various points of time in their lives (Antonovsky, 1979, 1987). Stressors are taken to be the forces experienced (Lazarus & Folkman, 1984) that causes an emotional and physical reaction in the body of stress (Schneiderman, Ironson, & Siegel, 2005). Not all stress is considered detrimental, although irrespective of the positive or negative nature of the force, a response is demanded. It is the perception of the stressor and the potential ways people can manage their reactions that are fundamental concepts regarding the impact of stressors and stress on how people may report their subsequent health and well-being (Holtslander, Bally, & Steeves, 2011).

The comments were read and applied against the most basic concept of the salutogenic framework, that women would have experienced stressors and stress in their lives (Antonovsky, 1979). How they may describe their own perceptions of these stressors, how they reported managing their responses to the events, and what they have interpreted as stress, was an important first step in the treatment of themes in the text, as all the comments were read.

The intent was to separate the references to stressors and stress where possible. In addition, the relationship between the two concepts was sought. Types of stressors, both positive and negative were sought, the degree of impact they appeared to have on the women, and relative lengths of time that they were felt were considered important. The reaction that women described, in the form of feelings of stress were also sought, in addition to how they managed
their reactions. If the stressor was noted to have occurred over time, either in a continuous experience (for example a chronic illness), or in the form of a discrete event (for example the death of a spouse or close family member), the way the women reported their reactions may have varied. This was recorded for comparison purposes, within individuals and between women, over time.

All comments were kept in their chronological order and context in order to preserve the meaning judged to be true to the intent of the participants. Patterns of similarity were sought to add weight to how a group of women of the same generation may describe stressors that were unique to their cohort. In addition, comments that reflected infrequent, unusual, and ‘out of the normal pattern of the cohort’ were equally considered as being valid and valuable to the woman who had made the contribution.

SOC: has been presented as being a central concept to understanding salutogenic theory. It is the inclination that people have to manage stress, using GRR’s and SRR’s, and create health, which in turn can promote a better experience of ageing (Antonovsky, 1987). People are said to move on a ‘continuum’ whereby health (health/ease) is at one end and total breakdown (dis/ease) is at the other end (Antonovsky, 1972; 1979; Mittelmark et al., 2016). A high SOC will mean that a combination of three key resources are present, including: making sense of (comprehensibility); control (manageability); and finding meaning within their lives (meaningfulness). People with a high SOC can identify and use the available resources to move towards creating better health for themselves. While SOC is undoubtedly a key concept in the salutogenic model, it is acknowledged that it is not a complete understanding of all areas concerned with subjective and social construction of health. Other contributory factors include the conscious and active decisions people make to minimise health risks by engaging in behaviours that promote good health such as participating in regular exercise and eating a balanced diet (Faltermayer, 2008). The construct of health and health behaviours are multi-dimensional and dynamic. Specific behaviours integrated into the overall orientation that people apply to their lives as they deal with stress, including significant life events (Lezwijn et al., 2011).

Ageing well: Antonovsky (1979) contended in his salutogenic model, that people who had access to, and the ability to use, appropriate resources to manage stressful experiences were far more likely to be also able to report that they felt they were healthy and doing well. The conceptual model that was developed after reading and reviewing the current literature on
ageing had six concepts that were proposed to be potential contributors to ageing well. They included: subjective well-being, objective well-being, physical function, quality of life, social engagement and cognitive function. All comments were read through six more times, each time with the specific ‘lens’ being used that sought evidence of each one of these six concepts (that is, the proposed contributors to the process of ageing well). The same approach that was used in the first analyses, which was to read all comments in chronological order for each participant, was taken. Comments from each woman were compared for each survey at which she commented, and then comparison of comments was made between the participants.

4.13 Chapter summary

This chapter has systematically presented the methodology that has underpinned and guided the design and conduct of this thesis. The source of the data that has been analysed has been fully disclosed and the participants for the study have been described, along with the reasons for making the choices regarding the sampling groups. The methods that were used to carry out the study have been outlined explicitly, in order for the trustworthiness of this qualitative study to be best presented for evaluation.

A paper that was published with the findings of the first study was then presented, with a report on the main themes that were described as being important to women as they age. Following the extensive literature review that was conducted (chapters 2 and 3), and taken together with the findings from the first study, a conceptual model was developed and was presented, with the chapter concluding with a summary of how the model was proposed to be applied to the data.

4.14 The next chapter

The next chapter presents the first of the findings chapters. Stressors have been discussed in Chapter 2, as defined by salutogenic theory, as occurrences common to all people. As such people have to find ways to adjust their response to the forces that are imposed upon them. The nature of stressors that are experienced by older Australian women are reported in this next chapter.
4.15 References


5 Findings about Stress

‘It’s not the load that breaks you down, it’s the way you carry it’ (Lou Holtz)

5.1 Introduction

5.1.1 What is stress?
Stress is a phenomenon that includes many different forces, often detrimental, experienced by all human beings. It is present across time, culture, gender and age (Antonovsky, 1979). Stress has been defined for the purposes of this study, as a state of mental, physical and emotional tension that is felt in the body as a reaction to stressors (Lazarus & Folkman, 1984). Stressors, in turn are defined as forces and events that result in adverse or demanding circumstances that can result in stress (Schneiderman, Ironson, & Siegel, 2005). Examples of stressors are bereavement, financial and health issues, conflicts, trauma, significant events and emotions, any of which could affect the lives of people reporting their occurrence (Holtslander, Bally, & Steeves, 2011).

Stress can influence physical, mental, spiritual and emotional aspects of all human life (Seib et al., 2014). More specifically for this study, stress has been studied in relation to older Australian women. The reaction of stress can be perceived in various ways by different people, and represents the balance between stressors and the resources people require to manage them. It is the tension between stressors and resources that can create salutogenic, pathogenic or neutral outcomes (Wennerberg, Eriksson, Danielson, & Lundgren, 2016). Stress may be observed and conveyed in numerous ways, even by one person, due to their unique and varying reactions to a wide range of experiences that may occur over a life course. A salutogenic approach promotes an understanding of determinants that may be used over time to strengthen the way people adapt to challenges of specific life events and to the experience of stress associated with the process of ageing (Lezwijn et al., 2011). A stressful occurrence reported earlier in life may be perceived differently later in life, even if the situation in itself was similar. For example, a mother may write about dealing with illness in small children, when she is young, in a different way to how she may write when she is older about the experience of illness in an adult child.
5.1.2 Stress in relation to the theory of salutogenesis

Salutogenic theory proposes that it is important to maintain a focus on the resources people have to create health, even in the midst of stressors (1979, 1987). Even when stressors are extreme, many people have the ability to mobilise their resources and thereby contend with the tension that such challenges can place on their lives (Lindstrom & Eriksson, 2005). According to salutogenic theory, not all stressors are harmful and not all exceed a degree of routine stimulus, although it may be difficult to ascertain when the demand of a stressor unduly taxes the resources that are available to the person involved (Antonovsky, 1979). As they age, women will experience multiple stressors as forces in their lives. The nature of these will vary for the individual, as will the degree to which these occur and the length of time over which they may be felt. However, whatever the specific events are for each woman, stressors will cause altered states of tension, that are perceived as reactions of stress, and these will require effort and resource to manage. Lack of resource(s) (GRD’s) that could ameliorate the tension associated with stress termed may cause a movement on the health continuum away from the health/ease end towards the dis/ease end. How far the movement is on the continuum will depend of the relative strength of available resource(s) when compared to the deficits of resource(s) (Antonovsky, 1993).

5.2 Research aims

The aims of this chapter are to examine women’s comments in terms of how they describe stress and its effects on their lives. In particular, the specific objectives are:

1. To identify stressors experienced by the participants;
2. To identify the manner in which the participants reacted to stressors;
3. To deepen the understanding of how the experience of stress may alter over time and with respect to differing marital status.

5.3 The concept of GRD’s

Antonovsky proposed that in a similar way that health could be portrayed as a continuum, whereby movement continually could move towards health/ease or dis/ease, so indeed could the idea of resources and deficits be captured as a unified concept but ranked also on a continuum. Further, Antonovsky added that the higher that a person is on the continuum of
resources (e.g. wealth, identity) the higher the likelihood of a stronger SOC. Conversely, the lower a person is on that same continuum, with greater deficits in the pool of potential resource(s), the weaker their SOC is likely to be. (Antonovsky, 1987).

Contrary to the alternative and more widely accepted paradigm at the time of his early research, stress was not an aberration of normal life to be feared and, where possible avoided. Indeed, stress was to be expected, although frequently the experience is not something people seek to encourage. Stress introduces tension into life experiences, by increasing a state of unpredictability, inconsistency and/or insufficiency or even exclusion in involvement with decisions that relate to a person’s life choices (Antonovsky, 1987)

Antonovsky had found many of the women who had participated in his research on menopause had also survived the holocaust of WWII. He recorded that they showed remarkable ability to recognise and utilise resources to deal with adversity, to develop strength of character and positive life experiences despite the stressors they had known (Antonovsky, 1979). However, it was also true that for some women there had been insufficient awareness of, inability to use, or lack of sufficient resources to counteract the tension caused by life stressors. The term GRD describes this lack, and makes possible movement towards the dis/ease end of the health continuum more likely.

Stressors that were identified for women in the current study included caring, spousal loss and widowhood, bereavement (other than spousal) and significant life issues, ageing, health issues, social issues, and financial and structural issues. The findings for each of these stressors are described below. Not all women were included across all findings. For example, the widowed women from group 1 did not make a comment about a living spouse, although retrospective comments about their relationship, leading up to his passing were considered in later sections such as dealing with spousal loss.

5.4 Findings

For every woman participant, their experience was unique, and the way they recorded their interpretation of life’s events reflected the nature of each individual. There was however, a general consistency in the patterns of stressors that were identified. The findings reported the challenges women described in their lives, from the perspective of how these were seen to
alter over time as they aged, and between the three groups, early widows, late widows and those who remained married.

5.4.1 How women describe stress

In common language, it was seen that the women often used words describing stressors and stress interchangeably. For example, many women wrote phrases such as ‘I was stressed because of…’, and then described an event or interaction. A phrase such as this encompassed both the stressful force, for example, a health challenge, and the reaction to the force, such as anxiety or sadness as a result of the challenge. Subsequently, part of the analysis was to identify whether the woman was describing a stressor, being the nature of the force or event being experienced, or whether she was actually describing the reaction she felt, and acted upon, following the occurrence of a stressor. It appeared that within one quote, both aspects could be described. These two aspects were identified and recorded separately where possible. Full quotes, or extracts of quotes, were kept in context so that the most accurate and consistent representation and interpretation could be made when reporting the findings derived from the women’s comments. For example, one widowed woman who described her experiences of stressors, which included the prohibitive cost of private health cover, wrote:

“I am a 70 year old widow, and ever since private health insurance came into being my family belonged to (name) fund, but now as I am on an old age pension I have had to give it up as on the pension I found it too hard to keep up (the payments)” (S1/EW).

Subsequent to the tension created by her financial situation was her reaction to this stressor, and this was described in the second part of her comment:

“…. So now that I am not in the private health fund I have to wait if needing an operation. I think this is very worrying. Having been in the scheme for so long I find it a little hard to cope with this difficulty” (S1/EW).

Table 5-1 lists key terms and the main stressors that were seen to contribute to stress and the operationalised definitions that have been taken for the current study. Examples of quotes are given, which illustrate the presence of that concept in available data from the six surveys, and from each of the four groups of participants (early widows, widowed at Survey 4, widowed at Survey 5 and married).
<table>
<thead>
<tr>
<th>Source of stress</th>
<th>Definition</th>
<th>Example of quote according to sample group</th>
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<tbody>
<tr>
<td>Caring for spouse</td>
<td>The state of offering assistance in an area of need to maintain living with some independent arrangement at home to the partner with whom the participant lives in a legal marital state as recognized by law</td>
<td>Early widows (EW): My husband is home and he can still help at times. He is 78 and has age problems, I assist him a lot but so far we manage ok. (S1)</td>
</tr>
<tr>
<td>Spousal loss and widowhood</td>
<td>(i) Death of husband</td>
<td>In the meantime, the husband of 58 years, whom I still miss, has gone (I think he thought I would go first, love him) 84 years (S4)</td>
</tr>
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<td></td>
<td>(ii) Is defined as the social state whereby a woman identifies that she has experienced the death of a spouse and has not remarried or taken up a formalised union with another partner.</td>
<td>(ii) Most of the time I keep well but I missed my late husband still after five years. Being widowed twice took me a long time to get my act together (S2)</td>
</tr>
<tr>
<td>Source of stress</td>
<td>Definition</td>
<td>Example of quote according to sample group</td>
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<tr>
<td>Bereavement (other than spouse) and significant life events</td>
<td>Defined as including significant events that occur over the life course that cause stress (positive and negative), including bereavements but excluding the death of a spouse. Note: If person notes an event as significant or traumatic it will be taken to be so with no further challenge made to the statement, as for that person that was their reality.</td>
<td>Early widows (EW): I cared for a friend (time period) who has since died of (condition). It was a most difficult and stressful time; our friendships spanned (number) years, and she died at the end of (date) (52) Widowed @54 (LW/2a): Unfortunately, two days after I arrived my (relatives) and I were in a head on car smash so it was a disastrous 5 weeks holiday. I had (number) fractured ribs, a fractured sternum, who is and seat belt damage which resulted in lumps in my right breast. my brother who was driving the car died a few months later (54) Widowed @55 (LW/2a): After his (husband's) death a truck backed into the back of my car, with such force that I was injured with a whiplash injury to the neck where I had permanent damage from another accident (number) years previously (55) Married (M): I have had trouble sleeping since my sister died last (month) and feel anxious and worried sometimes (54)</td>
</tr>
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**Aging:**

- **Two dimensions:**
  - (i) A process relative to time
  - (ii) The answers I have given relate to someone my age e.g., I have rated my health as good whereas...

(i) I think I'm doing OK for my age 79 (54)

(ii) The answers I have given relate to someone my age e.g., I have rated my health as good whereas...

(i) But at 72 I make the best of the years left, do what I can when I can and if I can (51)

(ii) When I look around and see other people my age I feel very...

(i) However, I still enjoy the wines! Doctor says not to worry. It's common the older we get (51)

(ii) Naturally, due to my age, I am gradually tiring easier, but then I...

(i) Also, as I am now in my 70s, my activities are less numerous (52)

(ii) I see older people with failing health, failing eyesight, hearing and mobility. I do not want to be
<table>
<thead>
<tr>
<th>Source of stress</th>
<th>Definition</th>
<th>Early widows (EW)</th>
<th>Widowed ≥ 54 (LW/20)</th>
<th>Widowed ≥ 55 (LW/2b)</th>
<th>Married (M)</th>
</tr>
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<tbody>
<tr>
<td>(ii) A state relative to others (either younger or older than the person concerned). We are always older than some/younger than others. We make comparisons between how we perceive our state to be with respect to that of another.</td>
<td></td>
<td>in the overall community I don't think it would rate that well. (S1)</td>
<td></td>
<td></td>
<td>see other people in my age group with severe disabilities I feel very blessed and hope to wear out and not rust out (S2)</td>
</tr>
<tr>
<td>Health issues</td>
<td>Experiences or opinions about physical/emotional, psychological/cognitive and/or spiritual health</td>
<td>Implants for R &amp; L eyes after cataract removal.</td>
<td>Mastectomy [date]. Second issue is that I fell on footpath down the street on [date], went to hospital in ambulance suspected fractured hip but luckily only badly bruised after X-ray and cat scan. I had the meals on wheels and physiotherapist coming for XX weeks. I have had XX hypox with my diabetes in 4 years.</td>
<td>Just before my husband died I was having a lot of trouble walking &amp; a scan showed that I have blocked arteries 75%. I have since had to have balloons in my left leg &amp; am walking better now. I do 1/2 hr on treadmill every day. The problem I have with stairs is because of arthritis in my other knee (S4)</td>
<td>I have psog and rheumatoid arthritis, I have also had DVT’s. I see a cardiologist for management. I try to strengthen my legs by going to hydrotherapy (S5)</td>
</tr>
<tr>
<td>Social issues</td>
<td>Defined as any matters that entail a challenge or tension that relate to relationships, roles, responsibilities, assistance required to manage life and</td>
<td>Unfortunately since husband’s death in [date] next door neighbour [who I try not to come in contact with] has harassed me</td>
<td>Due to caring full-time for my invalid husband (kidney failure - Dialysis) I can’t enjoy social activities at all (S3)</td>
<td>Due to caring full-time for my invalid husband (kidney failure - Dialysis) I can’t enjoy social activities at all (S3)</td>
<td>We are trying to juggle managing our home. Don’t want to say too much to our children as they might think we are not coping. On well,</td>
</tr>
<tr>
<td>Source of stress</td>
<td>Definition</td>
<td>Example of quote according to sample group</td>
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<td></td>
<td></td>
<td>Early widows (EW)</td>
<td>Widowed @54 (LW/2b)</td>
<td>Widowed @55 (LW/2b)</td>
<td>Marrieds (M)</td>
</tr>
<tr>
<td>Interpersonal</td>
<td>It's interactions between family, friends, and/or support networks in the home or community</td>
<td>leading to council intervention on my part - hence another reason for moving (S1)</td>
<td>we could get some help in with cleaning and those kind of jobs (S4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial and structural issues</td>
<td>Are defined as any matters that relate to any monetary issue e.g. income, expenses, bills to be paid, ability to pay for any item, inability to pay; Any matters that relate to housing e.g. selling and relocating; Any matters relating to travel and matters concerning community accessibility</td>
<td>I think pensioners are very badly off, especially if they are on lots of medication (S3)</td>
<td>At present I am living with (name), my younger daughter, having sold the house at (suburb), and we've been looking to buy something together. But what a headache this is proving to be - prices the way they are! I'm nearly 80 now and don't know if I'm doing the right thing. (Name) has been renting this house with two other people (I'm one of the two now) and has been in the area for XIX years and would prefer to stay in this part of (capital city) (S4)</td>
<td>...There is not near enough financial assistance for the old to remain at home in rural areas (S4)</td>
<td>We cannot afford to go out much. So we keep in touch by phone calls and letters. At least they are cheaper!! (S1)</td>
</tr>
</tbody>
</table>
5.4.1.1 Caring for, and other issues about a spouse

The groups who contributed comments for this stressor included later life widows and married women. Both groups of women wrote about caring for a spouse who was frequently said to be increasingly frail. Apart from needing to manage most, or all, of household tasks women described the challenges of physically assisting their spouse. They used phrases such as ‘I have to help him wash and dress now’ and ‘he needs help to move around the house’. One woman described how the added workload impacted her:

“I have nursed my husband through cancer until (date) when he passed away, aged 89, after a two year battle. My health suffered mainly from tiredness and stress ...luckily I was nine years younger than my husband, so was able to cope with the workload of caring for him, helping him shower, and his personal needs... and that sort of thing; I am pleased I was well enough to nurse him at home until almost the end” (S4/LW/2a).

Many women expressed that their husband had a ‘need for constant attention, day and night’. The impact of this meant that women often wrote that they were ‘sleep deprived’ which then affected their health, as two different women commented:

“…but due to the fact I am a carer for my invalid husband, who amongst many medical problems, and is now in advanced Parkinson's disease with some dementia, keeps me awake most of the night, he sleeps most of the day; He leaves a light on all night and keeps asking ‘what is the time’? I get so tired so I try to have a sleep during the day when I can, even though I did not ever like to sleep during daytime before this” (S3/LW/2a);

“Since the last survey I feel I am feeling much better since my husband passed away. Although my depleted immune system, after caring for my husband for 9 years, with not a lot of sleep, has caused me to pick up all sorts of viruses, such as colds, coughs and worst of all a cold sore on my eyeballs” (S4/LW/2a).

The need to be available ‘24 hours a day’ to assist the spouse at home, meant that women then suffered the loss of engagement with external social networks. The women commented on the ‘loss of social life’ during this time and also many expressed sadness that they were not able to continue hobbies and volunteering activities in the outside community. Over time, as
the period of assisting the spouse lengthened the awareness of the strain of care was heightened as this woman wrote:

“...And my partner who is now 83...has become very deaf, feeble and inactive. I have been caring for him for some years now. He cannot remember things much now, and the doctor said I can no longer leave him alone. I feel my life is only half over and I should be doing many more activities and interesting things” (S2/LW/2b).

Some women described that they needed to be at home to help manage medical procedures such as dialysis and wound care. Women who became ‘housebound’ at this time wrote about the ‘lack of time to have any sort of social life’, ‘no hobbies now’ and being ‘unable to do charity work’. From two women came these comments:

“...I was normally very active (with hobbies like knitting, sewing and other craft activities) but due to my present situation I cannot do what I used to do - which I hate” (S3/LW/2a);

“Some of my answers may seem like I am not involved in anything, but since my husband first got sick I had to give up everything which I was involved in. Church, bowls, friends & entertainment. So I hope this will help explain some of my answers about not being involved in activities outside our home” (S4/LW/2b).

Although most women wrote about ‘loving’ their partner of so many years and being ‘happy to be able to assist him’, the strain of providing care was exacerbated particularly where marital relationships were not so harmonious, as this woman wrote:

“Since Christmas, my husband, 82 years, has had two serious lung infections and after hospitalisation and a spell in respite care (from which he discharged himself) I was under acute strain looking after him. I am an untrained nurse, car driver, cook, housekeeper and general dogsbody to him. He is most ungrateful, selfish, abusive and cantankerous. This is my current life. Because of all these problems I have to deal with, my interests & activities are somewhat curtailed currently”(S3/LW/2a).
Many women described being emotionally distressed when coping with the experience of watching their life partner deteriorate. At times they also expressed that they missed the company and communication they had enjoyed over the years. This was said to be either because of a cognitive decline the husband had lost the ability to use words with which to communicate, or, although the brain retained cognitive function, another disease (such as Parkinson’s disease) had robbed them of the ability to speak. The following comments illustrate these problems:

“He suffered terribly with advanced Parkinson’s disease and other complications, he couldn’t speak but his brain was as clear and clever as always” (S4/LW/2b);

“Difficult to answer ‘emotional’ questions. Lately I have felt very sad (not depressed) and this is because of my husband’s mental and physical deterioration, not on account of my own health” (S4/LW/2b).

In order to cope with the stressor of providing care, women acknowledged that as time passed they could only continue to care for their spouse at home if they had increased support. This may have been needed in the form of medical and community assistance (for example with physiotherapy or nursing visits to the home), and/or it could have been expressed as a need for more family involvement in assistance in personal care or in home maintenance jobs. One woman, who had numerous spinal surgeries herself, wrote: “It was hard to nurse him and I needed some help to lift him and care” (S4/LW/2a), while another contributed:

“My husband of nearly 59 years has developed a condition known as (name) over the last 2 years (age 86). He has been a wonderful husband, provider all our married life but now into my turn to take over as his carer. This means I have now to care for both of us with great help from children, grandchildren. His brain is not affected so much as his body has become. Needs help with everything” (S4/LW/2b).

As the women aged and approached their late 80’s and even 90’s, having a frail spouse at times required expending more physical and emotional energy than could be sustained in order for the couple to remain living together in their home. In their later surveys, women referred more frequently to a husband being in care at an aged care facility. This introduced
the descriptions of the stress surrounding such a decision, with the attendant feelings of guilt and sadness, as can be seen in these comments from two women:

“I have nursed my husband for about six years with dementia. I feel so sad but unfortunately (number) months ago, owing to my declining health, he had to go into a high care nursing home where I visit him every other day” (S4/LW/2b); and:

“The last three years have been extremely stressful with my husband being diagnosed and finally dying as a result of both Alzheimer’s & Parkinson’s disease. It was difficult to deal with feelings of guilt about having to have him in a nursing home for the last six weeks of his life” (S5/LW/2b).

Married women described some different experiences regarding the stress associated with making choices regarding the most appropriate forms of accommodation. Some women described living in separated accommodation as one of the most difficult aspects to deal with in their later years. Given that the women who remained married throughout the ALSWH surveys had been married 50 years or more, the challenges associated with having to make choices to live apart, having ‘been together for so long’, lent added poignancy to reflections such as this:

“My husband has had to enter an Aged Care home which has been a great worry to me to see him as he is. He has memory loss and Alzheimer’s. I am now living on my own, which I have never done before. My husband and I have spent 65 years together, - and just lived for each other, so my life now is so lonely, and empty. I dread seeing him deteriorate. I am trying to be brave but it is so hard!!” (S6/M).

Within the married group there was a more obvious pattern of emerging stressors as the couple tried to maintain living together, with independence, in their own home, despite added challenges associated in maintaining this desired outcome. Pressure could mount over potentially many years of additional care that may have been needed for the spouse. This stress, possibly combined with the women’s own well-being issues as they aged, meant that women had to be able to cope with a need to source and accept help as needed, as this woman wrote:
“The only thing that changes my lifestyle is that my husband, after over 10 years of strokes is now very frail and needs full time care. Thanks to our son and his son (We still live on our farm) he is able to continue to live at home. (Name of organisation) is calling at present to dress an ulcer on right leg. As this is a dairy farm, there are always animals I care for and always a diversion. Consider I have the best of all worlds. What I miss doesn’t bother me. Still enjoying sewing, reading, family history and the reading of social history back to 1500 odd. Have a garden, friends and relatives in (countries) to correspond. Always wake early - for years never awoke any later than (time) (one has to round up the herd). Mostly I have to sleep with one eye open and I usually hear husband if he calls or rings his bell” (S3/M).

For married women, there were many references to the adaptations they had to make to ensure that they could continue an ‘independent and active’ life together. This could be that if one partner of the couple needed help with some aspect of personal care at home, then both partners had to be open to finding workable solutions. Women wrote comments such as ‘I can no longer do chores’, or ‘my husband cannot help me at this stage of our life’, and if not resolved, this stress could lead to the need for significant change to be managed, with a more appropriate housing choice required.

There were some married women whose comments revealed a different perspective in that they were being cared for by their spouse. Stressors had occurred in the form of health challenges (physical and/or mental health issues) and changes had to be made in order for the couple to remain living together. Women in this generation would have usually been more familiar with being the carer, and the role reversal was often challenging in itself. Women said they were ‘so used to doing things myself’ that having to accept help was not an easy choice to make. Some wrote comments such as ‘I will have to allow my husband to help me if we are to stay in our home’ or ‘I will have to accept help’ so that other changes to living arrangements can be delayed. The women who described needing help from their spouse did not add comments that indicated that their spouse felt that the situation was negatively impacting on him. Rather, there were comments that revealed that although there were challenges, and it was not always easy, the spouse was said to say of his wife that it was his ‘privilege to help care for her’ and she has always ‘cared for the family and others’ and now it was her turn to be ‘on the receiving end of help’.
Another group within the married participants, described that as time passed there was stress that accompanied becoming aware of gradual decline of the spouse, with potential changes being required, and forward planning needed to adapt to the health issues that arose that impacted on independence. Women wrote ‘I don’t want us to have to be separated’ or ‘I hope we can manage together here at home for at least a while longer’ and even more poignant expressions such as ‘it (i.e. living with husband) is the only life I can remember for so long now’.

Some women from all marital groups made reference to the stressors that were experienced as a result of their spouse being a veteran of military conflict. The advice given to veterans of WWII when they returned from overseas active duty and re-entered civilian life, was different to the advice and support given to later, and indeed current, veterans who leave the armed forces. Women wrote that their spouse said that on discharge from the services they were told ‘do not talk about the war again’. Many men ‘did not share details’ of their war experiences with their families and were usually offered no support and assistance to manage their psychological issues beyond the help extended to recovering from their physical injuries. Women wrote of the men having ‘periods of blackness’, ‘dark rages’, and episodes of ‘anger and despair’. They included comments about their husband’s ‘excessive drinking’ and ‘gambling’ which the women usually attributed to not being able to deal with ‘what they had seen when at war’. Women did describe that the services offered to their husbands by DVA did strengthen, and become more accessible as the men aged. In later surveys the references to the stress associated with being a family with a military service background lessened, and the references changed to there being support from DVA for the men if they had war-related conditions.

5.4.1.2 Spousal loss and widowhood

The women who contributed comments to this stressor were from the early and late widowed groups. At Survey 1, many women made at least one reference to the fact that their husband had passed away. There were often subsequent more detailed references as well in later surveys. Most women additionally referred to the loss of a spouse as a ‘difficult time’, many said at the least that they were ‘happy in their marriage’, and frequently, it was a more effusive comment. For some they expressed that they never ‘got over the loss’, the depth of the emotion being seen in this comment: “Nothing has prepared me for the extent of the devastation I have felt. There is nothing as final as sudden death” (S1/EW). One woman, who had also experienced the great difficulty of losing her house in a fire six months prior to her
husband’s death, wrote that the loss of her home was “…nothing compared to losing my life’s companion. It was harder than I could have thought. We were everything to each other” (S1/EW).

There were examples where women wrote that their days became lonelier as they got older and they missed their spouse. However, although the women continued to miss their husband, they had found ways to cope by making a new life. There was first an acknowledgement that the death of their spouse often came after a period of care for him which was usually reported as being a challenging time, with physical and emotional stressors involved for example:

“My husband passed away…. after me looking after him 24 hrs a day for 10 years. He suffered with chest, lung and heart problems so I was very tired but I am getting much better now” (S1/EW).

Women often referred to this hard time though as something that they were prepared to do as part of the commitment of marriage. The relief they expressed when the stressors of physical and emotional care for their spouse had finished, was usually balanced with a re-statement about a sense of loss remaining. This woman expressed that she had used coping skills that allowed her to perceive some positive experiences in the new life she had entered:

“I think since I lost my husband five years ago I have improved my outlook on life. It was hard looking after him all the time. But now I can go on a couple of holidays each year mostly with groups but overseas holidays are with two or three lady friends. I do miss my husband and no one will ever take his place” (S2/EW).

Many reported specifically that after their husband died there was a period of grieving, heightened sense of loss, adjustment to additional requirements and challenges. At varying points in this process there were frequent references to making a recovery from the acute stage of loss and grief, and a growing adjustment to a new stage of life, using terms of recovery such as ‘I am doing much better now’ and ‘I feel more like my old self’. Two women expressed this process with these words:

“My husband died just before the last surgery, there was the usual emotions, sadness, sickness and yes, anger. Now 3 1/2 years later there is peace and I feel whole once again. There is happiness and laughter inside me and it feels good” (S5/LW/2a); and:
“Since the last survey I have been widowed after fifty eight years of a happy marriage. With my Christian faith plus wonderful love and support from family and friends I have learned to be content and make the best of my circumstances and be thankful for the good memories and get on with life and take each day as it comes” (S5/LW/2b).

Women wrote often about the fact that they had to take on the responsibility for finances and for caring for all aspects of home and business after their husband died. This was especially difficult for many, considering that for many women of this generation they frequently had not had jobs outside the home since marriage. The husband was often said to have been responsible for most, if not, all matters to do with finances. At a time when women were experiencing emotional stressors, they frequently also had to respond to the additional stressors of needing to learn how to operate in the business and financial world in a way they had not done before. Comments included hurdles to be faced such as having to ‘drive again’, ‘do the shopping’ and ‘manage banking’, and some women added they would need to accept help, at least for a period, in order to adjust to the changes.

Some women continued to refer to memories about their husband in multiple surveys in a way that combined the idea that they had embraced the new season of life without a partner, and yet expressed an ongoing sense of loss and sadness. This was particularly evident at times of anniversaries, family celebrations where the absence of the husband was felt to be especially poignant. Even though 15-20 years had passed since her husband’s death one woman wrote:

“It (the recent death of her brother-in-law) also made me remember my husband’s death and the sadness effected my sleep for some weeks but I am over it now” (S6/EW).

All women in this cohort of ALSWH had lived through WWII. Many reported the challenges they have had in being married to an ex-serviceman, who had suffered ‘poorer health’, and showed signs of stress-related conditions such as aggression, depression, and/or violence. There were references to these issues being in some way related to war service. As one woman wrote:

“Many of us married ex-servicemen whose health was not always good, but how the war affected them was not something they liked to talk about; it was a dark time for them I think” (S1/EW).
Some women reported that after the husband died issues had come to light that they had not known previously, for example ‘serious financial debts’, usually attributed to gambling. This was extremely stressful for women. However, they wrote about it as being something that they just had to cope with in trying to recover some financial stability. During the time in which they had lived without their spouse, women referred to having to make do with ‘less opportunities to travel’, reduced choices regarding leisure pursuits and/or ‘it’s harder to see family because transport is expensive’. Some wrote that they had managed with reduced help around the home due to what they referred to as their ‘financial situation’.

### 5.4.1.3 Bereavement (other than spousal) and other significant life events

Women from all three participant groups contributed comments about these stressors and how they reacted to them. The most reported events that related to this concept concerned experiencing shrinking family and social networks as the women aged. They frequently used words such as it is ‘so sad’ to be one of, or even the last member left of a family or social group. They report grief and ‘almost unendurable’ devastation if they had lost a child, or grandchild, stating that you never expect to outlive your children and/or grandchildren. Women often said it was hard as time passed to watch ‘many of my friends & family’ go through severe illness and death and that this was draining on their emotional health. One woman wrote:

> “The death of my close woman friend 18 months ago has affected me badly. We had known each other from high school, university etc. We worked together. She was my bridesmaid. I knew her longer than I knew my late husband. Her unexpected death has caused me to be uninterested in things I’d normally relish. I now feel constantly tired” (S2/EW).

This same woman, at the next survey reported additional losses of friends and family:

> “I have just been to (state) for 10 days with a daughter of an old friend of mine who passed away last year & my granddaughter came too; Then my brother died the day before I had my operation and then within two weeks another family member and two close friends have died. I am becoming stronger each week, so I hope that by the time the next survey comes I will be more active though older” (S4/EW).
One woman from the married group described a difficult journey for her family. While the details of the circumstances were unique to her, there were many others who also wrote of situations that were similar in the complexity of multiple stressors that family’s face, with unexpected challenges to be met. At Survey 3, when she was in her late seventies, this woman wrote:

“\textit{We have had considerable strain and unusual circumstances…as our eldest daughter was very ill and hospitalised most of that time. Sadly, she passed away on (date), and since then our son-in-law (her husband) has been hospitalised and had a brain tumour removed – fortunately it appears to be successful for now. As he has no family, we have been very much involved with helping him cope with his problem also. Therefore, nothing has really been normal for quite some time, and the weeks have just gone on and on. It is a terrible shock to lose our child and to see another family member in such trouble. Fortunately, our family (other daughters and sons) are very supportive and we seem to have all come through reasonably well, helping each other}” (S3/M).

To cope with sadness and loneliness as they reflect over time on having fewer friends and family members left many women write that they try to ‘\textit{fill the gap}’ in their lives by ‘\textit{trying to keep busy, healthy body and active mind}’, and by substituting the ‘alone-ness’ they felt with being involved in other activities and family relationships, using expressions such as ‘\textit{seeing family as often as I can}’ and ‘\textit{helping minding the grandchildren}’.

**Disasters:** women also reported that events in and around their homes such as burglaries, fires, and damage from storms were hard to handle, as these made them more aware of how alone they felt during the latter part of their lives. In addition, events such as motor vehicle accidents, falls and other accidents were said to be hard to cope with especially if long rehabilitation times were required following the incident, and even more so, if less mobility and independence resulted. This quote included examples of two such traumas that one woman from the earlier widowed group reported at Survey 3:

“\textit{My circumstances over the past 12 months have had a great effect on my health & self-confidence. There was severe storm damage in the town where I live and the roof was blown off my home. Water damage to my furniture & belongings. It has been in storage all this time. I’ve been living in (capital city)}
with my daughter all this time & it has been a difficult period of adjustment for us both. 2 months ago I had a serious fall outside her home on the way to the shops and broke 4 ribs. I am 78 years old with age related osteoporosis and the pain over the past 6-8 weeks has taken a great toll on me” (S3/EW).

She continued later in the quote, still at Survey 3:

“….my health & nerves over the past 6 months have suffered badly as things have not been very easy dealing with insurance companies & putting my water damaged things in storage and now trying to set up the house again. It has been like packing up & moving houses twice in the past 9 months. I am very tired and undecided about the future as I live alone since my husband’s death nine years ago now” (S3/EW).

Motor vehicle accidents that were reported were described as being traumatic and the ongoing effects were often significant, impacting transport independence at least temporarily. For some women, they did not recover the confidence to return to driving again, and as one woman wrote: “I just can’t drive and I am now depending on taxis & friends to take me shopping and to other activities” (S4/EW). Some of the married women described the effects of injuries that were sustained if both the husband and wife were involved in an accident. They wrote about requiring ‘weeks of treatment’ and ‘needing help to manage everything at home’ for some period of time while recovery was taking place.

The women were appreciative of support given by family & friends during periods where stress from one or more stressors was perceived. They were often philosophical about the stressors they faced and recognised they were a part of getting older for many people. They used words such as ‘I reasoned that this would happen at some time’, or ‘at my age things like this have to be dealt with’.

5.4.1.4 Ageing

Ageing, as expressed in the comments, most often related to either how women felt about their decline in physical function over time, or how they perceived themselves in comparison to others ‘of their age’. Some women found ‘it harder to move’ as they got older, others knew they were ‘going to get sick’, while others wrote ‘old age is not good for your health’. The phrase ‘it’s a matter of time’ was used frequently by many women, particularly on earlier surveys. Many women wrote that they felt change would occur over time, often making a
comment with a sense of inevitability such as ‘what else could I expect?’ Some felt that being
old was more ‘a state of mind over matter’. From one of the married women came this
comment about what challenges may lie ahead:

“For my age I think I am doing I’m ok …… Whilst not depressed about it I do
not look forward to getting sicker as I get older - perhaps having to leave my
home - being left a widow etc. I guess I do alright for an old lady, and my
brain is working well even though I am in my eighties now” (S4/M).

There was a sense of pride in the women’s words as they described levels of busyness and
activity, such as being ‘a fit independent 80 year old’, and doing ‘some form of exercise every
day’, with some activities being mentioned such as ‘walking, gardening, housework’. There
was also recognition by some that not all older women have ‘complaints’. The uniqueness of
the experiences of this generation of women, is seen in this woman’s comment:

“I appear to be doing very well for my age and so will many others in my age group
70-74. We are mostly a tough, resilient group, having lived through the depression
years in our childhood, World War 2 (with its worries and limitations), and our battles
to make homes, work hard and raise families over the years” (S1/EW).

However, women’s references to ‘active’ and ‘busy’ may belie their feelings of being older.
More noticeable as the women aged, there was a separation of mind and body, as one woman
expressed it: “I am now over 87 years and my brain is still very good, people marvel at it, but
my body at my age is failing” (S6/EW). The women wrote about health in terms of functioning,
and age was a stressor described as a time of deteriorating health, for example, ‘I suppose at
my age this is natural’, ‘with my age I can’t expect to improve’, and ‘83 is not a good age for
recovery’.

One common expression that recurred over time was that the women thought they ‘were
doing very well’ for their age. This was both in relation to the passing of time as one grows
older, and also when comparing themselves to others. Talk of ‘decline’ seemed to appear more
in women’s comments for those who had been widowed more recently. Women who identified
with age as a stressor wrote about it as something outside of themselves, which they had no
control over:
“I am getting slower but given that I am now 3 years older than when I last wrote to you, it only stands to reason that some changes could be seen” (S6/LW/2a).

Some women described poor health as inevitable in their future and made use of self-deprecating language (often masked in their comments as humour), such as:

“Older age is beginning to curtail activities a little as I can feel that I am slowing as I get older – the good news I can still issue orders though!” (S4/M); and:

“Who at our age could even remember what our memory may have been when we were young...so long ago!!?” (S4/M).

Describing poor health as something to expect in older age also seemed to allow the women to justify their health problems as being usual, for example:

“I appear to look reasonably well but inwardly my body is feeling worn out, due to discomfort from constant aches in many of my joints.... normal perhaps for my age.” (S6/LW/2a).

This sentiment was not as present in the comments made by married women, as it was in that of widowed women. In general, the women recognised the difference that three years between surveys can make. One woman wrote that “getting old and being sick makes one feel very uneasy. I will be interested to see what the next three years bring in the way of changes to me as I age” (S3/LW/2a).

Ageing was not described as an intrinsic stress when related to self-image, social identity or position. The women in this study did not offer comments that indicated they felt ignored and/or overlooked purely as a response to their age. At times they felt other people, particularly family, were maybe too busy to be involved with them at points of need. Comments specifically about ageing and ‘being old’, were usually related to physical function, and their relative abilities to perform certain activities. Where women commented on age, they frequently used the term as a ‘discount’ or as a comparator where they used words such as ‘pretty good for my age’ or ‘I am good compared to people my age’. It is not known from these comments however, specifically how women arrived at their opinion of rating themselves with respect to others.
5.4.1.5 Health Issues

Health seen as significant personal events: Women wrote of medical events, for example operations, and the additional stress that accompanied these. Sometimes an operation had unexpected complications and unpleasant side effects; at times rehabilitation did not go to plan, which was considered stressful. There were reports of being unprepared for the seriousness of a procedure, how difficult rehabilitation could be, and at times the women felt that education and support was lacking either pre or post operatively. One woman wrote that due to an unfortunate reaction to treatment: “My last 12 months have been like going to hell and back with all the bad things that happened in the hospital for weeks and weeks” (S2/EW). At Survey 6, one woman wrote a lengthy description of her past three years where following a fall there had been ongoing and progressive issues that she described as ‘curtailing my activity lots’. One woman wrote that despite the past 16 years of good health a serious fall meant that she was advised that ‘full recovery would probably take about six months or more’.

Health problems: The women wrote extensively about their health issues including comments about conditions, medications, surgeries, and procedures. The more commonly reported conditions included diabetes, osteoarthritis, cancer, cardiovascular disease, osteoporosis, glaucoma and the secondary effects of falls, with resultant fractures and muscle tears. Health issues had the capacity to be perceived as demanding circumstances and as such were significant sources of stress for many women.

Across time, the severity of health issues faced by some women tended to become more serious with declining mobility and independence. With age, the effects of some disease processes meant that the affected part of the body could not repair as well as it would in younger people. This was true, if for example, there was soft tissue damage following a fall. An older person may not recover full strength in torn muscles, or full movement in injured joints. Sometimes the actual disease process worsened, and as a secondary effect there was less mobility, strength and function described. This could be true, for example, in Parkinson’s disease and glaucoma. There were women who, having reported managing conditions for years, wrote how they adapted to changing needs over time. For example, if they were feeling weaker in their legs for any reason, such as arthritis in their knees, they may describe that they have begun to use a walking stick. Subsequently they often added a description of how, over time, they have progressed to need additional support for example, wheeled walking frames, then electric recliner chairs and finally at times they write about the need for a wheelchair.
There were some connections between various health issues. For example, poor vision and/or balance issues were often reported as being the cause of falls. In turn, falls could then precipitate a negative slide in health, resulting in loss of independence, or the need to manage ongoing secondary issues such as fractures and an increased need for rehabilitation centres or therapies. The experience of this woman at two survey time points highlighted this finding:

“Two months ago I had a serious fall outside (my) home on the way to the shops and broke 4 ribs. I am 78 years old with age related osteoporosis and the pain over the past 6-8 weeks has taken a great toll on me” (S2/LW/2a);

and:

“I am now 87 years old and generally speaking my health has been quite good compared to people I know of my age. Over the last 12 months I have however developed a balance problem, which has been diagnosed as age related and I have had to start using a walking stick for balance on good days and a wheel frame for bad days if I go outside the house. Inside the house I am generally able to manage but occasionally use furniture or the wall for Support on a bad day. Because of this, I have had to cut back on unaccompanied shopping trips and other activities outside the home which I now have help with” (S6/LW/2a).

Emotional, psychological and spiritual health: These aspects of health were frequently mentioned alongside that of the physical domain. It appeared that there were connections between these concepts. If the women reported physical challenges this would often have an effect on their emotions and on their sense of psychological well-being, as this woman described:

“I suffered a very bad fall in the shower 6 months ago, resulting in a wedge fracture of lumbar vertebrae. Could have been a lot worse and I am mending slowly. We have had deaths of close family members…. Including (a relative) and several more close friends, which is hard to cope with. Not exactly the best of years but I live in a close knit rural area and the support of family and friends (particularly church friends) has been absolutely wonderful” (S1/M).

Many women wrote at length as to how severely the loss of their husband had impacted on their health in all aspects. While some said they never fully recovered emotionally from such a
loss, most women said that their health improved when the stressor of caring for an ill spouse was removed. This woman described some effects on her health in the initial weeks after her husband’s death:

“My health suffered mainly from tiredness and stress during the time of my husband’s death, but now after six weeks, I am beginning to feel more rested. Maybe I am now feeling better than I have in a long time, just very sad, but we were married over 60 years. That is a very long time. My faith was a bit shaken at times but then, it remains there in your heart to help manage hard times” (S4/LW/2b).

Some had suffered physical injuries, with backs and shoulders being mentioned specifically, during this care period, and many of these were reported as having improved once the strain of lifting and care had been removed. The lessening of sibling and friendship networks was reflected in the way women reported their emotional health over time as demonstrated by this woman’s comment:

“My blood pressure went up very high right after my sister’s death last year. Her death was very sudden and unexpected. She was so close to me. I will miss her” (S2/EW).

Comments did not usually specifically relate age to disease; for example, women did not tend to say that they had blood pressure problems, or fell over, ‘because of their age’. The presence of disease was usually mentioned without specific reasons mentioned for its onset, or, it was related to a genetic predisposition. Women made reference to their family history when they wrote about problems they perceived to be inherited. Some did say that many of their family had been known to have diseases, for example, glaucoma, arthritis, and heart problems. Many women added that they were hoping they would be fortunate, and not have the same stressful experience. If they did suffer the onset of a disease or condition, they hoped that it would not be as bad as it had been for other family members, and/or that they were taking steps to minimize the effects. As an example, women wrote that they hoped that by walking regularly they could avoid or minimise the effects of heart disease. One woman’s wry perception of a certain inevitability of worsening health stressors at some point in her future as she aged was expressed this way:
“I am fortunate to be the healthy one in my family, my sister is a frail little old lady .... while my younger brother has Parkinson’s disease. Of course I am going to die one of these days and barring accidental death, I’m going to get sick. You have to be awfully sick to die. It’s the way of things” (S2/EW).

While health conditions and increasing disability was a stressor for women, the comments about health problems were frequently qualified with expressions of optimism. Many women added words such as ‘it could have been worse’ or ‘after surgery, I am expecting things to get better again’. There were comments that related an acute phase of health management followed by the description of how there could be a positive outcome, for example:

“Awaiting hip replacement. This will enable me to be more active and walk again. Heart pacemaker due next month. Regardless of the many things not acting 100% I am contented, happy, mentally still wanting to actively do and help others. Blessed with a great husband and family” (S4/M).

Trust and control: Some women wrote about managing their health challenges by being as informed as possible about their choices, by choosing to change practitioners if they were not happy with the treatment protocols suggested, and by using their family support networks at points of key decisions. Some women add information about some of the interactions they have with medical practitioners to better manage their problems, for example ‘I asked for different tests’, ‘I suggested alternative drugs’ and at times, ‘I sought the opinion of another doctor’. Most women ‘remained hopeful’ that the operations and procedures suggested would be helpful to ‘relieve pain’ and to assist them to “manage better and be more active” (S4/LW/2b). A few wrote that some doctors or staff were ‘rude’, ‘uncaring’ or offered advice about which the women did not feel comfortable. Overwhelmingly though, these women wrote that they were satisfied with the care they received when suffering the stress of illness, either at home or in hospital, and if they were not in agreement with the suggested course of action they sought alternative opinion(s).

A few women combined the use of expressions such as ‘my legs won’t let me’ when describing the stress whereby they cognitively wished to do some activity with the recognition that their body would ‘not co-operate’. There was a sense that most women tried to maintain control over their functionality. Although they acknowledged there were stressors at work that made activities difficult, they expressed thoughts such as ‘I won’t let it beat me’, as evidence of their
determination to continue to exert control for as long as they could over their bodies and their circumstances.

Health care providers: Women often reported that they required the services of allied health providers, such as physiotherapists, chiropractors, massage therapists. This was due to the stress associated with pain, immobility and rehabilitation issues. Women often reported the need for ‘lengthy visits to the physiotherapist’, having hydrotherapy sessions or receiving advice regarding exercises that could help them recover after they had undergone surgery, or when recovering from falls or accidents. Even if the therapy was ‘not able to offer a cure’, the advice the women received regarding ongoing management of health issues was helpful for them to be able to make informed choices. A stressor that was mentioned about accessing allied health providers was that under the Australian health care system significant costs could be incurred whether the women were using the public or the private health system.

Accessing health services: A stressor that women described as being associated with their health was having to go on a waiting list for surgeries such as joint replacements. For example, one woman wrote:

“...after waiting 2 years for a knee replacement which I found most frustrating because I was unable to continue my usual activities” (S1/LW/2b);

this comment was followed up three years later with:

“I have had to wait another two years or more for another knee replacement. This does have consequences interfering with my health, e.g. stress at walking unable to do exercising. My first knee op I waited two years and was very stressed by the time I was operated on” (S2/LW/2b).

Women in rural and remote areas wrote comments about the stress they experienced with difficulty getting transport to centres offering necessary medical care, citing expenses that they could ill afford being an additional stressor at an already difficult time. Hospitals and medical centres in regional towns were also more vulnerable to closures, and to cuts in health care, which caused more stress for these women who were trying to manage their health, while remaining living on their properties, or within smaller communities.

5.4.1.6 Social Issues

As the women aged, their social networks were said to shrink. There were a few aspects to this stressor. First, family members and friends died or people had moved away and women
expressed this as being very stressful. One woman wrote at three earlier surveys about the deaths of friends and relatives and on the last survey she added:

“My brother-in-law died.... although he was (occupation) for (number) years I felt his death. Four of my friends have died over the past year and many are sick as well. Especially my brother-in-law’s death made me also remember my husband’s death and the sadness of it all has really affected me and I have not been able to get good sleep for some weeks but I am getting over it again slowly now” (S5/EW).

A later life widow wrote about similar feelings of sadness as a reaction to the stressors of losing family members:

“Well my last two remaining sisters passed away (ages). I now have no sisters left and am so sad about that. My brothers too have died but that was a while ago now. I think you always miss them and it is worse when there are no siblings left, except me. I am beginning to really feel my age now” (S5/LW/2b).

Networks could also be said to shrink, as people moved away from each other. Depending on personal needs for care and support some women described how they themselves had moved and missed their old home location. Others wrote that their friends needed to move away and they had found this to be stressful. This could be because they missed the social aspect that the company of friends offered, and they now had to rely on phone calls and occasional visits; for others it was also that they missed the instrumental support the friend(s) had offered them, as this woman wrote:

“A good friend who used to help me with transports & lifts to the shops for groceries has just moved away so I will have to find new ways of shopping, paying bills and visiting the doctor” (S3/EW).

Three years later this same woman wrote that she had moved from her home to a retirement village and her comment also included the words “… so now that I have moved into the new arrangement I am too far from former friends and activities and I am not able to keep in touch” (S4/EW). Many women reported coming to the end of their established friends and family networks. The staff members of residential centres were mentioned as being a group who, as
time passed, were said to provide more support and connection, considering they would be the group of people whom the women saw most frequently.

Not all women wrote about the stress of losing their close family members. For example, one woman contributed comments about the six remaining siblings in her family, who, except for one brother, all enjoyed good health, at least to Survey 4, where she was able to write:

“My husband and I keep busy and have lots of interests and many wonderful friends & ‘rellos’ with whom we are in touch all the time. We can pop in and visit them whenever we wish, which we do quite often. Not only my older family members see us but also my daughter and granddaughters come to stay with us whenever they wish which is so wonderful to enjoy” (S4/M).

Long-term friends, who appeared to be mostly in the same age bracket as the women themselves, were described as being an integral and positive part of women’s lives, often for a longer period than some younger members of the family unit. It was the sense of connection over this extended time, perhaps even a whole lifetime to date, that made comments about the loss of family and friends so significant. Some women wrote that they had known a friend since school or university days. At other times, they said their friend had been their bridesmaid at their wedding, and connection such as these were seen to be very meaningful. Comments that related to these losses helped to understand the depth of emotional attachment that was felt by women for others within their networks and why stress of the loss of friends and family members was felt so deeply.

5.4.1.7 Financial and structural issues

*Household bills:* For women who suffered the loss of a spouse, if they did not have means to be self-funded from private resources and superannuation, they then had to make a sudden adjustment to living on a government single rate pension, and no longer the amount they received as a couple. They described that it was hard to pay household expenses that were the same amount no matter how many people live at an address (for example, bills such as water and land rates, household insurances or rental costs if they were not a home owner). This woman from the early widowed group, described her experience, which was common to others in her marital group:

“I find it harder to live and pay my way being on only one pension coming into the home. Got costs the same as other people, taxes, Council rates,
insurances etc. on unit as well as contents insurance. I own my unit. I can’t afford to go on trips or holidays as it takes too long to save up enough money’ (S1/EW).

Women who wrote comments about financial matters while married and after experiencing the loss of a spouse reported different aspects of financial stress, and how it contributed to the decisions that needed to be made. For example, a woman who indicated she was widowed at Survey 4, contributed comments both before and after her change of marital status:

“We (my husband and I) are hoping to move soon and have the house up for sale as we cannot really afford to manage the expenses involved in a larger house any more. This is creating quite a bit of stress for both of us. My biggest problem is trying to maintain a positive attitude, but for someone who suffers periodic depression, it is very difficult to cope with this stress” (S4/LW/2a); and:

“At present I am living with (name), my younger daughter, having sold the house at (suburb) after my husband died, and we’ve been looking to buy something together. But what a headache this is proving to be - prices the way they are! I’m nearly 80 now and don’t know if I’m doing the right thing. (Name) has been renting this house with two other people (I’m one of the two now) and has been in the area for XX years and would prefer to stay in this part of (capital city)... who knows if I can afford to buy in the area; the worry of it all makes me feel so stressed right now” (S5/LW/2a).

For women who remained married, their comments about financial issues mostly related to reducing stress by moving to a smaller house. They felt the costs would be less than they would incur from maintaining a larger house, and therefore it would be more financially affordable for them, as this woman wrote:

“My husband and I are moving house in June to be in a smaller, more manageable house and surroundings; the upkeep on our big house was just getting too much and we felt we no longer had enough reserves to keep up paying the bills. Hope we can make the change!!!” (S3/M).

Housing issues: In general, women seemed to contribute more about housing concerns after they were widowed. The comments from married women about housing issues tended to only
be reported on as time passed and both partners in the relationship were said to be finding it harder to cope with the demands of a larger house and independent living.

Women who had suffered spousal loss reported that one way they coped with the challenges that surrounded home ownership was to adopt a shared style of accommodation, for example, a type of home or unit dwelling that was attached to a relative’s home. This type of comment was largely seen when a woman was widowed, and was not found as a common option for women who remained married. They used expressions such as ‘I can only manage because I live in a granny flat at my son’s house’ and “I am glad I do not have to pay rent anymore now I am living next to my family’. Women who wrote comments about shared housing arrangements usually indicated how they contributed to the family in some way, either with offers to help pay for certain items, or by offering to help with child care and/or cooking and other household tasks they could manage. They wrote they ‘didn’t want to be a burden’, ‘were happy to help’ along with the fact that they did appreciate that the ‘stress’ associated with home ownership had been eased.

Other women, both married and widowed, who wrote that they, (along with their husband if he was alive), were ‘downsizing’ their home, to a smaller house or a unit, in order to ‘lessen maintenance costs’. Some moved to a residential village. If the woman, (or couple), was a homeowner, the sale of the house may have released the only, or last remaining source of capital funding available. For some this money may have been sufficient to fund a move into a retirement village or assisted living hostels. Initially this type of housing choice may not have been a cheaper option, as there were costs involved in buying in to such centres. However, costs to maintain a house were no longer required in the new, assisted living/retirement village setting. In addition, women had often written that trying to access and pay for tradespeople to help them in their own homes was stressful because of the high costs involved, with some even writing ‘who could pay for these services?’ Many centres, on the other hand offer a solution to this stressor as they frequently included some offer of support regarding home management issues, for example, by employing a ‘handyman’ whose job it was to assist residents to maintain items in their home/unit.

Disruption to housing: In the current study, only women who had been widowed contributed comments about how they had experienced the need to move out of their home because of a traumatic event. Such events were at times health related, and others were secondary to a problem that had occurred with their home itself. For these women, they wrote about the
feeling of dislocation when being forced away from their homes for reasons such as their need for rehabilitation or because repairs to their homes were needed, for example, after storms or floods. The older they became, the women reported it was harder to adjust to feelings of ‘confusion’ or ‘being unsettled’ with respect to their housing, in addition to the other stressors that had brought about the dislocation initially. However, many described their process of rehabilitation and recovery as a journey of ‘adjustment’, as they dealt with the altered circumstances that accompanied periods of illness or injury.

Health costs: The other most significant and stressful factor mentioned was the difficulty and, for some women, the impossibility to continue to maintain private health insurance over the years when they felt they had most need of the security of that service. The comments were seen more in the earlier surveys. Although the comments were contributed by women in all marital groups, it appeared to be more an issue for widowed women. The reason could be that income received by a widow on a government pension dropped dramatically following spousal loss. Therefore, the ability to continue paying for private health cover may have proven to be under immediate threat for this group. Three women, representative of all marital groups, expressed their opinions this way:

“I have kept up my private health cover not because I can afford it but as a priority” (S1/EW); and:

“I find health insurance for ancillary services difficult to finance because of high premiums” (S1/LW/2a); and:

“I am dissatisfied that private health insurance is so expensive and that as Govt funding has become the norm (Medicare) people expect that they don’t have to contribute for themselves” I don’t know if we can keep up the payments for much longer although we need it. Such a stress to know what to do!” (S1/M).

Stress associated with payment for health costs also extended outside the issue of private health funds, to the area of coping with prescription medications, as this woman said in a very poignant comment:

“With the extra money I have to pay for medication, I find some weeks of the month when prescriptions have to be purchased, my meagre budget is very badly bent. I suffice by walking in the park each day and do my daily exercises
by bending and collecting the empty bottles, cartons, and spent soft drink cans, cashing them in for extra money. I never thought that I would ever come to doing that to survive. I wonder how many politicians and people in high places could do that to survive. Perhaps it is some of them dropping what I clean up for my existence. I am sure it was not the low wages folk who worked for the higher cost of medication. Enough said” (S4/LW/2a).

In comments about financial matters, most women implied that they dealt with the stress of these pressures by making specific cognitive decisions. These included: prioritising bill payments, electing to not have certain benefits, particularly private health cover, and also other choices such as going away for holidays.

Transport difficulties: Women who lived in rural areas, in particular, described challenges associated with managing their more remote social setting. Their stressors included the cost and difficulty in accessing specialist services that were usually only offered in larger centres. They found transport issues were a problem when they needed to get to medical appointments. Options were said to be insufficient and, what means were available, were expensive. Some women hoped that by contributing this information ‘maybe the government will listen to us rural women’. Others expressed that they did not know how they would manage if/when they could not drive, using expressions such as ‘I dread having to hand in my licence’. Others wrote that ‘they did not know how they could get to appointments’ if family, friends or a community service could not help at the time needed.

Budget issues: Some women offered insights into other areas of their finances apart from health and transport issues. For example, a few women wrote that they no longer could afford to take holidays, especially to overseas destinations. A few indicated that the only way they could enjoy a vacation was if their family helped them to pay. Comments such as “I have just returned from a holiday overseas... my grandsons wanted to help me and took me” (S4/LW/2a) and “my daughter organised and helped pay for a cruise for me; I could never have paid for that” (S5/LW/2b) indicated that there was often family participation to enable women to have this experience. It is noted that none of the women in this study reported selling their cars or other items to help pay for living expenses, or described having no resources for basic living needs such as food and clothing.

Future provisions for children: There was concern expressed by some women that they had disabled children who would probably outlive them. They were worried about how to make
provision for them in terms of a safe and accommodating home, plus how to plan for the costs that would be involved in that over the longer term for whomever took on the responsibility. Expressions such as ‘who will care for them?’ were poignant. By later surveys some women who had expressed this problem had come to a point in time where they said that another person (usually a family member) had agreed to provide ongoing care for the person with the disability. For others the future plan was yet unknown and this caused ongoing stress. Other women had to deal with the fact that some of their family were not able to provide for their own needs and many women felt stressed as to how their children and subsequent generations would cope financially in the future.

5.5 Chapter Summary

Key stressors and resultant feelings of stress were identified in the free-text comments. They included caring for a spouse, spousal loss and widowhood, bereavement and other significant life issues, ageing, health issues, social issues, and financial and structural issues.

For widowed women, comments written in the initial years after the death of a spouse were more inclusive about how they had reacted to his death and how it had affected their health and sense of well-being. They then identified more over ensuing years that the stressors of bereavement and widowhood had changed, and in some ways, the effects had lessened. They often reported that their health had improved and in addition, they described how they had adjusted to the changes that accompanied losing a spouse. Many had developed new interests in life, and/or had re-established past connections. Additionally, the freedom to pursue interests and relationships outside the home allowed women opportunities to combat the stressor of loss and loneliness, and to maintain physical and cognitive function. Outside interests and activities also provided opportunities for valuable social engagement. It enabled contact to be had within family and friendship networks as a single woman and no longer part of a couple. Married women wrote more comments about the companionship offered by their spouse, and noted that their relationship spanned 50 to 65 years. Some did include comments about other friendships they shared with their spouse, inclusive of long-term friends and family members from a wider circle. They wrote much less about friendships pursued with other women in a separate social network to their husband than was described by widowed women. As time passed, women tended to write less about friendships, partly due to the
deaths of many in their networks, and also due to increasing difficulty in getting transport suitable and affordable for them to get beyond the confines of their homes.

In addition, the findings showed that women often managed multiple co-morbidities over time. The relative severity and impact on their independent function and overall health status consequently varied with episodes of ill health, or the need for surgeries being described. As is identified in salutogenic theory, the concept of the continuum of ‘health/ease’ and ‘dis/ease’ accommodates the occurrence of fluctuation of events. The comments women wrote showed evidence that they managed periods of stress following onset of a medical condition, with the associated medications and procedures, with determination and as much knowledge and support as they could gather. Frequently then, they reported recovering from episodic setbacks and resumed meaningful activities and valuable function often with a formidable degree of success and enthusiasm for life, until very late in life.

As seen earlier (section 3.2.1), some degree of stress is generally thought to be manageable, even enjoyable, and can be the incentive that people need to continue being motivated, challenged and productive in their lives. It was also suggested, that heightened and prolonged stress can negatively impact a person’s health and well-being. It appeared that many women in this current study identified sources of stress, and this formed a basis for them to either avoid or ameliorate the negative effects they may have felt as a result. Many of the processes involved were evident in the comments offered by the women as they conveyed what had happened, what they initially felt about it and, over time, more comments were offered about how both the stressors may have altered along with their responses to them. If the level of stress created a tension response that was too hard for women to cope with, proved too painful, and/or if there appeared to be no end to the difficult situation(s), then adverse physiological symptoms may have been reported.

There can be a tolerance developed to stress, which may alter over the life course according to personal health, social circumstance and environmental factors. For older Australian women, who are the participants in this study, the data contained information that relates not only to events that occurred during the period for which they were active contributors to ALSWH, (which ranged from 70-90 years), and also reflected on events of their entire lifetime. The way a woman may report events from her earlier life could be different to how she describes situations that occur over time, and in later life, and need to be considered alongside her advancing age. Some decline associated with ageing may well affect her ability to cope with
the challenge and change of her circumstances. Events that occurred within a normal life span, for example births, marriages, professional promotions and personal achievements were considered to be form of stress, yet were more likely to be associated with the idea of eustress. The effects of the tension perceived from such events were usually considered to be pleasurable, despite the effort that may be involved, and were sources of great memories for a lifetime.

This chapter provided a thematic analysis of the comments women made about the stressors and stress they perceived in their lives, as they aged, over a 15-year period. For the early widowed group, the first survey of the ALSWH was completed after they had experienced the loss of their spouse. The later widowed group contributed comments that spanned the period of stress of caring for a spouse and the period when the spouse died. All early and late widowed groups offered comments about adjusting to the stressor of widowhood for varying lengths of time. All groups, including the women who remained married for the length of time they were participants in the study, described many stressors, and these were found to include caring for a spouse as he aged, bereavement other than spousal, other significant life issues, ageing, health issues, social issues, and financial and structural issues.

5.6 The next chapter

The next chapter will present the findings about the SOC, and the presence of resources that were seen to be available to the women, and were evident to help women cope with the challenges over ageing. The use of resources will be reported according to the comments women write, considering their marital status, and changes described over time.

5.7 References


6 Sense of Coherence

‘Having a place to go – is a home; having someone to love – is a family; having something to do - is worthwhile; having them all – is a blessing’ (Anonymous)

6.1 Introduction

A question that intrigued Antonovsky (1979), was why some people despite obstacles of stress and hardship, managed to stay well, and even thrive. The theory of salutogenesis has generated a greater interest in a positive approach to understanding how people can utilise resources that support self-care and in turn, strengthen the maintenance of health and well-being (Tan, Chan, Wang, & Vehvilainen-Julkunen, 2016). This emphasis on a positive drive towards promoting good health is in contrast to the past, where managing the risk factors of disease and preventing future occurrence was more the focus (Hansen-Kyle, 2005; Lindstrom & Eriksson, 2006; Milberg & Strang, 2007). A more thorough explanation of the theory, its development and applications, was described earlier in chapter 3.

6.1.1 Resources in relation to the theory of salutogenesis

GRR’s and SRR’s are best seen as responses to challenges (section 6.3), and can be used to counter what are more commonly termed ‘stressors’ (Eriksson & Lindstrom, 2011). On a scale, where a potential measure of complete health and total absence of disease is positioned at one end, and total disease is positioned at the other, the theory of salutogenesis and the associated health model suggests that so long as there is life, GRR’s and SRR’s can facilitate movement for any one person towards the health end of the continuum (Antonovsky, 1987). Even when viewed in a palliative care situation, there is thought that there is the possibility that the availability and use of resources of hope and meaning could ease the strain associated with the some of the most serious of challenges in life, the care of a spouse in an end of life period (Milberg & Strang, 2007).

Antonovsky (1972) put more emphasis on GRR’s that can be applied to meet a wide domain of stressors than he did on SRR’s, although their relevance and importance was acknowledged at the appropriate times. He wrote that as important as SRR’s may be, they were mainly useful when particular stressors were perceived, rather than the broader application of GRR’s. SSR’s are assets, skills and talents of an individual or group that, when activated, can help exert
control over, or avoid, specific stressors. Examples of SSR’s are disaster relief teams, vaccination programmes and groups that assist those with specific illness (Mittelmark, 2001). It has been suggested that although GRR’s can be considered a broader term, the specific situations that are described by people who are experiencing stressors can reveal more specific and individual examples of SRR’s. As such, the use of SRR’s can form part, although not all, of managing a stress response (Wennerberg, Eriksson, Danielson, & Lundgren, 2016).

Antonovsky also suggested that GRR’s were developed through the experiences of life. They can be defined as characteristics within individuals, groups, and cultures that promote effective management of the tension caused by stressors (Antonovsky, 1979). He further proposed that GRR’s could be both internal and external, and were likely to be material and non-material, physical, psychosocial, cultural and/or spiritual (Eriksson & Lindstrom, 2014). Some examples of GRR’s are stable financial status, social resources, positive disposition, education and sense of control (Eriksson & Lindstrom, 2005). The most common thread that links the identification of various GRR’s is that the presence of resource facilitates the ability to make sense of the wide variety of stressors and stress that constantly confront people at any stage of life, and in doing so, they provide the basis for the development of a strong SOC.

6.1.2 How resources contribute to SOC

The construct proposed and developed by Antonovsky (1979, 1987) was that some people utilise resources to help manage tension in their lives in a way that promotes effective choices of coping strategies and this in turn leads to a greater sense of well-being. Antonovsky (1979, 1987) called this type of orientation to life as exhibiting a SOC. He described people who are aware that they have appropriate resources, and are skilled in using them, as using their SOC to view their lives as being comprehensible, manageable and meaningful (Antonovsky, 1987).

The presence of a well-developed SOC contributes to enabling people to consider that life for them will unfold in a reasonably structured and predictable manner; that they have confidence that they have available resources to manage life’s events; and that there remains sufficient reason and purpose to continue to meet the demands of life and invest in a worthwhile future. People with a high SOC were said to have been exposed to GRR’s and SRR’s, and over some time they became more proficient in identifying the presence of resources, and also being aware of how to activate appropriate resources in a timely manner (Tan et al., 2016). The development of SOC is dynamic and occurs over a lifetime. Antonovsky (1993) referred to it as a flexible orientation rather than a rigid adherence to strategies that may be more typically
associated with coping mechanisms. Antonovsky (1987) felt that SOC develops until the third decade and then remains a relatively stable dispositional orientation until retirement when it decreases. More recent research has shown that although SOC is dependent on early experiences, it does develop further in the social environment over time. SOC has been found to be at its highest in later life (Lindstrom & Eriksson, 2010). It is best developed in a situation where there is a balance between too little and an overload of stress (Eriksson & Lindstrom, 2014).

6.2 Research aims

The aim of this chapter is to examine women’s comments in terms of their orientation to life, specifically their SOC. With respect to SOC, the current study will look at how older women describe resources in their lives that help them face stressors. In particular, the specific objectives are:

1. To identify the available resources utilised by women;
2. To identify whether or not the availability, utilisation and type of resources altered over time;
3. To deepen the understanding of the availability and utilisation of resources with respect to differing marital status.

6.3 Findings

6.3.1 GRR’s that contribute to SOC

Resources that were seen to contribute to the concepts of comprehensibility, manageability and meaningfulness, and thereby to SOC, were sought in the data, using a deductive approach. Table 5.1 first lists the main resources that were seen to contribute to SOC, with the operationalised definitions that have been taken for the current study. Examples of quotes are given, which illustrate the presence of that concept in data available from each of the four groups of participants (early widows, widowed at Survey 4 (S4), widowed at Survey 5 (S5) and married). The final row in Table 6-1 includes the definition of SOC, and one quote as an example of how the overall concept has been seen in the data.
<table>
<thead>
<tr>
<th>Resource</th>
<th>Definition</th>
<th>Example of quote according to sample group</th>
</tr>
</thead>
</table>
| Positive disposition | Origin: Old French from Latin: “to arrange or dispose one’s attitude to...”  
Refers to the positive emotional and intellectual attributes that determines a person’s characteristic actions and reactions. In turn this affects the way a person views the world.  
A person’s mood or attitude | Early widows (EW)  
Widowed @ S4 (LW/20)  
Widowed @ S5 (LW/20)  
Married (M) |
| Resilience        | The ability to adapt well and to sustain some degree of strength, health, success despite ongoing action of repeated adversity and ongoing stressors, usually those which have an element of harm or risk attached; an ability to “rise again” despite there being the potential to no longer fight or resist against the difficulty of the forces in action | You reap what you sow!! And I don’t sit and wait for things to happen. I am so fortunate to have a happy situation in life (S2)  
Everyone has been so helpful. We get meals on wheels and home help e.g., vacuuming, cleaning bathrooms, lawn mown. P.S. Loved the suggestion of a coffee break while doing the survey!!! (S3)  
I have been very lucky in life. I had a sore knee in (date), not since. When I got breast cancer it was the first time I had been hospital since my children were born. I had XX stitches in my ear after the operations, I am the oldest of X, X girls, X boys. Brothers and sisters. I think that this is where I got my positive attitude (S2)  
On (date) I had to have 4 bypasses (heart) which left me for a little while unable to do some household jobs -- but I overcame this problem and have managed well. Also I had a keyhole gallbladder operation recently -- without any complications. I was in an abusive relationship, which seemed to be dangerous for my health so I have ended it. I have re-married since then.... I am very happy now (S2) |
| Locus of Control  | Locus: the position, place or location where something occurs  
Control: the power to determine outcomes by directly influencing actions, people and events.  
Examples of types: | Being widowed twice took me a long time to get my act together. I feel I am in better control now, back on track and now getting things in my life ordered the way I like and cope with them (S2)  
Since my husband died suddenly I have had to reorganise my life. I have found changing addresses etc. from joint to single a trial at times. However I am able to sort it out myself, manage and understand all that I have to do. But I am slower at times - but I want to be independent (S2)  
My world is slowly closing in around me -- I am still allowed to drive a car -- but for how long will the doctor and government let me? (note: lack of control) (S2)  
Mobile phones are my downfall but I'm determined to master them |
|                   |                                                                           | However I have learnt to live with it and feel very grateful that that is all I have to contend with. I can see, hear, speak, write, etc. - How lucky am I! (S1)  
We have had considerable strain and unusual circumstances throughout (months) as our eldest daughter was very ill and hospitalised most of that time.... Fortunately.... we seem to have come through reasonably well. (S2) |

<table>
<thead>
<tr>
<th>Resource</th>
<th>Definition</th>
<th>Early widows (EW)</th>
<th>Widowed @54 (LW/2a)</th>
<th>Widowed @55 (LW/2b)</th>
<th>Married (M)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identity</td>
<td>The role and position that women self-identify; it includes the way they interpret their situation within multiple networks e.g. family, community</td>
<td>I do a lot of child minding for my daughter (only child) who has (number of children including a set of twins). I enjoy it. She has (health condition) and does not have real good health. Most of the time I keep well but I missed my late husband still after five years. Being widowed twice took me a long time to sort out how my life would be now that I am not married and living as a widow. I feel I am getting my act together. I feel I am on closer to being on track again now (52)</td>
<td>Sometimes I feel that my role is just to be the wife, nurse, housekeeper and taxi driver... all these jobs can take the smile from my face (52)</td>
<td>I live a busy life doing a number of responsible tasks for (name of) projects (56)</td>
<td>I live on a farm - dairying and running a beef enterprise - and still work the same in partnership with our son and his family (51)</td>
</tr>
<tr>
<td>Knowledge</td>
<td>Facts, information, awareness and skills acquired through experience and/or education</td>
<td>Left school at 14 to work in a solicitor’s office. Higher education was not readily available for country children then (52)</td>
<td>Leaving school at 14 years I was educated in (city). When I applied to (state) Education Dept. to become a teacher in (date). I retired as headmistress of (suburb) High School in (date), after a rewarding career (51)</td>
<td>Accepted for secretarial training - not started. Would have like the opportunity children have today. Grew in depression years wasn’t able to continue schooling. Also we were in war during our twenties - Fortunately my children all have university degrees (51)</td>
<td>For schooling at that time in 1940 there was no money to be kept at school I was 14 yrs and 10 months when I finished. I have just kept learning things myself with not much outside help (53)</td>
</tr>
<tr>
<td>Social Resources</td>
<td>Includes: Social networks Any matters relating to relationships and responsibilities required to manage interactions between family, friends and support networks at home or in the community, Social engagement the degree of an individual’s engagement &amp; interaction in collective activities of a social group, in varying roles and</td>
<td>As I feel it is only a matter of time when I will be in need of help, and my daughter has wanted me to move up for some time. I will not be living with her (55)</td>
<td>My husband is home and any help I need he supplies. He is 78 and has age problems but so far we manage ok (53)</td>
<td>I have a wonderful family, still quite a few old friends and having lived here for so long, my neighbours keep a watch over me to help me if they know I am finding something hard. (55)</td>
<td>We have XX wonderful daughters &amp; their husband will do anything to help us, we are very lucky (54)</td>
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<tr>
<td>Resource</td>
<td>Definition</td>
<td>Example of quote according to sample group</td>
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<tr>
<td></td>
<td>relationships;</td>
<td>Early widows (EW)</td>
<td>Widowed @S4 (LW/2a)</td>
<td>Widowed @S5 (LW/2b)</td>
<td>Married (M)</td>
</tr>
<tr>
<td></td>
<td>Usually excludes paid work; lacks a</td>
<td>I am pleased that I bought myself a (mobility device) and it has given me a lot more in-dependence as I can</td>
<td>I am a self-funded retiree; sadly I have a reduced income due to such reduced interest rates during this</td>
<td>We have built an owner built home, which is large and lovely in every</td>
<td>We may sell our home if we need to move a place that offers care as we get older. It is hard to decide but we</td>
</tr>
<tr>
<td></td>
<td>sense of compulsion, usually takes place with some regularity and outside the family unit and the home;</td>
<td>take myself shopping &amp; to doctor appointment without having to worry anyone else. I still am able to help others in more</td>
<td>period of crisis but I am sure it will improve again! (S1)</td>
<td>every way! ... of which I am very proud (S1)</td>
<td>are think we will have enough funds to do this (S3)</td>
</tr>
<tr>
<td></td>
<td><strong>Social capital</strong></td>
<td>financial need than I am (S4)</td>
<td>(S2)</td>
<td>(S2)</td>
<td>(S3)</td>
</tr>
<tr>
<td></td>
<td>The resource which operates like 'glue' that takes effect in the space in which interactions occur between people; it is based on connections and networks; it operates on principles of trust, mutual reciprocity and norms of action.</td>
<td>(S2)</td>
<td>(S2)</td>
<td>(S2)</td>
<td>(S2)</td>
</tr>
<tr>
<td></td>
<td>Financial resources</td>
<td>Yes, life is hard, but my faith is such a comfort especially if I feel alone (S4)</td>
<td>My church and the community around that has been a lifeline for me. Always something to do to help them. But it is our shared</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Defined as having some level of resource within financial affairs whether it is from savings; Superannuation, other streams of income from investments and properties; references to having income from other than a pension</td>
<td>(S2)</td>
<td>faith that is so lovely, at my age too, it such a help</td>
<td>(S2)</td>
<td>(S2)</td>
</tr>
<tr>
<td></td>
<td>(S2)</td>
<td>(S2)</td>
<td>The reason I have been restricted and/or needed assistance is because... (list of details of medical issues that need to be</td>
<td>(S2)</td>
<td>(S2)</td>
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<td></td>
<td>(S2)</td>
<td>(S2)</td>
<td>dealt with for a period of time)</td>
<td>(S2)</td>
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<td></td>
<td>Spiritual beliefs</td>
<td>A trust in a deity</td>
<td>(S2)</td>
<td>(S2)</td>
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</tr>
<tr>
<td></td>
<td>A feeling of being sure that there is truth, rightness and value in more than what is seen in the physical realm; A trust in a deity</td>
<td>(S2)</td>
<td>(S2)</td>
<td>(S2)</td>
<td>(S2)</td>
</tr>
<tr>
<td></td>
<td>Comprehensibility</td>
<td>All this upheaval for one who does not like change, probably has not been good for my emotional well-being, even though I can</td>
<td>I soon understood the difference between being clinically depressed and just being a bit sad and miserable. When I was</td>
<td>(S2)</td>
<td>(S2)</td>
</tr>
<tr>
<td></td>
<td>A sense that life has a certain amount of structure, predictability and explicability; the extent of the belief that the problem faced by the person is clear and able to be understood</td>
<td>see the necessity for things being as they are at present. I shall endeavour as soon as possible to get some order back into</td>
<td>depressed I never wanted to get up in the morning, looking back I must have wasted so much of my life in bed (S2)</td>
<td>(S2)</td>
<td>(S2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>my life and enjoy the lovely surroundings and the company of the people about me (S2)</td>
<td>(S2)</td>
<td>(S2)</td>
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<tr>
<td>Resource</td>
<td>Definition</td>
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</tbody>
</table>
| Manageability     | Available resources are recognized and are sufficient to meet demands that are experienced. | Early widows (E/W)  
I was very stressed and bitter after my husband's death but my emotional health is improving. I didn't take drugs to relieve anxiety. I have made it myself and I have tried to feel better. I have started my social life again (S1)  
Most of the time I keep well although I still miss my late husband after five years. But I have learned how to get back on track now (S2)  

 Widowed @54 (L/W/2a)  
The second fall I fell on footpath down the street on (date), went to hospital in ambulance suspected fractured hip but luckily only badly bruised after X-ray and CAT scan. When I came home from hospital arranged for meals on wheels to come and also arranged for the physiotherapist to come for XX weeks.  
I have had XX type of my diabetes in 4 years so I think I manage that OK too considering everything!!! (S3)  
I feel it's a privilege to be part of this survey and thank you for including me (S4)  

 Widowed @55 (L/W/2b)  
(Since a medical problem arose) ...I am exercising  
More and this has made a lot of difference to me. I now manage my problem by doing stretching and tummy exercises before I get up - walk dog 4-5ish and then more floor exercises at night. It's so helpful to help yourself where you can! (S5)  

 Married (M)  
My husband and I share managing our home. If we can't do something...well, we have to ask someone else! But we usually can manage most things. Just slower now (S5) |
| Meaning-footlooseness | A belief that life makes sense and the challenges of life are worth investing in, hope and purpose can be identified. | Early widows (E/W)  
I enjoy good health despite failing eyesight and deafness. This does not prevent me from doing things I enjoy, like running a shop, gardening, bushwalking. I have a small circle of helpful and supportive friends...I enjoy life and will probably live to be 100 (S2)  

 Widowed @54 (L/W/2a)  
I have a hobby, knitting dolls clothes, to keep ambitions out of my hands. I give them to charity. I love doing this work (S3)  

 Widowed @55 (L/W/2b)  
I have a hobby, knitting dolls clothes, to keep ambitions out of my hands. I give them to charity. I love doing this work (S3)  

 Married (M)  
We cannot do as much outside our home now. But we enjoy it if we can help others in need. It brings us joy. Plus our family, What a blessing they are to us (S6) |
| Sense of Coherence | The inclination of life orientation of some people to cope using available resources which enable the events in their life to be seen as being comprehensible, manageable and meaningful. | Early widows (E/W)  
I feel that doing volunteer work in the community helps one to have a balanced life - with benefit to others also one's thoughts are turned outwards from one's own problems. We delight in going to nursing homes to sing all the old time songs (so different to the modern versions). Feeling safe in one's surroundings must surely play a large part in a person's well-being. I live among flat-dwellers - some retired and some young and working. It works so well (S2)  

 Widowed @54 (L/W/2a)  
I feel that doing volunteer work in the community helps one to have a balanced life - with benefit to others also one's thoughts are turned outwards from one's own problems. We delight in going to nursing homes to sing all the old time songs (so different to the modern versions). Feeling safe in one's surroundings must surely play a large part in a person's well-being. I live among flat-dwellers - some retired and some young and working. It works so well (S2)  

 Widowed @55 (L/W/2b)  
Things have not always gone to plan, that's for sure. But I have always managed to see the bright side and find ways to cope when things are hard. There are always people who will help...sometimes you just have to ask! (S5)  

 Married (M)  
We are so lucky to have each other to try to figure out the best way to manage things that happen. It's not been a good year but we are counting our blessings...we still have those (S5) |
6.3.1.1 Positive disposition

A positive disposition was seen to be apparent in a few ways. First it was seen against the backdrop of negative events. Many women wrote that, despite the presence of difficulties, loss and sadness, they were able to express a more uplifting response that may have been expected, given the challenging circumstances described. Some terms that were used by women with a positive disposition were how ‘lucky’ or ‘fortunate’ they considered themselves to be. They were ‘lucky’ that a diagnosis was not as bad as first thought; lucky that they were able to find someone to help in the house or garden; lucky that the fall ‘was not as bad as it could have been’; that family lived ‘close by’. Others chose to use the term ‘fortunate’; fortunate that they had good health and energy; that they lived in a good town where people were helpful and friendly; fortunate that they were not ‘as badly off’ other friends in their network, with respect to their health or mobility; fortunate that they enjoyed such good health that they could interact socially with friends and in the community. Women also wrote that they were ‘coming good’ after a fall or operation; that they had ‘better genes’ than some other friends or family; and that they were ‘happy’ they had a ‘good and caring doctor’.

One woman from the early widowed group wrote comments on four surveys that demonstrated the presence and persistence of the resource of a positive disposition:

“I realize how very lucky I am to be so healthy & to have so much energy” (S1/EW);

“The elderly don’t all have complaints! When one loses her husband especially when very close of course we get lonely and depressed at times but if we don’t cheer up and pull ourselves up no one else will, so we just have to keep going. Unfortunately I fell (location) but luckily with some rest for a few weeks my injured leg healed quickly and well” (S2/EW);

“I know I’m very lucky with my good health and active life” (S3/EW); and:

“Thank goodness I am so lucky that I am still blessed with good health but I am starting to slow down a bit though” (S5/EW).

Second, it was seen in the way many women reported the presence of challenges in their lives with less emphasis on difficulties and hardships, and more about the enrichment they felt when describing their ‘wonderful lives’, ‘kind and generous families’, ‘support’ from the medical profession, and plentiful opportunities for social engagement. The women who
expressed positive feelings about their situation most often related a comment that included the presence of some form of instrumental assistance they had received from family, friends or other support networks. For example, one woman expressed a very positive response to medical staff following a stay in a hospital and rehabilitation centre. What was even more remarkable about her positive attitude was that the first of the two comments that follow was written just after she had been involved in a motor vehicle accident in which her husband had died:

“I’d just like to say that the treatment I received at the (name) hospital and especially at (suburb) rehab was absolutely TOP CLASS and the staff, nurses sisters physiotherapist, kitchen staff and the cleaners, were all very helpful and extremely pleasant (I can’t remember much about the doctors)” (S4/LW/2a);

and:

“There is so much negativity talked about hospitals. I felt I must say something positive. I was on the waiting list for some months, but I was lucky, & I wasn’t in a lot of pain, so I wasn’t worried…..I’m very lucky! Many thanks to you all for doing this important work” (S5/LW/2a).

Where women showed evidence of having a positive disposition at early surveys, a pattern emerged where the same women reported ongoing events with the same optimistic view, despite the effects felt from challenging circumstances. One example of this is from a woman who was widowed at S5 (LW/2b) and who contributed comments on four surveys. Despite the presence of stressors in her life she expressed her opinions this way:

“I have learned to accept what I cannot change, particularly in health problems, and I appreciate the good things of life. There are still many things to enjoy and small pleasures to enjoy” (S1/LW/2b);

“….and I think that I am so happy because I have a happy home life, loving friends and keep occupied….also having plenty of good laugh helps too!!” (S2/LW/2b).

“I am very fortunate that I have a loving, close family and good friends. Whatever happens, keep up your sense of humour and always try to have a laugh where you can. It does help!” (S4/LW/2b); and
“I know I shall come through this (missing her deceased husband). I have always looked for positive things out of hardships” (S5/LW/2b).

Other women expressed that they were ‘lucky’ to have help with house and garden maintenance, ‘fortunate’ to have assistance with shopping and transport to medical appointments, and were ‘grateful’ for emotional support in the form of phone calls and visits. How well the women rated themselves in the process of ageing often related to the degree of integration of numerous support networks within their world.

Third, evidence of positive disposition was seen where there was a combination of a description of hard experiences alongside the presence of support structures and networks that had helped the women rise above the stressor(s). Frequently it was seen that women found sufficient positive energy to be able to move forward and even flourish after the difficult event(s) that were described. It can be seen within all marital groups that women in the study do continue to write about their challenges with a remarkable sense of buoyancy and optimism that persisted across the process of ageing and changes in marital status:

“I have a wonderful family. They are always there for me when I need them & vice versa. I feel I have slowed down a lot after my operation & treatment for (condition) 4 years ago & by recent diagnosis with (condition), but still manage to do the things I want to do. I don’t worry about things that really aren’t necessary. I am heavily involved with my church & conducted the church choir. Something I have done for many years. I feel I am the luckiest person in the world!” (S4/EW);

“My interests & activities are somewhat curtailed currently due to my severe pain and immobility. However I am not letting things get me down!” (S3/LW/2a);

“What a great family we had, it was not all gloom & sadness we all had (describing a family tragedy), but somehow a time of laughter & joy. Thank you for reading all of this - it helps me to share this. (Name) & I had sixty years of marriage - how wonderful!!” (S5/LW/2b); and:

“My doctor and others are amazed by this and question how, with my ongoing health problems at present, was I able to do so much to keep helping my family during ongoing traumas after (tragic event). My answer to them
all – a smile and love conquers all. Regards to you all, carry on with your good work. I think by now you would have found out - women of all ages are the greatest in Australia, no cancel that, the GREATEST in the WORLD!!!” (S3/M).

In writing about the struggles and challenges of ageing, many women included insights that they realised life could have been even more difficult than it had been. Those whose comments reflected a positive disposition, showed thankfulness and gratitude in their words, that although they had experienced negative events, they could still see a positive perspective. They wrote about the ‘blessings’ and ‘good fortune’ they felt they had been afforded. A grateful spirit, a sense of contentment, and a zeal for looking forward to even better things were seen in the expressions used by women such as ‘glad things are not worse’, ‘hopeful things will get better’, and ‘yet in the future’. It seemed they really did think there could be ‘better days ahead’.

Women who exhibited a positive disposition often included the thought that they have preferred to not ‘harbour negative thoughts’. They have felt that it was better to look outward, to think ‘the best not the worst’, and to remember there were people ‘worse off than themselves’. Positive disposition appeared to be a stable trait in that if women contributed comments that showed this way of looking at things on early surveys, they still appeared to show evidence of that as they aged. Many women added comments that they have always been ‘that way’, ‘I prefer to find the positive in things’, implying that they felt that they had always preferred to look on the bright side of events, and believed the best of their family and friends. Overall, it did not seem that positive disposition was only seen in people who were necessarily well, not suffering, and/or who had specific advantage. It seemed present despite, and amidst, disadvantage as much as in those who had more obvious ‘reason to smile’ at their circumstances.

Not all women showed evidence of a positive disposition. Some wrote that comments such as ‘my life has been disappointing’, ‘I feel I have missed out’ and ‘other people I know have had better chances that I had’. One woman contributed comments at three surveys that showed a consistency regarding difficulty in viewing her life in a positive way:

“I am so very lonely and I do not see that things are going well for me, but worse since my husband died 7 years ago” (EW/S2);
“My family just don’t seem to be kind or care for me at all; well, one of them is a bit better than the others. It has always been this way” (EW/S3); and:

“My daughter is not very kind. I have to go everywhere on my own. If I have to go to hospital I have to depend on the ambulance. Going by myself for tests makes me feel down.” (EW/S6)

There was evidence in some comments that women may have become tired of making the effort to stay positive as they aged, particularly when the people closest to them for long periods of time were no longer alive. One later widowed woman wrote that “Even though my husband has died I try to stay positive” (LW/Gp2/S4). However at S6, the difficulty she experienced, and the sadness she felt can be sensed in her comment: “I am feeling so lonely, No friends left. Sometimes I cry at night”.

6.3.1.2 Resilience

As was described earlier in chapter 3, although there are many similarities in the backgrounds of resilience and salutogenic theories, there are also fundamental differences. Similarities include the idea that both resilience and SOC are processes not personal characteristics. Both theories emphasise resources as key to understanding how the concepts can be developed. In addition, both see the development process as being a continuum not a dichotomy (Eriksson & Lindstrom, 2011). One of the key differences that have been mentioned, is that resilience as a theoretical concept, is usually associated with heightened risk factors and potential negative outcomes. Although the term ‘resilient’ was seen to be used by many women, they most likely did not have awareness of the specific nuances of meaning behind the term in an academic sense. Even if the women had not described extreme hardship and adversity in comparison to the experiences of others in more dangerous circumstances, they had often shown a pattern of adaptation, where they had found a resource that enabled them to ‘bounce back’. Many appeared to have recovered from whatever deprivations they had experienced in their childhood and younger years, which included the Depression and WWII. There were many descriptions of ‘fulfilling’, and ‘satisfying’ lives that had unfolded after some references to ‘difficulties in the early days’.

There were some comments about the poverty of the Depression, with examples such as ‘we cooked in fat because that is all we could get’. The women added little extra comment in the way of detail as to how that part of their life, and the war so soon after, affected them.
personally in the years that followed. There were references to expressions such as ‘we are a strong group of women’, ‘we have survived hardships’ and ‘together we have made it through some tough ups and downs’. There was not a great deal of additional information provided regarding details of what the hardships may have entailed. The following comments provided an insight from two different women about resilience, and their perspective that this concept was widely evident in their age group. The first woman wrote:

“We are mostly a tough, resilient group, having lived through the depression years in our childhood, the second world war (with its worries and limitations), and our battles to make homes, work hard and raise families over the years. Many of us married ex-service men whose health was not always good. Now so many of us are widowed and no longer, or do not drive cars, are finding it very difficult living in the country because we feel rather isolated by distance and limited transport options for us all” (S1/EW).

The second woman wrote about these challenges at three surveys, over a 12-year period:

“I think of the WWII wives and mothers who only received a telegram at the death of a serviceman and who had to overcome their own shock and distress. They had no additional support or care at the time and yet they had to comfort their children and family when they themselves were grieving” (S1/LW/2a);

“I think our age group is fortunate (discounting a depression and a world war) in having been part of the time where a lot of people went to church” (S2/LW/2a);

“Our generation never looked for or depended on government help. We made it on our own and I have never had any outside help up to now” (S5/LW/2a).

The most frequently reported traumatic events were the death of a participant’s spouse, deaths of other close family and friends, illness and operations, accidents and falls. While events such as these are no doubt traumatic and significant, they did not fit well with all aspects of the definition that had been taken from studies on resilience. A common element in most definitions of resilience was that it included the aspect of a person’s ability to cope with repeated adversity, ongoing stress, and usually involved the potential of danger, and/or the heightened risk of a negative result. Although the comments from the women did not fit
entirely into all aspects of this definition there were some areas that resonate with the meaning. For example, for approximately two years after the survey where a woman had contributed a change in marital status from married to widowed, physical and mental health scores were seen to drop. The aspect of resilience, often termed being able to ‘bounce back’ and recover was seen where the descriptions of loss and the associated grieving period were frequently followed by comments about recovery and adjustment to the altered circumstances.

It seemed that women felt that challenges in their lives were viewed as being part of the ‘normal’ journey that had to be adjusted to, and managed. The use of terms such as ‘all par for the course’ and ‘what else could you expect?’ were seen quite often in the comments. It was difficult to determine with certainty if women were showing that they were resilient in a process of ‘bouncing back’, with access to sufficient resource and knowledge to adjust after serious challenges, or if they were resigned to the difficulties associated with ageing. The most wearing and repeated examples of stressors, that taxed the resilience of the women seemed to be related to managing deteriorating health over time, as it affected strength, mobility and independence, along with the challenges associated with managing a less than desirable financial situation. One woman from the married group expressed in a later survey how with the support of her husband she was ‘rising up’ to combat long term health challenges that had been mentioned in earlier comments. The essence of the comment that reflected resilience, was the fact that this woman reported dealing with ongoing difficulties for an extended period, yet retained an ability to persevere despite adversity:

“In my own case I was until 3 years ago a happy reasonably healthy women in my early 80’s. I had participated in voluntary work and performed all my housewifely deeds, with no really bad trauma except years of aches and pains due to arthritic problems, which one learns to live with. Nearly 3 years ago I fell on an uneven footpath in a nearby suburb, fracturing both my elbows, the left one quite badly and after 10 months of pain and unable to use the arm properly, had surgery. Recovering from this, I then had arthritis in my hips and 12 months ago had a total hip replacement which relieved a lot of the pain. Unfortunately 3 months ago I dislocated that hip and am once again trying to cope with the problems caused by this. I’m blessed with a loving caring husband who has been my total help throughout all my problems and together we cope. I am mobile, cautious of course, I have been
told I’m to have the other hip replaced in time..... All the above has of course changed my health and my activities. I spend a great deal of time at home; I can do things in the house and knit profusely, do some tapestry, write letters, visit friends when possible and my family are not too far away, so we see them often or we are in contact with them by phone calls” (S5/M).

Some women did express that maintaining resilience was harder as they aged. They wrote more comments in later surveys, after S4 that they had less ‘energy for things that require effort’, that it is ‘not so easy to bounce back anymore’ and ‘perhaps as we age it just gets a bit harder to get back up again’. Women rarely wrote that they did not wish to go on living, but they some did express that there would be a ‘limit’, with ‘100 years of age’ being mentioned on a few occasions, as to how long they felt they would like to keep on trying to have a valuable life that could still make a contribution. They hoped that any declines would not be as severe as to make them a ‘burden’ or of ‘no use’ to help others. There seemed for most sufficient resilience to retain some faith and hope that help would be present to ensure their latter days would still have value and worth.

6.3.1.3 Locus of control

In keeping with the definition of this resource, the analysis aimed to identify ‘where’ control was held with respect to the women’s experiences, and ‘how’ control was exercised. The ‘where’ aspect of the control could be held by the women themselves, as in ‘I’; or by others in their world, as in ‘they’. The ‘how’ aspect considered whether women could alter the actual situation, or did they rely on altering their response(s) to events that happened.

In most circumstances, women in the study expressed that they could usually exert primary control over their health, medications, future treatments and/or surgeries, their housing, their relative closeness of the relationship with their families, and their finances. The extract that follows was taken from a detailed comment made by one of the women in the early widowed group. This comment, made at Survey 1, described her longstanding health problems, how she has taken control over investigations and subsequent choices regarding treatment, noting the use of the word ‘I’:

“History of present problem: Hip replacement in 88 due to accident. Husband’s death in (year). In (year) sudden tiredness in right leg, also back pain on same side. I suspected loose hip. It did not show on x-ray so I sought the opinion of a physio, and other treatments, which were not successful, and
they told me to live with it. I did not accept this as the end of the matter; at times I had severe pain requiring spells of complete rest relying on care. So I decided to move closer to son and family. I changed doctors and the new one suggested I see the specialist again. Another x-ray, still not showing anything. Naturally he did not want to operate, explaining that it is a big operation, the chiselling away of the cement can also damage bone. He suggested a test with the Isotope; finally this took place five months ago and yes! It showed the looseness of the replacement. I was told the new replacement had to be done eventually so I opted to go on waiting list as I was in pain at the time. Since then, now that I have finally got a clear idea of what is wrong I have elected to limit my walking to the most necessary chores, having more breaks, doing a little every day to be able to cope on my own. I would love to walk again without being restricted in this way and free of pain. From what I can gather from people as I try to find out about my problem, is that specialists prefer people like me to wait as long as possible. This is to apparently avoid further replacements in the future, as there is seemingly more risk involved the second time around; this is why I am anxious. At time of 1st operation I was 63; I was told it would last approximately until I am 80 years of age” (S1/EW).

Over the next six years this same woman added information of a similar type where she describes the challenges she faced when exerting control over choices that needed to be made regarding the ‘expenses of private health cover’ and ‘additional hidden costs’ that were accrued when older people like herself lost mobility and strength when they were on long waiting lists for operations. Other women contributed comments about the need to ‘pay for more visits to doctors’; some wrote that they have ‘required more medication’ and they had to get ‘more help at home’ in order to manage their condition while they waited for surgeries, or went through recovery periods from injuries. There were also comments about the difficulties encountered when ‘needing to balance medication costs’ against limited finances. These comments indicated that when faced with some of the difficult situations that accompanied ageing, many women still tried to remain in control regarding decisions and directions of acute treatment and ongoing management of chronic conditions. From the later widowed group, a woman contributed at all surveys, over the entire 15 year period of available data, that despite
some health issues with fractures following falls she felt in control of her situation, with these two comments being examples:

“Since the last fall when I fractured my arm, I have had to do exercise which I do daily. Naturally I have paid a price in committing to exercises etc. but I feel I am in control of my life; I can get around most things and really can’t complain” (S1/LW/2a); and:

“On (date) I broke my wrist on the way to water aerobics & then (number) weeks later I broke the top of my arm falling over a foot stool. However I am now feeling much better & I am able to do lots more. I do have help cleaning bathroom, kitchen & family rooms as I do have trouble after a back operation years ago that comes against me. My daughter mows my lawn for me & my son-in-law does any heavy work in the yard. I still have physio on my neck & shoulders every week, also I do exercises in a heated pool which is helping me greatly I do it at the physio’s & I find it helps me. I am very grateful to (organisation) for help but seeing as I am nearly 86 years I am very lucky; I do have lots of pain but I feel I can manage and I can control my situation with some help” (S6/LW/2a).

At other times family members seemed to lobby for their opinion to be heard and possibly acted on. The reaction felt by the woman not always commented on, as to whether they felt uncertain regarding the ‘locus’, or position, of control. They may have felt that their family members were attempting to take a position of control, and when it came to particular decisions and they may have not been prepared to yield that position, at least at that time. It was not always clear as to whether their reaction to this overt pressure was to challenge the suggestion, to conform to an opinion or to negotiate an acceptable agreement. Some women did report that they took a negative view when this form of control was seen or felt by them to be either unnecessary or unacceptable. For example, some family members at times wanted women to sell their houses in order to perhaps be closer geographically, or to be in receipt of higher degrees of care. Some of the following comments made more use of the word ‘they’, indicating the efforts some people in their network appeared to be making to exert influence over a decision. One woman expressed her feelings this way:

“They (being my family) keep telling me I should move. I suppose they are right. I will probably have to get more help soon enough; However I don’t want to leave
my home though and I feel sad. I will get over that I guess and will make the
decision to move to a new place and make a new life when the time arrives”
(S5/LW/2a).

Although most women recognised that changes were inevitable at some point concerning such
matters, it was usually the timing of the decision that was the source of the disagreement, if
such occurred. This type of control could be seen whereby women may have changed their
response to potential or actual changes, rather than being able to change the environment
itself. An example of this situation for one of the later life widows was seen in her comments
contributed over three surveys:

“They, (that is our family) think we should move. We feel we are in a dilemma
as to whether we should sell up out home and try a move to a retirement
village. We do feel worried but are trying to just take one day at a time while
we decide” (S1/LW/2a);

“We are choosing to stay in our home as we think we can manage for now. Our
family, well, they think we should move closer to them. We understand that they
would like to help us. But so much history is here for us. We are trying to not get
too concerned about how the choices will turn out for us as we get older. I guess
the next survey may tell you more!” (S3/LW/2a); and:

“I have moved from (name of state) to (name of another state) after my
husband died. I now live closer to my daughters as they were hoping I would.
My health has improved as I now grow my own vegetables and have time to
help others in my age group” (S4/LW/2a).

At this point it is acknowledged that the reasons behind family members trying to exert control
are complex. There are issues regarding the pressures felt by families and social networks, who
were involved with assisting older women. These issues could involve the amount of time,
energy and even financial support that was required. There may be past family tensions that
surfaced at such times, and emotions such as guilt, sadness and regret may have a place in
how things are handled at multiple levels. Beyond the awareness that such complexity may
exist, further speculation about these background events, and their effect on what women
write is beyond the scope of the data that was available for analysis in this current study.
There were issues mentioned about choices regarding the type of housing, or its location, and some women said that they had taken control and made the choices that suited them best. Some women said that they had made decisions that had not turned out well and they then had to rise up to make another decision to alter, and hopefully improve, the end result. An example that was described by a few women was that they moved houses twice even at the later stage of their lives because the first move they made was not considered successful, either due to the location or type of home chosen. Even though such changes were described as being disruptive and stressful, the women reported that they were glad they had exerted control and changed their outcomes for the better.

Some women disagreed with the opinions offered by doctors regarding management of a problem. Women in this study did not comment as to whether they felt pressured by doctors to continue with a treatment protocol, merely that they had not been in agreement. Many women in this study did however write about the fact that they persisted in finding new sources of guidance and management. They wrote they had continued to exercise control over whom they would consult, until a diagnosis or treatment plan was found that suited them better, or was more successful and/or appropriate. If treated with disrespect, some women took control and moved their appointments to another practitioner.

When the women wrote about making a decision for themselves they often followed this up by writing that even if they were not happy that they had to make these choices, they felt a sense of worry being lifted when they took control and made choices with independence. At times decisions such as these were forced on women due to safety issues, for example where doctors revoked their drivers’ licences, or that of their husband. Others wrote about when they had been involved in an accident that resulted in their car being written off. Some included comment that they had not been able to replace the car, for numerous reasons. Women described how difficult they felt these situations were. Their independence was severely challenged in many ways and the reactions varied to annoyance, distress or acceptance that new methods of managing their situation would be required.

Driving a car represented such a degree of independence that decisions concerning the safety of older drivers were fraught with emotion. Whether the woman was the designated driver, or the husband, the difficulties surrounding choices regarding driving in later life were mentioned often by women. For example, this woman shared her journey this way:
“I don’t know what I would do without our car to get around to visit people and to get to appointments” (S1/LW/2a);

“My husband can still drive and we think the time might be coming when we should let him hand in his licence before the doctor... or our family!!!...forces him to do so” (S3/LW/2b); and:

“Well, it has happened. My husband stopped driving. It was his choice but we all think it was for the best safety-wise! Now we have to find community buses to help us or get a taxi. Still I think I am relieved to not be responsible on busy roads now for all our sakes” (S4/LW/2b).

If there were multiple events outside their immediate control some women had the insight to feel these things would pass at some time in the future and things would most likely either improve, or return to status quo. For example when periods of illness occurred, either for the woman or her spouse, the comments often related to ‘there is nothing else I can do now but wait till things get better as I am sure they will’; or ‘if things don’t get better soon I will make another decision at a later date’.

Following on from the measures women took to exert control, and change the circumstances, other control measures were also seen, whereby women altered their response, rather than the circumstance. For example, women who could not change a situation wrote that they had ‘made some adjustments’ and described things as ‘the new normal’. They often wrote that they were hoping to resume some ‘former state’ or ‘way of doing things’. The process of ageing and becoming less able-bodied at times took precedence over the hopes for ‘better times ahead’ and, as one woman, said ‘her ambitions seem to outrun her abilities’. For many women, acknowledging that not everything can revert to a former situation, allowed them to come to terms with changes. Following ‘making the adjustment’ in expectations, some women reported that they had a better physical and emotional outcome. They describe ‘having to accept’ and ‘alter how I do things now’ in order to stay in control of their lives. So if mobility issues arose, the women chose aids to assist them. If they could not walk as fast as they used to, they allowed more time in order to complete the distance required. If they could not complete household tasks they recruited additional means of assistance. If they could no longer drive, they organised alternative transport.
Not many women in this study wrote about ‘giving away’ control of matters in their lives as an issue of preference. More frequently, increasing frailty of body or mind would have been the precipitating factor for a woman to no longer have control over her own concerns. Families at times wrote on the women’s behalf on the surveys, and described how they had placed their mother ‘in care’ or they indicated that they had ‘taken over control’ of managing her financial and health care, usually expressed with a sense of ‘regret’ or ‘sadness’. Often there was added information that their mother’s health had deteriorated to such an extent that these types of steps were considered to be necessary.

6.3.1.4 Identity

The roles and positions that women described related to personal, community and business areas. Most of these areas altered over time in some way although references to the resource of identity remained even in later surveys, from some women in all marital groups. The roles of wife, mother, grandmother, and great-grandmother appeared to take precedence for almost all participants who offered comments. Women took pride in referring to these roles, considering them to be vital to the functioning of the family unit. They wrote about how ‘proud’ they were of their children, and their offspring, of their own long lasting and happy marriages, that despite various ‘setbacks’ they had helped to care for their immediate family and often the wider family network as well.

They referred to the valuable role they played in supporting and caring for younger grandchildren using expressions such as ‘I do a lot of child minding’, ‘I help the children’. They often then linked these comments with helping the smaller children as they ‘learned reading’, were taught to ‘knit and sew’ and how they enjoyed ‘teaching games’. It was not able to be determined from these comments if women felt that helping their family justified their existence, or if it was more related to retaining a sense of being valued, appreciated and loved by their family.

Some women, particularly in the early widowed group, refer to their role within society as being a ‘widow’. The comment from this woman expressed similar sentiment to that of many others:

“I was widowed 3 years ago suddenly, after (number) years of happy marriage. It is a big adjustment to being called a widow, and to thinking of yourself as being a widow, and as well, to living alone again” (S1/EW).
Some women refer to themselves as being ‘war widows’, a unique category in itself. This was particularly true for women in the early widow group, as these were the women for whom the death of their husband was more likely to be linked to war related injuries or illness.

“My husband died nearly two years ago so my lifestyle has changed, and now I am a war widow. I cope by being very busy in the community i.e. I am president of two organisations and I still do some relief teaching I sew and paint. I have very little spare time!” (S1/EW);

“I am very involved in community work -- president of a very successful organisation. We war widows run workshops i.e. (examples of work) and generally we are very active in the town. I have just bought a computer and can "surf the Internet!!"” (S2/EW); and:

“I am still fairly active & involved in the community, particularly with other war widows. I am president of the (organisation)” (S5/EW).

Many women refer to an identity as being ‘carers’, with a few in early surveys referring to themselves as ‘daughter’, still needing to help their own parents. More often it was that they offered care to their children and grandchildren. As one woman from the late widow group wrote on two surveys:

“A good deal of my time is spent helping care for our daughter’s two children. She needs to work and they are occasionally not well enough for one reason or another - usually because of colds or asthma - to attend school. I pick one up from school on a regular basis twice a week” (S1/LW/2a); and:

“I care for my own home and garden, weeding pruning etc. and I do the same for my daughter” (S5/LW/2a).

There was an enormous variety of roles women described taking in community, special interest and sporting groups. They were quite specific in noting their position(s) as president, committee member, secretary and/or conductor of groups such as choirs. These roles were most frequently noted in earlier surveys and the most prolific comments were made by the earlier widowed women. This woman, from the early widowed group, was occupied in numerous areas and her comments over time were reflective of those made by many other women:
“Since my husband's death (date) I have attended to his company business - mostly finance. I am the family historian” (S1/EW);

“Owing to my busy schedule of being (position) of this retirement village of (number) units and filling a (position), (organisation) position in my (denomination) I have very little thing called ‘spare time’!!” (S2/EW);

“I help with Meals on Wheels. I belong to Legacy group, also RSL auxiliary and hospital auxiliary” (S4/EW); and:

“I am writing a family history of my family and hope to have it published for family and friends this year. I use the computer. I researched for 11 years prior to putting it into story form with sources noted” (S6/EW).

It appeared that for many of the women who remained married, or who were widowed at Survey 5, the roles they pursued over time were more within their homes compared to the women who were widowed earlier. Their interests appeared to be more centred on their spouse and their family. Some of the reasons women gave for this lack of external involvement were seen in the following comments from four women:

“My work with (organisations) is a little limited as I never know from day to day how (name) is, and if I am to spend time away from home (S4/LW/2b);”

“We have to stay home a fair bit and care for each other. My husband has a heart condition, and cannot go out much, but with the aid of good friends we have been able to manage together” (S1/M);

“My husband needs 24hr care but is always in good humour and we manage well but I know I can get help if needed” (S4/M); and:

“Being a carer for my husband after his stroke my activities (or rest) are restricted to the one day a week that I have respite or to events we are able to occasionally attend together” (S5/M).

Some married women did report long standing business interests that were managed alongside their husband, or that they continued with some external role(s). The following comments from four married women indicate some of this breadth:
“I have always been an independent active person getting one with my work in managing a retail boutique. I believe I am skilled at assisting women to look their best” (S1/M);

“My husband and I work in our business together; He acts as manager and I keep the books and all the other records” (S1/M);

“We run a beef cattle enterprise together” (S4/M); and:

“I trained as a nurse during the war...enjoyed 30 years of work after that until I was in my middle age” (S4/M).

Some specific business related roles that women reported taking on were those of business owner, book-keeper, accountant, real estate manager, retail assistant, nurse, office worker, rural property owner/farmer. These roles did appear to lessen over time, and they did not appear to be as commonly experienced by as many of the married women. A key finding was the multiple roles with which women identified, indicated diverse opportunities for community engagement.

### 6.3.1.5 Spiritual beliefs

A resource that provided a source of stability, hope and purpose was some form of spiritual belief. With due consideration that the participants in the study were mostly from an Anglo-Australian tradition, expressions of faith were largely represented in terms of orthodox Christian faith. Some women did embrace other spiritual expressions such as meditation, yoga practice and a general awareness of a ‘higher being’. Faith was described by many women as being the means to ground themselves in ‘something more certain and comforting’ than what they were experiencing in their physical and social world. It appeared that women in all the three marital groups used similar expressions regarding their faith if it was described as being part of their lives. In addition, the idea of spiritual faith was seen across all the surveys, and was not limited to comments in later surveys. It could be anticipated that where women expressed thoughts about end of life experiences and/or awareness of mortality that comments about faith and spiritual values may have increased. It was seen that the resource of spiritual values, in whatever form they appeared, was evident across the life course, and gave women a life-long sense of purpose and personal values. They expressed the benefits they perceived in their family as a result of the sense of support, and from the friendship
offered from church meetings and the wider engagement of churches in the community. One woman offered these two comments over a 12-year period:

“One’s upbringing has everything to do with health and how one copes with life. Being fortunate to be brought up in an extended family of parents, grandparents, aunts, uncles, cousins & friends etc. (as was my husband also) where Christian values and faith in God were solidly entrenched - I think this has stood me in good stead, and has helped me enormously since my husband suddenly collapsed & died just over two years ago. Having a firm faith has helped me get over my sadness and coming to a peace within myself” (S1/EW); and:

“My faith has sustained me over the years since my husband died and I remain involved with the church and its work in the community” (S5/EW).

The comment from the next woman also reflected something of the generational attitudes from this cohort, and the societal values that had shaped their experience:

“I think our age group is fortunate. Although we have lived through hard times we have been part of a time where a lot of people went to church. It was part of the community and many families all knew each other- we knew their children, and watched them grow up. We had the same values because of our faith and I think that made us stronger as a group. We still enjoy seeing our old friends there…. although we are less in number now! We know that there are people there who watch out for us. We only have to call them up and they would help us. Lovely to know” (S5/M).

Other women mentioned that they prayed, meditated or took part in some form of yoga practice. These personal habits centred their thoughts, and brought some peace and calmness in the midst of uncertain times. Again, if the women described a form of spiritual practice it appeared to be something that was consistent and persistent throughout their lives.

6.3.1.6 Knowledge

Knowledge, according to the definition taken for the current study, embraced orthodox and mainstream learning found in more formal institutions and settings, and also more informal and experiential awareness and skill developed over a lifetime. The women in the cohort wrote about the cultural attitudes and significant events of their generation, which when combined meant that many of them did not finish high school, and even fewer went on to
study at higher level institutions. This was often expressed with a sense of disappointment that they didn’t have ‘much opportunity to complete an education’, and in particular it was often noted that ‘boys had far more chances to stay in school than we girls did’. However, through more informal means many women described the ways they grew in knowledge about a wide range of areas over their lifetime. There was no observable difference between the experiences described by women in all the groups of older women studied, irrespective of their later life marital status.

Comments about formal education, if mentioned at all, were mostly seen at the Survey 1, and rarely thereafter. Women expressed the opinion that, at the time of their school years, girls were considered to ‘not need’ as extensive an education as boys, and they were steered into job opportunities deemed ‘suitable for a girl’, presumably until the girl married. Two key events that occurred in the late 1920’s and 1930-40’s were the Great Depression and WWll. Money was scarce for families during the depression so not only could money not be found to send many children, especially girls, to school for more than a minimum number of years. In addition, family members often had to contribute to the household income as early as possible. As one woman wrote:

“I would have chosen to be a nurse, however war intervened and my brother became a soldier. I left school to assist my parents on the dairy farm” (S1/EW).

The advent of the war meant that so many young men were no longer around the home and local community. Women then, by necessity, left school and started to fill jobs that would otherwise have been taken by men. It usually appeared that they were accepted into various employment roles despite having limited formal education. The comments from these two women typified many of the experiences of others at that time:

“No opportunity for high school. I had to work in a factory, as there were not enough men left to do the jobs. I married a (capital city) boy after the war and we settled in (capital city), where I did various jobs. I finally made my way into social Welfare Department, where I gradually worked my way up” (S1/EW); and:

“I was accepted for secretarial training – but I never got to start. The war was on. I had to go to work in a shop. Would have liked the opportunities children
The comments from the following woman echoes the limited education offered for girls of that era. The role of education is said to positively affect quality of life as people age, and there is an awareness that even today there remains gender inequality in the opportunities for education, and subsequent employment opportunities, for older people, particularly women. The women in the current study were affected by the inequality in educational opportunity far more than will be true of following generations (Pruchno, 2012; Radovic-Markovic, 2013).

For the women in this current study, the resource of education (at least in the formal sense) was not seen in the findings to be available to any extent as a valid source of strength of the SOC. However, future studies may see the appearance of the role of formal education as a stronger resource for women of subsequent generations. Younger women will likely have more opportunities to pursue higher education and a career path, outside their roles within home and family, than the participants in the current study. The term ‘knowledge’ taken for this study has accommodated that women wrote most about acquiring skills and information informally, compared to formal opportunities, such as those offered in schools, colleges and universities. It was also found that women who had grown up in rural areas had been required to contribute on the family property rather than ‘waste time at school’ when ‘help was needed at home’. This woman’s experience was just one of many:

“Left school at 14 to work in a solicitor’s office. Had to help on the farm before and after work. There was no money for extra hired help. Higher education was not so readily available for country children then” (S1/EW).

They often sought other opportunities later in life to learn skills and included comments about how they ‘worked their way up’, they described ‘doing courses here and there’ and they wrote about taking ‘chances to improve things’ when they could. This woman described her opportunity later in life this way:

“I just worked hard at different jobs and eventually I became Superintendent of a girls’ home. I did a 3 year part time course at Uni, which put me in the deep end” (S1/EW).

Many women wrote about investing in the education of their children in order for them to have benefits that they themselves had not been privileged to have. They recounted memories
of their limited education, balancing some level of disappointment about what could have been, with a pride of achievement and faith in their own abilities to make the most of what was offered at that time. Despite the restricted opportunities of their younger years when they became parents, women chose to invest in the children of the next generation, to assist them to achieve higher goals. The following quotes, taken from women in all the marital groups studied, provided an amazing insight into the history of these women, showing that despite the limited opportunities many of them had for formal learning they valued whatever chances they were given:

“Also we were in war during our twenties - Fortunately my children all have university degrees” (S1/EW);

“I came to Australia in (date) and am an old (county) girl "a school girl of the London blitz" having lived through the exciting days of the "Spit fire" (aeroplane) dog fights in the skies. Leaving school at 14 years I was re-educated in (cities) where I applied to (state) Education Department to become a teacher. In (date) I retired as headmistress of (suburb) High School, after a rewarding career. I am never bored. I sing and I am always open to learn new things. My interests help me to do this. I am currently Secretary of (suburb) Choral group, and probation officer at (suburb) Court” (S1/LW/2a);

“At 14 I had to leave school and I went to work in a shoe shop for 7/6 ($1-50) a week. I had sat and received my merit certificate in (date). At nineteen/twenty I wanted to go nursing (my merit certificate was an acceptable qualification at that time) but encountered family opposition. I married at (number), had a family and did a (profession) course and worked for a while, had another child and cared for ageing and ailing parents. I have always regretted not doing nursing, but in later years did short courses on various subjects and have read a great deal. I can at least say, I have achieved an education. Now in my 75th year, I am writing a family history for my sons and grandchildren and the families of my cousins. Yes, I am at last satisfied with my life and my sons are well educated” (S1/LW/2b); and:

“For schooling at that time in 1940 there was no money to be kept at school I was 14 years and 10 months when I finished. I was taught elementary shorthand, intermediate shorthand, book keeping. The (religious order) nuns
taught all of us at the time, excellent spelling. My opinion: I did better in those years and qualified successfully to carry out work as I was educated to do than most children today. We were taught how to write a business letter, my 2 sons never got that” (S1/M).

Women referred to being involved with community colleges, University of the Third Age (U3A) & senior citizen centres where specific classes were offered. A few wrote about taking lessons in art, language & computers at unidentified centres. Some mentioned that learning new skills helped to keep their mind active. The location or source of the learning experience was not always mentioned. Families also provided opportunities for ongoing skill development and women wrote that they had been helped to learn how to learn to use computers, and access the internet, by their children and grandchildren. Some made reference to being President of community organisations. It was unknown whether they had to have had any specific education prior to taking the position in order to take that leadership role. It was presumed that most of the organisations mentioned functioned on volunteer help so formal qualifications may have not been a requirement to fulfil the position.

Some women wrote about their General Practitioners (GP’s) who had offered medical support to the spouse in the period of care that was required, and also medical and perhaps emotional support to the woman during that time. In addition, many GP’s were also said to have offered help regarding the necessary knowledge to manage mental and physical health issues that occurred more frequently in the initial period post-loss. This was an important resource that women knew they could access, and indeed they wrote about how they had made use of this form of support. A competent GP, with whom the woman was familiar, and who had proved trustworthy in the past, could provide a valuable knowledge resource.

Other trusted medical professionals (such as physiotherapists and social workers) also offered their knowledge to help support and inform older women when making decisions, when without specific guidance, the situation could be more difficult. This was especially seen during challenging periods of greater stress, when women were coping with deep sadness, and also facing many decisions that now had to be made without spousal support. There may have been other people who offered support about information that would be helpful around the time of funerals, housing decisions and other matters of financial concern. However, in this study women did not make further comments about other professional input and/or help from additional external sources of knowledge and support.
6.3.1.7 Social resources

This concept was broad and encompassed the relationships, roles and interactions between family, friends, and community and support networks. To adequately represent the various aspects of social resources, the findings are presented in four sections, social networks, spousal support, social engagement and social capital. It is noted that there were many instances where the aspects were seen to overlap.

Social networks: Women drew great strength from having ongoing relationships in numerous areas. For early widowed women, their involvement with family members seemed to be stronger in the first surveys, and then at times, a resurgence again in their later years. In the intervening period it appeared that women had created a new life, as single women and no longer partnered, the results of which was seen in evidence of flourishing friendships and external interests. There were often specific references to the value of ‘long term friends’. While many women spoke of ‘losing’ friends as the years passed, there was great value placed on those who remained. The memories shared included comments about friends from school, about weddings, of families growing up together, and were spoken of as ‘precious times’.

It was the sense of connection over many years, perhaps even a whole lifetime to date, that led to such friendships being described with such significance. Some women wrote that they had known a friend since school or university days. At other times they said their friend had been their bridesmaid, and other similar connections over major life events were seen to be extremely valuable. This led to a greater understanding of how much emotional attachment was felt by women for people within their networks. One early widowed woman shared the value she saw in her resource of her networks over four surveys, and included expressions such as:

“The support of family and friends (particularly church friends) has been absolutely wonderful!” (S1);

“I have known some of my friends longer than I knew my husband!” (S2);

“Love the support from my friends at my club and voluntary work” (S3);

“Hey…I can drive wherever I need to go and have a lovely network of friends... though we are fewer in number. Grateful for who we have!!” (S6).
The networks were seen to vary according to marital status. While women remained married they were often more focused on the more discrete family unit, as these two women wrote:

“3 years ago my husband had a leg amputated & has been in indifferent health since. I don’t leave him on his own but we do enjoy our company together when we get to go out every week to the shops or for lunch” (S3/LW/2b); and

“My husband and I visit our daughter every week and at least one of our 3 sons visits each week. Others ring us. We have a loving family grandchildren (number) great grandchildren; we feel so good when we see them & enjoy their visits; I also communicate with them often by phone & SMS” (S6/M).

Married women who lived in smaller or regional towns seemed to write more often that they continued with activities outside the home than did their city counterparts. It appeared that this resource was more likely to be accessed by women who described the benefits that a smaller, more close-knit community offered.

One woman wrote these comments at four surveys:

“I live in a small country town and have always been involved in community affairs Church, sport, CWA, Hall committee, senior citizens, schools” (S2/M);

“Our small town is a caring community - I am about to visit sick & "house bound" friends. Support & take part in most community organisation Church” (S4/M);

“I have always been involved in community work: bush nursing centre, infant welfare (we had to raise the money to build both), CWA (61 years) mission fellowship church, guild, golf, tennis, bowls – hockey, hall committee” (S5/M); and:

“I have been involved in most community organisations, schools, Infant Welfare, Local Hall, Church, Mission Fellowship, C.W.A (64 years) & Church Guild, and managed to enjoy it all” (S6/M).

Some examples of how the networks functioned over time were visiting another’s home for shorter day-long visits, and more extended visits to family or friends while the women remained active enough to participate this way. If people in the network lived further away, then women described the value of phone contacts, letters and Skype calls. The importance of
phone contact was emphasised often, and this increased over time if social networks could no longer be accessed, with a physical presence. Telephone calls were said to be especially valuable to rural & remote women. Women seemed to draw sufficient resource from this contact if they knew that that was all that was possible when distance was an issue. There appeared to be a security in knowing that family and friends cared emotionally even if that could not be expressed in physical and instrumental ways. Even if family were not close by, the knowledge that they would be prepared to help if they could, offered a source of strength.

One difficulty mentioned about phone contact being a source of support was that costs could be prohibitive for some, with comments such as ‘who can afford the phone charges these days?’ This was particularly a challenge for rural women, who, because of distance from family and friends, relied more on telecommunication for support. In addition, they also were the ones who had to pay the higher costs, often for a less reliable service than what was available to city dwelling women. Some women expressed that ‘their families were not involved’ or seemed to be ‘disinterested’ in supporting them. For others, they wrote that their friends had ‘moved away,’ and over time, as both parties were feeling less able to keep up communication and support from a distance, this contributed to a feeling of lack of social support.

Spousal support: Whereas in the previous chapter, issues to do with caring for a spouse were a key finding to do with stressors for women, one difference that was observed between both widowed groups and the married group was that for some married women care from a spouse was seen as a resource, even if it was only required for shorter periods when the women herself was unwell, or recovering from surgery. For example, this woman wrote:

“I had an operation on my shoulder for a torn rotator cuff on (date) and I am still trying to lift my right arm. I have been attending hydrotherapy pool classes ever since it is a long process - just a slight improvement. My osteoarthritis is getting worse take more pain killers (names of drugs used); I have to learn to live with it. My husband is a big help to me and is currently doing all the heavy work as I can’t lift anything much at all yet. I am sure I will get back to helping in the months to come” (SS/M).

Another woman, who described keeping quite fit and active with walking and swimming activities, at least until S4, indicated that she needed her husband to assist in managing their home. She wrote:
“At the moment, due to some troubles I have been having, my husband does the vacuuming and most of the gardening - lucky me!” (S3/M).

This was also seen in the way women wrote about sharing chores, and by offering help with jobs within the home that one partner could no longer manage. For example, this woman contributed comments at four surveys across 15 years that showed that as a couple, they had adapted to sharing responsibilities and helping each other. This served as a valuable resource over time:

“I’m blessed with a loving caring husband who has been my total help throughout these past 3 years and we cope” (S1/M);

“But I am able to keep any housework done and am helped with vacuuming, bathroom cleaning by my husband. We shop together regularly... my husband and I are moving house in June to be in a smaller, more manageable house and surroundings” (S3/M);

“Three years has made a lot of difference to my health but life is still good and with my husband of 56 years and independent age as I am, being so helpful, I manage well, even though I am very arthritic and must take care when we go to the supermarkets.... My husband refuses home help & does vacuuming & bathrooms but this will change” (S4/M); and:

“I have had several vertebral fractures which were very painful at first and which caused very severe kyphosis which is very debilitating and prevents me from doing a lot of things so I use a wheeled walker an am taken to the shops in a wheelchair I am able to do a few chores with difficulty but have a very helpful husband and we manage at present but I will have time in respite care to give my husband a rest & we will eventually seek full time sometime in the future” (S6/M).

A few women reported that their spouse was younger, more active, and therefore more able to fulfil a carer role. Their need for care extended at times beyond merely physical needs. One spouse, wrote on three surveys on behalf of his wife. He indicated that his wife was suffering from depression, and was not able to make the ordinary decisions of daily life. Two examples of the information he shared about how they were managing this problem follow:
“For a long time planning & cooking meals was too much for her, however, with encouragement she is finding it easier to do a little bit but with assistance from me (husband)” (S4/M); and:

“I make up my own muesli mix to ensure sufficient roughage is provided (along with seeded breads) and added dried fruits. (Name) does not like meat now so I cook mince dishes such as bolognese etc. or stewed or curried meat dishes loaded with vegetables” (S6/M).

Social engagement: Whereas the resource of social network maintains a focus on the dynamic between the participants of a particular group within the network, engagement refers to the degree of involvement that people may have in an activity. This includes the aspects of regularity, commitment, yet lack of compulsion, associated with the activity.

For early widowed women it has already been noted that they were seen to have a higher involvement with the veterans’ community and related groups. The experience of living with an ex-serviceman offered a shared bond for many women, as the long-lasting effects of military service had been a hallmark of many of their marriages. These women often wrote about how much they enjoyed activities such as ‘cooking for Legacy stalls’, ‘helping out at RSL (Returned and Services League) and Red Cross events’. They felt a sense of contribution from participating in War Widows groups, which included opportunities such as ‘selling badges for the RSL on Anzac Day’. Other activities that were mentioned as being a source of valued resource, particularly for women in the early and later widowed groups, were opportunities to visit nursing homes on a regular basis, to be part of singing groups who often performed at community and church events, and participation in events on the church calendar such as fetes, hospital stalls and bible studies. Women felt that by ‘giving back to others’ and ‘by being around other people than the family’ that they themselves benefitted from the ‘outward focus’. Some interest groups that met regularly, for example gardening clubs, had a charity focus. Women expressed that they received ‘much pleasure’ when they could ‘contribute to events’ where the money raised from sales of goods was used to benefit ‘less fortunate’ groups, both in Australia and overseas.

Married women wrote less about these diverse types of social engagement. When activities were described, the comments reflected that both husband and wife were ‘still interested’ in investing in groups such as church and local community groups such Meals on Wheels. This
was in evidence in these comments by two women in the married group, one from an earlier survey, and one from a later one:

“My husband and I enjoy helping others with Meals on Wheels. He usually drives and I take the meals in but sometimes we swap. We volunteer once a month and I think we get as much enjoyment out of it as do the people who are receiving the meals! It works so well for us” (S2/M); and:

“We have been very busy helping out church with its (number) year anniversary. We have been in that community for (number) years now. We have different jobs to do there but we have part of that community since we got married. That is a long time now...more than half a century!” (S5/M).

There were some comments from women who expressed disappointment that they could no longer keep up with volunteering, or interests outside the home. This could be due to being ‘unable to leave’ their husband as he became more frail or dependent on her, it could have been due to difficulties to ‘access transport now’ and other women wrote that their own physical challenges had proved to be too much to overcome and they had ceased their activities outside the home, often with a sense of ‘regret’ and ‘sadness’ as they missed the interaction and support such interests had provided.

Social Capital: The social resources for women concerned the activities and the relationships, and also covered the aspect of the quality of the interaction between the women and the people with whom they connected. The qualities that were described as being of inherent value in this resource included trust, mutual reciprocity and a recognition that women felt a level of respect was offered to them.

If women remained married, and the relationship was reported as being a happy one, there appeared to be less reference to them being affected by the attitudes of people outside the marriage relationship. However, for women who were widowed, perhaps it was the need to receive the support of validation from somewhere within their network that they contributed comments such as:

“I get a lot of love and respect from my family which I appreciate and that helps me also feel better” (S5/EW); and:
“My family & friends are all good to me, the young & the old. I have just been to (state) for 10 days with a daughter of an old friend of mine who passed away last year & my granddaughter is taking me to (state and capital city) for 2 1/2 weeks in end of October. I go anywhere the young ones want to take me. I love that they enjoy having me with them. It helps to keep my mind from growing old. My grandson is just finishing (number) years of University with music studies so I get lots of entertainment with him & family; he is very good to me” (S4/LW/2a).

Some women even commented how they could disagree with friends and yet still feel respected, and could benefit from genuine relationships, as evidenced by this woman:

“My friend and I have a saying. If we are starting to disagree with each other we say 'Change of Subject' and it really works!!” (S6/EW).

6.3.1.8 Financial resources

Financial resources have been taken to include any matters that relate to sources of money, the ability to pay for bills, and those that had a bearing on choices related to housing and transport. This is distinct from the other aspect of the women’s financial situations, which was discussed in Chapter 5 (section 5.4.1.7), where the stress associated with a deficit of financial resources was elaborated in detail.

Women from all groups studied did not offer as many direct comments about their financial resources as they did about their financial deficits. The comments about financial resources were more related to the fact that they appreciated the opportunities they could pursue when they had sufficient money to support them rather acquiring or describing material goods. Some of the women wrote about the enrichment they felt their travel opportunities gave them:

“Last April I went to (overseas destination) for a couple of months and climbed for (number) hours, (name) (height). This April I’m going for a trip (country) to (country) and hope to climb the (name) on (name of island). It is such a wonderful thing to have enough money to be able to enjoy these trips even later in my life. I enjoy it SO much!” (S4/EW).

Others wrote about selling their properties in order to buy another that was more suited to their needs. When women contributed comments such as ‘we are selling our big home’ or ‘I
am waiting for the sale of my home so I can downsize to a smaller home’, there was usually no additional comment clarifying the value of the resource they had. It was actually more obvious that this situation was indeed a resource when contrasted against comments from other women who had written about suffering financial stress. The stories concerning lack of financial resource, hampering choices of more appropriate housing highlighted the benefits other women had who could make their preferred choice, even if they had to wait at times in order to achieve the exact result they were seeking.

The differences between marital groups was most noticeable that the women who remained married shared more about the choices they could make because of the strength of their financial resources. And there was more evidence that business ventures lasted longer for married women than for those who were widowed, whether that was in terms of looking after rental properties, helping to run a rural property, or other unspecified businesses in which the husband and wife shared responsibilities. Some of the later widowed groups referred to the fact that as a couple they were self-funded retirees. After the death of the spouse there was little additional information given that could convey further insight.

One resource that was strong in the women in this cohort was being supported in some way by DVA. This generation of women had experienced so much additional pressure because of war related issues, for example, the health and possible early death of the spouse, the loss of other family members, and the financial pressures of wartime food rations and restrictions on numerous goods (for example, limited number of bricks for building homes). By the time the women became participants of the ALSWH, many were already receiving financial support from DVA. Given the stress many women had described regarding the burden of maintaining access to private health, the benefit for women whose medical and associated travel costs were now paid by DVA was almost beyond measure. These quotes are just two of many who frequently stated almost the same words:

“As a war widow my medical expenses are taken care of by Department of Veterans Affairs… I am so grateful for all they have done. I could not have paid for all my health needs without their help. It would be the waiting lists for me!!” (S1/LW/2b); and:

“I am also lucky in that we have a shire community car which takes us to specialists, dentists etc. Veterans’ Affairs pays for my trips as our local hospital
recently closed its doors to in-patients and I have to travel a long way now to (name). I could not have afforded to get there any other way” (S1/LW/2b).

6.3.2 SRR’s that contributed to SOC

Most literature on salutogenesis has emphasised the concept of GRR’s (section 3.2 and sections 6.1.1-6.1.2). It was true for this study that, as in other research that had derived knowledge from Antonovsky’s (1979, 1987) earlier works, that the resources that women describe are many. They have wide application and there can be many iterations of resources. However, some specific resources were seen. These were related to unique experiences of this generation of women and the specific stages of ageing, seen over 15 years. The experiences or features that have been encountered by these women are described in separate sections that follow.

6.3.2.1 A unique set of events throughout the world

Truly, every generation has had, and will continue to have a story that is uniquely ‘their own’. As has been mentioned, the women in this study are ones who have lived through huge economic deficits and ‘booming’ success times. They have seen almost their entire world at war, and in addition have had other significant conflicts, since then, potentially impacting their families. They have seen a rapid rise in technology that has affected every area of their lives, and as such, is almost inescapable.

The women of this generation frequently experienced effects within their families of the war, as husbands may have dealt with post war issues and injuries. As time passed, and more husbands who had seen active duty in the war passed away, the women remained closely involved with service related groups such as Legacy and war widows. This was a unique relationship born out of time of adversity and challenge. The connection was forged into a valuable resource whereby women felt supported by others who understood specific challenges that had been arisen out of times of war and disruption. To counter the negative and ongoing after-effects of military conflict, often felt by the service community and their families, women formed bonds through formal organisations and informal support networks. These networks offered social support and could suggest strategies whereby families could respond appropriately to challenging behaviours. They may also have offered education about physical illnesses and injuries, that many service personnel may have been suffered during, or since, military service.
6.3.2.2 A unique social community

As was seen in earlier findings, a thought that was expressed with pride, was that this generation of women were part of building the fabric of post-war Australia, particularly in the 1940-1960’s period. The Australian community was at that time largely Caucasian, although they welcomed a large wave of European migrants initially, which has widened over time to include Asian, and Eastern and Southern European migrants. For these women, in their earlier days of marriage, when children were young in the 1950’s and 1960’s, there was a strong Anglo-Protestant element among the families, regarding their affiliation with religious denominations. This was a strong part of the community the women knew, from the time they married and lasted throughout the time in which their children grew to adulthood.

Women wrote about how much they valued the social and spiritual resource of neighbours, church friends and the social network that provided the context for their families social and community involvement. Recognising that for many women, their neighbours remained the same for decades, and hence the value of the resource of peer friendship, support and encouragement was strong. Many women did not work outside of the home in paid employment, particularly in the years that their children were at school. This set the scene for these women to have spent significant time with other women in their neighbourhood. Many made significant long-term friends right across the backyard fence, across the road and within the same suburb. They found their resource of identity was anchored in the roles and relationships that strong nuclear family units engendered, and that cohesive communities encouraged.

6.3.2.3 A unique marriage story encompassing love and loss

The women in this cohort often married at quite a young age, and within the period of mid and post-WWII events. Their marriages lasted most commonly for the entire length of time that both partners lived. Marriages that lasted 50-70 years were not uncommon among these women. It has already been seen in other research on ALWH participants, for example on the cohort that were born 1946-1951, that this type of ‘marriage for a lifetime’ is not being repeated in the generations of women who are following on in Australia (ALSWH, 2014). When the women of the oldest cohort of the ALSWH wrote about the death of their spouse, it is within the context of them suffering the loss of the ‘love of their life’. Some women described their marriage was not particularly fulfilling or harmonious. However, most had remained married for reasons that were grounded in the morals and popular opinions of that time. Excluding women who had suffered abuse of some form, most of the women who experienced
spousal loss, were bereft of the one person with whom they had shared their longest memories, the journeys of ‘their family’ and frequently their ‘dearest friend’. This is the context that frames the formation of the resource of resilience, and is seen in a unique expression within this generation. To endure deep loss and yet to be seen to re-invent a new social life, to re-capture old interests and to recover emotional strength, all were seen as significant and specific evidence of social, spiritual and knowledge resources.

At this key time of change and adjustment, women turned to the resources of family to help support and at time assist in making major decisions that may have been made around the time of spousal loss. It was often the family who provided the resource to help women make sense of, and recover from, their husband’s death. Women described that their children were the key resource to find comfort and meaning in the early periods of grief and loss. The family unit represented the shared bond and outcome of the relationship between the women and their husband.

6.3.3 Sense of Coherence

“What matters is that one has had the life experiences which lead to a strong SOC; this, in turn, allows one to ‘reach out’, in any given situation, and apply the resources appropriate to that stressor” (Antonovsky, 1996, p. 15)

According to the basic concept of salutogenic theory, resources can be accessed and developed to help strengthen SOC (Antonovsky, 1987; 1993). The first part of this chapter has identified many of the experiences in women’s lives and the resources they have used. The following part of the chapter builds from these findings by seeking to describe how the resources have been applied in the development of a strong SOC.

Evidence of the three main components of SOC, comprehensibility, manageability and meaningfulness, were discernible from many of the women’s comments and very often there was a reference within a quote to more than one of the components. The presence of any one component may have influenced and interacted with another. For example, having the resource of understanding of a situation may have affected how a woman managed decisions, which in turn, may have been influenced, both by her perceived meaning of her life at that time, and by her reasons for taking steps to move in any one direction.
6.3.3.1 Comprehensibility

Women used words such as understanding, reasoning, thinking and expecting throughout the comments as they described their lives. There was a sense of logical progression in the thoughts expressed by many women. They said that they had reasoned that if given that a particular event had occurred in the past, then it was only to be expected that a specified result could be foreshadowed in the future based on their interpretation of the logic of history. Other similar interpretations of events were evident with the use of expressions ‘as I thought it would be’ and ‘what I expected over time did happen’. It was not able to be determined with certainty if women used these types of words, as it helped them feel prepared for future challenges, or if some may have felt a sense of resignation that losses could be ahead in a few domains. It could be that using the resource of knowledge about possible future events (for example, the onset of physical health issues or the occurrence of deaths within their networks) helped some women minimise the stress of the unknown. For others it possibly alerted them to be prepared for harder experiences that may have to be negotiated in their older age. For some women there was an awareness that at least a certain amount of change would probably be associated with the ageing process, including potential losses in physical, psychological and emotional domains. The comment from this woman indicated something of the difficulty of the process involved for widowed women making these decisions without the support of a spouse:

“At the present time I am trying to make a decision if it would be wise to sell my home & move into Retirement living- a very difficult conclusion to come to, especially as I am used to discussing all of these types of things with my husband” (S3/EW).

Other concepts that could demonstrate how women brought understanding to their lives as they aged was the way they used the resource of control. For some, the resource of understanding of their circumstance allowed them to effect control over the environment, and thereby add a dimension of manageability as well to their lives. Overwhelmingly, many women described an ongoing ability to exert primary control if at all possible.

If changing the circumstances was not possible, some women went to another method of control by changing their internal response to the stressful situation. When this occurred, they may have chosen to accept events with a sense of resignation or even fatalism, and adjusted to what they felt were inevitable changes. However, these concepts did not form a strong
element in the data available in this study. For most women in this study it was seen that they comprehended their choices in terms of how they could best exert control. They usually made efforts to remain engaged in, and adjust to, altered circumstances of their lives and to seek a reasonable explanation of events. As this woman said after moving house:

“I sold my house last year & moved into a villa. It has taken me a while to resettled but like most things there are pluses & minuses but as I think about the options that were available to me at that time I think the plus side outweighs the minus” (S4/EW).

Women seemed to moderate their understanding of events, and what could reasonably be expected to happen for them in the future, by evaluating their social resources, and considering what other people around them had experienced before, and so this introduced the role of peer example. They wrote about the opinions and actions expressed by friends and contacts, and at times this could offer supportive advice and information from shared experience. It was considered possible that the opinions of others would not necessarily be the same as that of the women involved, and expressions such as ‘my family and friends do not always have the same opinion as me’ were seen. Many women were clear about the identity that they felt was theirs, and did not write about being coerced into making decisions against their will. Many reported that they had the support of their family to make the decisions for their future. One woman wrote:

“My family respects my opinions. I know we do not always think the same thing but I know that if I need their advice I will ask for it!... My friends are more likely to need my advice!” (S5/LW/2b).

It was not always certain if the women were responding more to a perceived pressure or to a sense of support. For example, this early widowed woman wrote at Survey 3 that she was going to move house, as she felt she may need assistance from family in the future and “my daughter has wanted me to move up for some time. I will not be living with her, hopefully within walking distance”. There was evidence in later comments from the same women of a positive disposition, where she expressed that she had hopes that things would work out well for her whatever choices she made. She exhibited an assurance that whatever choices had to be made, she would have the capacity to access resources that would allow her to adjust given time.
At times women spoke in detail about the plans they had thought to be reasonable, notably regarding housing and direction of health care. There was a pattern whereby use of more than one resource could appear within one quote. For example, for women who had sufficient financial resources to support their preferred choices, they described their knowledge skills, with a stated rationale for making decisions. They used expressions such as ‘thinking through my possible choices’. Many wrote that their choices were acceptable to them and that they resulted in being able to live with some level of independence, perhaps with the support of additional services. These could be offered by some part of their social support network, and could be increasingly accessed if needed in life, as they aged. One example among many that indicated an awareness of how roles and responsibilities could interact was this woman’s description of how both she and her family had mutual input into her proposed housing move:

“I am shortly moving to a Retirement Village to be nearer to my daughter at (suburb). No reason, only I’m older & don’t get to see any family very much (hence my big phone bill!!) & the collective family thought it a good idea (as did I). I have not sold my home yet to enable this move to take place” (S4/EW).

Many women explained that others in their age group were also experiencing similar events or needing to make decisions within the same genre, for example, housing that suits their needs in their later years. The resource of social networks was seen to be in use when women considered their opinions, and then weighed them against others in their world. There appeared to be a sense of validation derived when there was additional support regarding decisions that the women shared were needing to be made. For example, “I do not want to move away just now and my friends agree with my choice at this time” (S5/LW/2b).

The opinions of friends in their social network carried weight regarding support for decisions, and the women also asked their family for input. It was interesting to note that in addition, some women felt that the people who were reading their responses at the ALSWH actually cared for their generation and asked for feedback from the survey results. Women felt that this information would help them with feedback as to how the cohort as a whole was reporting their experiences, and this woman’s comment is just one example:

“I always look forward to completing these surveys. Would appreciate some feedback on where we are headed” (S2/M).
At times some women described using their knowledge resource to assist in coping with an earlier decision that did not work out well for them. Some had moved house and had chosen a different type of dwelling (for example, a free standing home in a suburb to an assisted living apartment in a different area of town, or another state). Some then wrote of how they reversed the decision, for example by moving back to a former geographical location. Others had ‘made do’ with the current choice, with the reasoning that there were no positive alternatives, or that over the future years, they hoped that they may ‘settle down and feel more comfortable’.

Decisions made with less than acceptable outcomes were a source of stress for many women. Some women, particularly from the widowed groups, had moved away from friends to be near family and it had not worked out the way they had hoped. As the women applied the concept of comprehensibility to the situation it appeared that although they continued to confirm the stress involved, they reasoned it was something they had to manage, as the stressor could not be changed at that time. This woman, from the early widows, wrote at three survey time points that she had not been happy with her decision, yet over time the reasoning process regarding her choice becomes more evident:

“A lot of stress is I miss where I lived before my husband passed on seven years ago. I lived at lakes and beach for 25 years at (suburb) and came here to be with family and am afraid I can’t get used to being in (suburb) area, which causes a lot of stress, which causes my ill health” (S1/EW);

“I came here when my husband died (number) years, & I have never liked here & this does cause me a lot of unhappiness, but I have thought about it all and as my family are all here I think it is the best thing to stay” (S5/EW); and:

“I came here (number) years ago from (suburb and region) when my husband died & I still don’t like it down here & miss (regional city) very much. However, it seems best to not move again and one good thing is that my family are here. So ‘staying put’ is what makes best sense to me now” (S6/EW).

The dual resources of resilience and positive disposition could be seen when women described that their reality did not often equate to their preferred situation. Many women of the generation that formed the older cohort noted that they were of the era who ‘just got on with things’, and ‘made the best’ of a life that may not have turned out the way they may have initially hoped for when they were young. For some women there were comments that
showed the complexity that is involved with making and adjusting to the changes of living without a spouse and associated changes that may have to be thought through, as expressed by this woman:

“I sold my house after (number) years and moved to this retirement village last August. It has been very traumatic, and even though I am quite happy here I find it seems now to have just caught up with me and I really sometimes question my move. I know I shall survive very well but occasionally I get very low and question my decision. My son and his family (wife and one child) are close by, hence my decision so I guess I shall settle down eventually” (S3/EW).

Women applied knowledge when seeking to understand the structure of their lives (i.e. comprehensibility) by applying some specific measurable goals to their plans. For example, they may have decided they would like to be able to walk a certain distance, perform certain tasks at home or return to a community activity or sport in the future and undertook exercises or activities that would enhance their likelihood of regaining strength and mobility. Some wrote of their specific programmes and outcomes:

“Every week I plus friend walk 5-6 kilometres, plus I walk 30-40 mins each day, and practice yoga daily. A bone density test stated I am non osteoporotic” (S3/LW/2a).

Numerous women wrote about using control, resilience and knowledge when they pursued their recovery programmes after illnesses, procedures and more major surgeries, such as this woman who described with some detail what she had done to assist her recovery after extensive heart surgery:

“I have returned to leading an active life again - gym x 3 times weekly, walking swimming periodically, gardening and travelling lots - nothing has held me back anyway” (S5/EW).

Women at times wrote about ‘not understanding’ events around them, for example, certain financial decisions being made by other family members close to them, and this was written with a sense of anxiety. They said they felt ‘worried’ if they did not know how events may ‘turn out’ with respect to impact on themselves or others. These comments were frequently left in an unresolved position as the woman had to live with the reality that she ‘could not control’ the actions of others and indeed how these may affect her. The stress reaction associated with
this was a concern for women, as the time frame for resolution to the problem was not known, or if indeed a resolution was even possible.

Others expressed that given circumstances happening around them they were exerting a measure of control by developing a plan for what they would do in the future if events unfolded in a challenging way. If they were lonely they understood how this had affected them and many had a plan of action concerning things that made them feel better about their life. For example, some said they would ‘make a phone call or visit a friend’, or as one woman wrote, ‘I count my blessings’ as a way to acknowledge, and to possibly ‘re-orientate’ their thinking to embrace the positive aspects that remained in their lives. Some wrote that they understood that in order to stay strong and independent they needed to continue with a programme where they ‘walked more’, participated in ‘exercise groups’ or kept their ‘brain busy and active helping others’. If they became less independent they wrote that they had a plan to move to a residence offering assistance.

Experiences over a lifetime were seen to influence how women gained further understanding of what had happened already for her, and what may happen in the future. Women may have gained a sense of ‘knowing’ as elements of life have a certain repetition about them. By the time the women even commenced the ALSWH study they had already experienced a wide range of events, for example the Great Depression after 1929, WWII, deaths of family and friends, sadness, injuries, and joyous events such as births and weddings. In the ebb and flow of life, which constitutes the reality of a ‘lifetime’, women have commonly already had to accept lowered expectations than those with which they may have started out. They showed an ability to consider events, to recognise and utilise available resources such as support and assistance from family and friends, and to accept an increased use of medical and allied health professionals if required.

The comments showed that it was not always possible for women to express ‘comprehensibility’ about aspects of their lives. Some examples of these were where women did not expect an event to happen and were unprepared, such as the death of a child; where they said something had been hard to understand; where they had not yet resolved a specific problem; and where they did not know what else they could do in the circumstances. Associated with these expressions were those that indicated worry, anxiety and/or a sense of ‘alone-ness’ (where women were not describing being lonely, rather that they were aware that they were no longer part of a couple and functioned alone as a single unit).
alone seemed to be present when women described trying to navigate these latter years without the support of a spouse, and with fewer life-long friends. One woman who was trying to adjust to having to do so many jobs around the home with no outside help made this comment:

“I can’t afford help…. I try to do all the housework and garden…. but I cannot do it, even though I am healthy for my age…. No family live near me… being alone worries me at times. (S1/EW).

There was a sense of ‘summary of life’ in how the women viewed their situation and this could be seen in some comments. Women used phrases such as ‘overall I think that’, ‘when I consider what has happened’, ‘what might happen’ or ‘this has been acceptable to me during my life’ to capture their reflection on what has been, and in some cases, what may lie ahead. This was expressed by one woman this way:

“In general my life has had its ups and downs but I think I have had a very good home life as a child and quite a good happy marriage of (number) years and have a lovely family of (number) children, (Number) grandchildren and (number) great grandchildren. My health has been reasonable having had a few problems but nothing too serious” (S1/LW/2a).

6.3.3.2 Manageability

Over all, the widowed women in this study tended to write that they managed their life with the use of the resource of social support and this varied in type and degree over time. Situations that women mentioned required management included coping adjusting after the loss of their spouse. Following on from this was the concept that the women had to use their own primary control resources to help establish a new life that may have included potential episodes of loneliness. Sometimes the emotion was described as reflecting ‘alone-ness, when women were trying to adjust to there not being a spouse to include for company, guidance, encouragement and support. In addition, over time, women from all marital groups wrote that they had to cope with ‘all the jobs around the home’ with less, or perhaps no, spousal assistance. This problem was often noted as getting worse, or harder to manage, as their health deteriorated.

One helpful resource was access to finances that enabled women to do specified activities or to meet bills or responsibilities. If necessary, financial resources allowed some women to pay
for outside help to help manage their home for longer. Another key resource was social support that was offered most frequently by families, and also by friends, communities, organisations and/or churches who provided assistance with social, physical and economic needs. It was noted that another resource was the presence of an ability to cope with circumstances, in order to manage health, personal issues, and housing. Many wrote that, even amidst difficulties, they had tried to ‘not give up’ some measure of control of their lives, and they attempted to ‘do the best they could’ with whatever resources they had available.

Women also wrote about the knowledge they gained from advice, support and education that were offered by medical & allied health professionals. This often seemed to assist the women to make the best of their situation for example, by encouraging them to commence or continue exercises, which was seen to help prolong strength & mobility, and in turn, this helped the women to keep their independence. As time progressed the idea of ‘independence’ included an awareness of a change in how this could be fully expressed; however, ‘by myself, with help’ possibly gives an unusual and yet perceptive view of how women make the adjustment to accepting changes in circumstances that formerly may have been ‘unthinkable’.

In earlier days, women may have thought they would never have to accept help to shower, dress and/or shop. Now however, the best possible way forward was to adjust goals in order for them to remain realistic. In so doing, women could manage the challenges that were being experienced with respect to their mobility and strength.

Some women wrote in their comments that they had learned new skills. Previously many said that their husband had handled matters such as banking, and even driving and shopping. After the spouse had died women had to manage such tasks. In addition, they may have had to develop new skills that were needed in modern society as technology had brought many changes. For example, the social resource found in the family may have been accessed to help them learn to adapt to unfamiliar tasks, such as using the Internet for banking and communication purposes.

Women used a variety of terms to describe the resources they used to help make their situations manageable. Some used expressions of independence, such as ‘I have always just tried hard and somehow managed’ or ‘I always have attempted to do things by myself as best I can’. Others expressed co-dependency within extended family networks, whereby there was an understanding that certain roles fell to particular people in the network, and taken together, the situation was seen to be under control. For example, a woman may say she has
done ‘cooking and cleaning’ in a shared home arrangement while their sons, who have remained or returned home, were said to manage the ‘heavier outside jobs’.

In a reciprocal, inter-dependent relationship, some women wrote about their resource of social support. They said they felt the benefits of families offering assistance with tasks such as shopping and home maintenance, and then many women enjoyed being able to reciprocate the kindness and care, for example:

“...I have a very good daughter who does my shopping and my heavy washing but I look after myself quite well do my own cooking and also I cook cakes and biscuits etc. for my daughter -- I also do a lot of knitting and sewing for my daughter and (number) granddaughters so I am quite busy most of the time so I am happy while my brain is busy” (S1/LW/2a).

Helping out within a family also incorporated the women’s need to feel significant and involved within their social networks, that is; they continued to feel they were identified as a valued contributor within their communities. The ongoing resource of social contribution and engagement seemed to help women adjust to the changes they had seen in themselves. This was particularly evident when they were dealing with the fact that many jobs around the home were becoming difficult to manage, or that they were slower and less agile. If women were able to reciprocate the help and kindness they had experienced, by being supportive to others, it could enhance their understanding of the structure and purpose of their lives as older women.

In the years after the spouse died many women reported that they found that ‘keeping busy’ in numerous ways helped them manage the situation of not having a partner with whom to do things if this choice of activity was expressed on early surveys, it was often found that the pattern continued across the surveys. The terms women used suggested considered forethought as to what would work for them, for example, the use of phrases such as ‘I find I can manage’, ‘I know I can manage if I have some extra help’, ‘I have to manage; what else can I do?’, and ‘I have always managed’. The ability to still exert some control, perhaps within their own home, was helpful for women who may have had to yield control, and accept help with other areas, such as their transportation needs or business dealings.

Many of the women who had remained married wrote about the way they managed their health, their home and family matters with reference to how ‘their husband was helpful’, how they ‘worked together as couple to manage’ and how the partnership that was usually older
than 50 years at any given survey, was founded on ‘mutual respect’ and ‘shared roles’ as the changes in situation indicated various needs that had to be met. As time passed, women did contribute comments that it was ‘harder to manage’ particularly if their spouse had become in greater need of help and support. The woman’s own physical challenges that at times accompanied the process of ageing was reported as making it ‘harder to keep on going’ and the possibility of ‘needing more help’ was anticipated in the ‘near future’.

It seemed that few of the women in any of the groups studied wrote with more than a passing reference regarding how they managed recovering from any traumas that may have occurred in their younger years. For example, given that the birth years for these participants were 1921-1926, one could assume that many from that age group would have lost siblings at a young age, or in WWII; there would have been some effect of the WWI on the fathers and extended family members of that generation of women, some of whom may have been veterans themselves. There would most certainly have been some childhood illnesses and injuries, and there would have been effects on almost all families as a consequence of living through the Great Depression of the early 1930’s. However, none of these things received more than a scant comment and no message about this time of their lives and associated experiences was described with any detail. The experience of a childhood illness seemed only to be mentioned if there had been any persistent effects felt over time. For example, they may have said ‘I have always had a limp since I had polio as a child’. Some mentioned injuries such as fractured bones that had been ‘badly set’ and there had been a subsequent weakness for the rest of their lives. The women offered few other details were offered by these women regarding how these challenges had affected them, or how they had needed to have the resource of resilience to ‘bounce back’ from adverse circumstances.

6.3.3.3 Meaningfulness

The comments written by the women were rich with descriptions of meaning, purpose and worthy investment. These concepts could be described as being found within their own perspective that their lives were shaped and supported by value and contribution. This could find expression within their families and/or within their communities. Comments that show some different aspects of the source of meaningfulness follow.

Within themselves: Women often took time to add reflective comments about how they had derived meaning and pleasure from what they had achieved in lives as they looked back. They often noted how much they have enjoyed ‘helping others’, being ‘involved’ in many
contributory ways and felt a ‘sense of satisfaction’ that their life had been a worthy investment. The reflection on their perception of the meaning of life was varied yet common themes were being ‘generous’, ‘kind’ and ‘outwardly engaged’. One woman wrote across surveys one, three, four and five how much she “enjoyed so many ways to help” in her community, which she “loved doing”. The resource of spirituality was seen here as expressions of ‘faith in God’ and a ‘greater purpose for their lives’, often strengthened the resolve within women to continue to make investment in their future years.

Within their families: Women felt a sense of pride and satisfaction to see their families making notable contributions, and achieving worthwhile goals during their lifetime. Some pondered ‘have their lives been valuable?’, and frequently were seen to answer the rhetorical question in the affirmative, as they related the achievements of their children and grandchildren. Perhaps for many, there was a sense that children hold the potential for future generations. Where a woman may have felt they had not achieved their full potential, due to restrictions unique to their era (for example, the Depression, WWII and/or unequal opportunities for women of this age group) there was the possibility seen that their offspring could rise to heights they themselves could not achieve.

Pausing to reminisce and reflect on past events and future opportunities could also be seen to be a coping mechanism, as women can consider what control options may be open to them. They may then adapt their thinking, so that lost or unrealised dreams can be adjusted to the reality of the present. These moments of reflection seemed to be a way to pay tribute to the past, and give hope to the future.

The women continued to find ways to both draw from, and contribute to, their invaluable social resource of their families over the years. They enjoyed helping where they see they had available time, energy and skills to add to the fabric of a family network. They found hope in ‘looking forward’ to significant events such as engagements, weddings and births of grandchildren. They showed their positive disposition by using expressions about how they felt ‘lucky’, ‘fortunate’ and ‘grateful’ when they considered the benefits they enjoyed of loving and supportive families. If family members lived close by there were descriptions of how much value and support the physical contact brought to their lives. Even if this was lacking, women were often proactive in their coping mechanisms by seeking other ways to continue meaningful relationships and exchanges. This could include the use of telephones, using the
internet to make various types of calls, such as Skype, and by making physical visits when at all possible.

Within their communities: Women found the resource of social engagement rewarding for many reasons. They were glad that they could be involved in the community. They felt that being outwardly focused helped them ‘stay balanced and not think about things that were not so good in their own lives’. In addition, they found being socially engaged was ‘interesting’, ‘useful’, and ‘challenging’ as well. They felt they had a deeper appreciation of life and it made them review their ‘own good fortune’ and be more ‘grateful’. Another aspect that assisted their desire to pursue a meaningful life was that volunteering meant they kept busy, they felt ‘a sense of belonging’ and of ‘giving back’, in helping others. In keeping busy they spent ‘less time on their own worries’ and realised that usually there were people ‘worse off than themselves’.

Women who described having the spiritual resource of ‘faith’ related in multiple comments that this in itself gave a sense of purpose and meaning that was greater than just this life itself. They felt that their communities of faith gave them opportunities to participate in activities that gave them strength to continue. They expressed that being involved within church and community groups increased their sense of value, which for them was inherent in contributing to others. This concept expressed the benefits to women of aspects of life that go further than what was seen externally, and beyond what could be necessarily articulated objectively. It was said to be rewarding on many levels.

Whatever form meaning and purpose took in the lives of the women it was often described with a positive disposition that exuded enthusiasm. The comments included expressions such as ‘things that I love doing’, ‘I have a happy time’ and ‘it is so rewarding for me’. They maintained a sense of hopefulness that ‘things would get better’, that they would make sense of, and find purpose in, whatever occurred their lives. Many felt there was ‘yet more to enjoy in this world’, that they were ‘not wanting to leave this world yet’, or they were ‘not ready to die or anything silly like that’.

Although many women did indeed find purpose and meaning, it must be said that not all women felt that way. For some, they could no longer be bothered, their life felt empty, and some expressed that they were at times unwanted, ignored, unappreciated and even a bother. Difficulty was experienced by some to find the necessary motivation to participate in
meaningful activities, and some linked this with feelings of depression and suffering. As one woman wrote:

“I am so very lonely, and am still missing my very wonderful husband, who has been deceased five years now, I cry a lot at times because we were so very close, mostly I start feeling depressed on waking of a morning, and of course living alone, and having meals on my own” (S2/EW).

However, 12 years later, the same woman wrote that although most of her family did not live close by, and she relied on DVA and community services for help at home, she felt much better and concluded:

“... I get all the love in the World from my (children) so that love keeps me so happy, a phone call every day or night makes my day from them” (S6/EW).

For the women in this study the most recurrent pattern across surveys was not an increased lack of meaning as time passed. Rather, lack of meaning appeared to be reported as a temporary problem that was linked to another event. For example, during the early period of adjusting to loss of spouse, or during periods of ill health, women may have lost contact with friends or activity groups, and had felt the meaningfulness in her life had declined. Many women wrote about how this had improved over time, with the adjustments having been made, as one woman said:

“I am feeling a lot better again now; it’s been nearly a year since my husband died, and I have just recently begun to feel so much brighter in myself. I can now look forward to being picked up to go to meetings, and activities, where I can enjoy the company of my friends and do something helpful for others” (S5/LW/2b).

6.4 Chapter Summary

Women have identified resources that have been important in supporting their SOC. The inclination to view their lives as being comprehensible, manageable and meaningful has been seen in multiple ways, across time and through possible changes in marital status. Key resources included positive disposition; resilience (with links to the hardiness concept); locus of control (whether that was over events and the environment or their responses to these); identity, (both in relation to roles and relationships); spiritual beliefs (including orthodox
expressions of formal religious involvement, alternative spiritual expressions and awareness of non-tangible expressions of self, considered to be held in a spiritual domain); knowledge (both formal and informal, skill based and experiential); social resources (within families and communities); and financial resources (enabling women to have freedom to participate in activities and to make choices, in particular with respect to housing and medical care).

Women offered rich descriptions of what resources were used to support them in the process of ageing. They were consistent over time with the way they described the resources to which they considered they had access and ability to use. For example, a key finding for women with evidence of a positive disposition was that they had written about events in their lives over multiple surveys, consistently using words that described how lucky, grateful, happy, loved and fortunate they were. If this disposition was seen in early studies it was usually seen in later ones as well.

Similarly, with the idea of ‘resilience’, (as discussed section 6.3.1.2), when women used this term, they were frequently trying to describe their ability to ‘bounce back’ as a response to difficulty. Again, when women showed evidence that they were determined to not let the challenges of life crush them and their spirit, they often wrote on more than one survey about similar reactions over many years. On later surveys there were a few more references to the fact it was becoming harder to recover from ongoing setbacks or hardships of various kinds, for example, deaths, illness, disappointments.

The loss of a spouse was a significant event to consider when looking for evidence of a resilient response. It seemed that when this event occurred earlier in life (for example, the early widows and to a lesser extent the women widowed by Survey 4) women had more resilience as a resource than later in life. Possible reasons offered for this decrease in resource was first, because assistance given to their spouse had been through later years, when the health of the women themselves may not have been as good. Second, the period when spousal care had been required may have extended over a greater length of time. This factor, in itself, could have proved more taxing on the resources of an older woman than when she was younger.

The comments offered by later widows indicated that the challenge of spousal loss when they were older was not followed by a new phase of greater community activity. More often they wrote of ‘moving to a facility’ where they were offered more assistance to do with home maintenance, more social support with staff in frequent attendance, and help with transport
to shops and appointments, as they were often no longer driving. For women who felt that the resource of resilience was diminished, due to age or illness, a key benefit that they expressed after they moved to some kind of assisted housing was that their transport needs were met more easily than when they lived in their former home, and this removed an ongoing and persistent worry that they had been dealing with.

The resources of spiritual beliefs, knowledge and finances also proved to be fairly stable over time. It seemed that women came to a place of confidence and certainty in these areas earlier in life and this was able to give them strength over time. Women often wrote how their faith had sustained them during periods of stress. Being part of an organised ‘faith based’ group (typically an orthodox church for women in this age group) offered the possibility of social interaction through attending religious services, or doing community work through a denominational organisation.

The resource of knowledge was stronger when expressed as a life-long learning experience. For the women in this study, it was more often informal learning, given that many of them expressed that they had not had the opportunity for lengthy formal education. Women did not emphasise financial resources as much as other resources. It was seen, however, that adequate finances contributed to less stress, and a greater peace of mind, with being able to pay for medical and housing costs over the years. Women did not show evidence of putting the additional weight of social status alongside a comfortable financial position. They did not write of elaborate ways to spend their disposable income, such as buying jewellery, cars or large items for their homes. It seemed that if, over time, their income was sufficient for the important matters to them, for example, being able to pay for private health cover and appropriate housing, then they were satisfied that their resources were more than adequate.

Social resources were of a great importance to the women in the study. The way this resource was utilised altered over time according to changes in marital status and other social changes. These included examples such as moving house and/or mobility issues that affected the ability of women to move in social settings. During periods of more acute grief, particularly following spousal loss, women accessed the resource of family members for their source of social support. Depending on when this occurred throughout the study period, the comments reflected where the women turned to for forms of comfort, assistance and interaction. For women who, after spousal loss, had sufficient time and energy to invest in social networks outside the home, such groups as Meals on Wheels, Probus and Red Cross were seen as a form
of resource that could be accessed. These types of groups provided interest, support and meaning for women, as they made a transition to a new way of life.

This section of the chapter examined the main concepts that contribute to SOC. It has been seen that many women did utilise many resources, which strengthened their inclination to view events in their lives as being comprehensible, manageable and meaningful. The resources women accessed were seen to have developed over the life course, with many women reporting that their attitudes about optimism, ability to manage, and meaning in life were things that they had been taught from a young age by their parents, and they had found to be useful for them as the years passed, and more experiences were encountered.

The generation of women who were born during the period studied, 1921-1926, identified a strong sense of the collective ‘we’, as the significant events that had challenged and shaped their lives were seen by them as unique and bound them together. They wrote that although their life had encountered unpredictable and unstructured events (economic depression and the conflicts of war, along with the major social disruption that these events entailed, being just two examples) they had been able to find sufficient understanding to bring about order from chaos, and a way forward despite the setbacks.

They had utilised resources of knowledge, reason and thought to consider what plans could help shape their future and what actions could provide immediate benefit to them, their families and their wider communities. Late in life some women indicated that they were feeling more uncertain. Former structures in their lives were changed by death and illness, along with increasing challenges to maintain sufficient mobility and strength to exercise independence. The death of a spouse also challenged their sense of comprehensibility, as this was such a significant loss for women, for whom many had been married for a very long period of time. Whether it was for early or late widows, the sense of devastation was great, irrespective of the exact length of years of the marriage. For married women, who did not have to write about their husband’s death, they were still challenged by deaths of many close people in their family and friendship circles. There was also a cumulative sense of loss that challenged women as they aged as they began to report that the shrinking of their networks was so significant that the overwhelming sense of loss was at times almost too much to bear.

Women used a broad range of resources to bring manageability to their circumstances and they described how these resources strengthened their ability to view the challenges they faced to do with health, families, matters concerning their spouse and issues to do with the
broader community as well. The way that resources had to be accessed and used was seen to vary over time. More frequently worsening health issues as women aged proved to be a challenge for them to manage. Again, as was found with other concepts, it was expressed as a relatively stable trait within women, over the time that data could be analysed.

Many women wrote comments as to how their resources of faith, family and financial reserves allowed them to continue to find meaning and purpose, despite the stressors that may have been present. Frequently women expressed that they felt their lives had value, that their voices still mattered and they had a role, which allowed them to make a contribution to their world. Women who found meaning in their earlier years seemed to also maintain this resource as a valuable means to continue to invest in life even when that proved more difficult. Losses, illness, disappointments were all possible, even probable, challenges. Some women expressed feelings of being ‘stretched’ to find sufficient resources, for the necessary length of time that their life afforded them. Most anticipated that their resources could prove to be sufficient for their later years, although others felt some doubt about how long they could cope with the challenges of ageing along with social and environmental changes associated with living alone or with an ageing spouse.

This awareness added to the understanding of how a strong SOC helped many women to describe their later years with a sense of worth and pride in the achievements that they, and their generation, had made. SOC was recognised in the broad range of comments that the women contributed throughout the ALSWH study and a greater understanding has been developed concerning the resources that contribute to a SOC.

Not all women showed that they had a SOC. Mention has been made throughout this chapter where it was seen that some women had difficulty accessing the concepts of understanding the events in their lives, that they lacked sufficient resources to manage the challenges and their sense of meaning and purpose was either not evident or was fading as time passed. For these women, their interpretation of their lives was not as rich with understanding, with ability to manage challenge, and bounce back from stressors, and to feel a sense of positivity and purpose. The absence of a strong SOC was equally as significant a finding as the presence of a strong SOC. The relative presence or absence of SOC was used when evaluating how women described their later years. Each of the three concepts of SOC, comprehensibility, manageability and meaningfulness, featured strongly in many of the comments women contributed. These concepts frequently overlapped in their occurrence within comments,
which indicates that there was a relationship between the three. The strength of each one may have varied, according to the stressor and circumstance described. Overall, although a sense of meaning and purpose in life was very significant concept, it would require the presence of comprehensibility and manageability in order to be experienced in its fullest sense. This chapter has described the resources that women accessed and the skills they utilised, in order to counter the effects of stressors. A thematic analysis of the concepts that contributed to resources, which in turn were seen in a strong SOC, has identified that many of the participants in the study showed evidence that their SOC was a vital part of how they described their lives as they age.

6.5 The next chapter

The next chapter will examine the themes that have been seen to be associated with how women express their experiences regarding the ageing process, in particular, how they describe ageing well.

6.6 References


7 Ageing Well

You might be on the back nine of life, but it’s good to finish strong (Morton Shaevitz)

7.1 Introduction

The previous chapter presented findings concerning resources women found available and useful to counter the stressors of their lives. It was found that effective use of multiple resources strengthened SOC, which in turn was significant in enabling women to feel that they could experience an understandable, manageable and meaningful life. The way in which women sought to access and use available resources altered according to the occurrence of specific stressors. As such, one resource was not considered more important overall, but could be considered of more relevance at any given point of time, according to circumstances being described. Literature that related to the construct of ageing well was reported in Chapter 2.

This chapter will present how the free-text comments written by older Australian women revealed their description of their ageing process. The SOC, and the resources that contribute to it, will be considered in the findings. In addition, the way timely use of appropriate resources can support and strengthen ageing well, over time, and with respect to changes in marital status will be explored.

7.1.1 The construct of ‘Ageing well’

Earlier on, the researcher reflected on the experiences in her professional life that piqued her interest in investigating why it is that some people seem to age better than others, and what that may mean (section 1.3). What were the factors that supported some people remaining engaged, able to express a good sense of well-being, having a valuable contribution to make and continuing to find meaning and purpose in later years? Engagement in later life can be seen even among people who manage multiple co-morbidities, and may face significant additional challenges other than those that are health related.

It has been said that no-one wants to age, and indeed, people do not want to be “old” (Hayes, 2014). However, given the inevitability of the passing years, there is a wide scope of experiences of ageing described. Examples can be seen of people who appear to act and feel much younger than their chronological age, and also of those who are younger, yet are unable
to keep up with others who are much older than themselves (WHO, 2015). Images of ageing can include associations with vulnerability, invisibility and frailty. For those who espouse the message of positive experiences of ageing, the images they may choose to represent an alternative view include people who have continued to function with strength and presence within their own environments.

In Australia it is becoming increasingly common for people to live longer, to show greater interest in maintaining measurable levels of physical and mental health, and being more determined to live with independence and engagement in their communities (AIHW, 2015; Edgar, 2014; Kendig & Browning, 2011). The experience of many older Australians as they age can be represented by accumulated wisdom, and a time when they can reflect on, and express satisfaction about a life ‘well-lived’ (Hayes, 2014).

7.1.2 Recognising ‘Ageing well’

Along with many of the other terms associated with ageing (for example, successful, healthy, productive), possible definitions for ageing well have not reached a point of wide acceptance and as such, are still open for refinement. The multi-dimensional concept of ageing well was described as representing a range of bio-psychosocial concepts of health and well-being, recognising the importance of the opinions and desires of the individuals who are experiencing their own process of ageing (section 2.7) (Fernandez-Ballesteros et al., 2010; Fernandez-Ballesteros, Schettini, Santacreu, & Molina, 2012; Kendig, Browning, Thomas, & Wells, 2014; Strawbridge, Wallhagen, & Cohen, 2002). This multi-dimensional concept integrates elements of other models of ageing, such as successful and healthy ageing, and notably seeks to recognise concepts that are deemed important to the older people themselves, such as cognitive ability, life satisfaction and good social function (Woods et al., 2016). There remains, in many societies, a persistent ageist view which concentrates on negative stereotypes of the ageing process, describing it as a time of losses in cognitive, emotional and physical domains (Nelson, 2016; Ng, Allore, Trentalange, Monin, & Levy, 2015). It has been found that those who believe negative stereotypes of ageing will actually perform worse in memory skills tests. Further, the effects are the similar to that of a self-fulfilling prophecy, in that psychosocial influences are found to be long lasting and can predict memory decline over future years (Levy, Zonderman, Slade, & Ferrucci, 2012).

By way of comparison, successful ageing emphasises the quantitative measures that signify low risk of disease and disability, high physical function and a high engagement with activities
of life (Rowe & Kahn, 1987). Those who do not meet set criteria are then consigned to an ‘unsuccessful’ category by professional opinion that may not compare at all well with the opinion of the lay person(s) involved (Cosco, Prina, Perales, Stephan, & Brayne, 2013). Active ageing places emphasis on how the opportunities for physical, social and mental well-being impact longer life expectancy (WHO, 2002). Healthy ageing focuses on levels of function that can be maintained as the body slows down its processes (Hansen-Kyle, 2005). Productive ageing seeks a measure of how people can continue to contribute to their society, primarily in economic terms (Johnson & Mutchler, 2013). In this current analysis opportunity was provided, by way of free-text comments, for women to describe what seemed to be most important to them regarding their individual experience of the process of ageing.

7.2 Aims

The specific aims of this chapter are to examine women’s free-text comments against concepts that contribute to ageing well. The specific objectives are:

4. To identify concepts that women use to describe their ageing process;
5. To interpret from the comments if it can be assessed that women feel they are ageing well;
6. To identify from the women’s comments if SOC and GRR’s and SRR’s can be interpreted as contributing to a process of ageing well;
7. To identify how descriptions of ageing well may be seen to alter over time and with respect to marital status.

Advantage was taken of the available quantitative data to show how the qualitative comments fitted against the different trajectories of change in HRQOL for the three groups of women.

7.3 Findings

Table 6.1 lists the concepts that were related to ageing well, with the definition that has been taken for the study. The concepts therefore cover physical, psychosocial health and cognitive factors, social engagement and quality of life issues. Examples of quotes are given, which illustrate the presence of that concept in available data from each of the four groups of participants (early widows, widowed at Survey 4 (S4), widowed at Survey 5 (S5) and married women).
<table>
<thead>
<tr>
<th>Concept</th>
<th>Definition</th>
<th>Early widows (EW)</th>
<th>Widowed @54 (LW/2a)</th>
<th>Widowed @55 (LW/2b)</th>
<th>Married (M)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjective Well-being</td>
<td>A good mental state; A sense within people of a positive report of their circumstance and it is linked their evaluations of their lives with respect to sense of happiness and life satisfaction and fulfillment;</td>
<td>I do lots of voluntary work in the large hostel attached to my village and on rosters in library kiosk secretary for the village council &amp; involved in (type of) work and (type of work @55)</td>
<td>Apart from this (description of some recent procedures), my health is fairly good (S2)</td>
<td>...but I have continued living a very active life. I feel very grateful for my health even in spite of my difficulties (S3)</td>
<td>We think life is great and we both want to live to be 100 years (not more) (S3)</td>
</tr>
<tr>
<td>Well-being</td>
<td>Relating sense of well-being to quantifiable measures of health and health management; Requirements that indicate people have achieved or satisfied measurable goals to manage health or control of conditions they may have to manage</td>
<td>I have found improvement in respiratory problems by using exercise bike for 30 minutes per day (S4)</td>
<td>I exercise by walking 3km on a machine at the club four times a week also I do water aerobics (S1)</td>
<td>As a result I still take painkillers every 6 hours. My ability to walk for more than 15-20 minutes is not more possible as is driving my car for more than ten minutes at a time (S5)</td>
<td>I enjoy a half-mile run, takes about 3/4 hour. I know generally I am fitter than others my age (S4)</td>
</tr>
<tr>
<td>Physical function</td>
<td>A level of ability to 1) Perform measurable activities such as Timed-up &amp; Go/numbers of specific functional exercises 2) Cope with normal ADL's e.g. dressing, showering, independent dressing and eating etc. 3) related to how well a person functions in everyday life, alongside their perception of perceived well-being</td>
<td>I now have help (this year for the first time) with the washing of floors &amp; vacuuming of carpets via the (community service) (S3)</td>
<td>I feel I keep very good health for a person of my age. I exercise by walking on a machine at the club four times a week also I do water aerobics, as I have XX years ago had an accident which resulted in a back operation and which I try and keep under control by exercising. I still have pins and needles in my right foot. However on the whole I am in good health, of course like most people I have arthritis but I find exercise helps greatly (S2)</td>
<td>Just before my husband died I was having a lot of trouble walking &amp; a scan showed that I have blocked arteries 75% I have since had to have balloons in my left leg &amp; am walking better now. I do 1/2 hr on treadmill every day. The problem I have with stairs is because of arthritis in my other knee (S5)</td>
<td>At 73 I don’t consider I’m old and have a good GP who is caring too. Arthritis still plagues me and I may in time have my left hip replaced (R hip was done in (date)) but I walk without aid and manage to look after all myself at home quite well I think (S2)</td>
</tr>
<tr>
<td>Quality of life</td>
<td>A relationship between how well a person functions in everyday life compared to their perceived well-being</td>
<td>“I’m very fortunate as I have a wonderful and caring family” (S2) “I have a great family who are always (S3) I have a wonderful family, son and daughter, who live in the same area so I feel I am very lucky (S5)</td>
<td>But for a 74 -year-old I give thanks that I can still walk and have all my faculties and enjoy my life. Thank you. (S2)</td>
<td>Yes I am happy with my life, with love and attention from my family and husband. My husband is 85, - we help one another with our chores and are very happy (S3)</td>
<td>Three years has made a lot of difference to my health but life is still good and with my husband of 56 years and independent age as I am, being so helpful, I manage well (S3)</td>
</tr>
<tr>
<td>Concept</td>
<td>Definition</td>
<td>Early widows (EW)</td>
<td>Widowed@54 (LW/2a)</td>
<td>Widowed@55 (LW/2b)</td>
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<td>Social engagement</td>
<td>Refers to: 1) The degree of an individual's meaningful engagement &amp; interaction in collective activities of a social group, in varying roles and relationships 2) A distinction whereby social network focuses on the group, but social engagement focuses on the activity, not the group itself or the resources available; it usually excludes paid activities and family. There is a lack of commitment involved. An interaction is involved between 2 or more people. Involves the commitment of a member to stay in the group and interact with other members. It is often quantified by the volume of activity e.g. number of times church attended per month. Often contains the thought of contribution.</td>
<td>I live in a huge Retirement Village - covering about (number) acres. I walk everywhere within it when necessary - to &amp; from bus stops, meetings &amp; Chapel Services. I do volunteer working (number) bed hostel attached to my village &amp; do work there 3 days a week (56)</td>
<td>I have lots of friends I meet at new club in (suburb) called (name). We get questionnaires to answer. Good for brain and have visitors to talk to us and to demonstrate interesting things to us that we might like to share with others (55)</td>
<td>I love to attend church on Sundays &amp; say hello to all my friends there, although I cannot be quite as active in the church as I once was (59)</td>
<td>I have always been involved in community work (56)</td>
</tr>
<tr>
<td>Cognitive function</td>
<td>Level of ability to: 1) Pass accepted mini mental tests, basic recall tests etc. 2) Communicate effectively to others in a way that is considered understandable to a lay person (not to a specialist trained in a health service who may understand more readily). 3) Participate in activities of the type required. 4) A level of understanding in order to make the activity meaningful to the participant and not more difficult for other participants. b) Memory of skills or interest areas that may be learned or practiced at some required schedule, class, group etc. c) May involve leadership of groups, require reading and understanding of systems, rules, ethics, basic societal rules. d) May involve reading and understanding books in a home setting.</td>
<td>Regardless of the many things not acting 100% I am contented, happy, mentally still wanting to actively do and help others (54)</td>
<td>You might be interested to know I will be 80 this year. I am still managing our body corporate, which I have done for the past 15 years, on a voluntary basis (54)</td>
<td>I am mentally fit, i.e. computer wise (54)</td>
<td>My brain is very active so finding right phrase takes time to verbalise (56)</td>
</tr>
</tbody>
</table>
7.3.1 Changes in HRQOL for the three groups

A measure of HRQOL, the SF-36 (Ware & Sherbourne, 1992), has been included in each ALSWH survey (section 4.7.2.7-4.7.2.8). The SF-36 includes eight sub scales, listed below, with examples of the range of options given to the women to frame their choices:

1. Limitations in physical activities (e.g. bathing, dressing, walking, climbing stairs, vigorous sports and lifting) because of health problems;
2. Limitations in social activities (e.g. the ability to engage in usual social interactions because of physical or emotional problems);
3. Limitations in usual role activities (e.g. limited in work or other activities because of physical health problems);
4. Bodily pain (e.g. none, moderate, severe);
5. General mental health (e.g. compared to others was there feelings of psychological distress and well-being);
6. Limitations in usual role activities because of emotional problems;
7. Vitality (e.g. feelings of energy or fatigue); and
8. General health perceptions (a single question was asked: “In general, would you say our health is...”, and can identify perceived change in health over time) (Ware & Sherbourne, 1992).

Figures 7-1 and 7-2 present the change in mean scores over time for each group of women, who had survived until Survey 6, in 2011 (not only those sampled for the qualitative analysis). Compared to married women and later widows, early widows had poorer HRQOL and worse physical function in the early surveys and by later surveys the scores had converged.
Figure 7-2 Mental Health in 1921-26 Cohort Considering Marital Status

- **Vitality**
  - Mean score (66/4 Q1)
  - 1996-2011: (70-75) (73-78) (76-81) (79-84) (82-87) (85-89)

- **Social functioning**
  - Mean score (66/4 Q1)
  - 1996-2011: (70-75) (73-78) (76-81) (79-84) (82-87) (85-89)

- **Role emotional**
  - Mean score (66/4 Q1)
  - 1996-2011: (70-75) (73-78) (76-81) (79-84) (82-87) (85-89)

- **Mental Health**
  - Mean score (66/4 Q1)
  - 1996-2011: (70-75) (73-78) (76-81) (79-84) (82-87) (85-89)

Legend:
- Early widows (n=4,335)
- Late widows (n=1,027)
- Married (n=1,809)
7.3.2 Ageing well, in the women’s own words

7.3.2.1 Subjective well-being

Subjective well-being encompassed physical and emotional elements, with physical challenges frequently impacting on the women’s emotional well-being. For many participants, a comment about a physical event such as ‘I have a bad back at the moment’ or ‘the arthritis in my knee has been a problem lately’, was also accompanied by expressions such as ‘but I still feel OK’, ‘can still drive’, ‘I am up and around so I am doing quite well’, ‘I am well enough to still look after myself’, and ‘I am well enough to get out to lunches with my friends’. It was a finding of interest that women so often wrote within one comment about significant challenges and health issues, yet combined this information alongside a reflection that they felt their well-being was good, particularly ‘for their age’. Their comments often conveyed such hope, optimism, and expectation for the future that ‘life was good’, they were ‘fine’, ‘lucky’, ‘fortunate’, ‘coping well’, ‘may get better’, ‘expecting better things’, and were aware that as they got older such events could ‘be expected’ and yet ‘could be managed’.

Some women reported that they have not had many significant illnesses or conditions to cope with up to the time of participating in the ALSWH. Others reported challenges to their health, some ‘from childhood’, and many more had experienced a degree of health crises ‘from middle life onwards’. There was usually an understanding reflected in comments that women were ‘used to managing’ certain conditions or limitations and found appropriate ways to adjust, so that their mobility and independence were not compromised. Some felt that worse things were ‘yet to come’ but they ‘had faith they would cope’ with future events. Interestingly, a few women even felt after going through some health crisis that ‘the worst was behind them’, although further details about why they felt that they would not have to repeat such a challenge in the future was not made clear.
One way of creating a balance between both positive & negative events in their lives, was for women to express that for them the ‘positive outweighed the negative’. They recognised that as they aged they did indeed have to deal with difficulties. Many women felt that a balance was possible, with the support of others and using their own personal skills and the available resources. Some expressed that even during difficult times, it was best if they did not only ‘think about things that weighed towards the negative’. For many women, they compared their situation to that of others who they wrote appeared to be ‘worse off than them’. This then made them feel aware of how ‘lucky’ or ‘fortunate’ they were to have ‘good genes’, ‘manageable’ health issues, adequate mobility and a sense of appreciation of ‘valuable people’ and support structures in their life. One woman from the later widowed group made comments at four surveys, which included:

“I feel I am in control and really don’t feel I need to complain. (S1/LW/2a);

“I have arthritis and some other conditions, but other than that I am well” (S3/LW/2a);

“However I am now feeling much better & I am able to do lots more. For my age, now nearly 82, I am lucky. I have lots of pain but I can manage it” (S4/LW/2a);

and:

“I have a fair amount of pain…. Other than that, I keep very good health. I can’t complain. I also have had a knee replacement 2 years ago but I feel it has all helped me feel well enough and strong for my jobs” (S5/LW/2a).

It was noted that certain events, for example, the death of a relative, burglaries and accidents impacted on how women reported feeling unwell, both physically and emotionally. Women used expressions such as ‘feeling down’ or ‘depressed’ due to events such as loss of family & friends. Some women wrote that although they did not feel good at the time of writing the comment they expected ‘things to improve in the future’. There were expressions for example about blood pressure being higher, and about lack of appetite and inability to sleep following traumatic events. Women also included comments about being more ‘anxious’, ‘lonely’, ‘teary’, ‘upset’ and ‘isolated’ at the time. They frequently also added that they expected these problems would ‘not continue for a long time’, and some form of recovery and adjustment was to be ‘expected’.
The opinions of the women in the comments were not necessarily defined by specific and measured criteria. This allowed for the women to assess their own situation and report that ‘apart from’ or ‘despite’ a challenge they were experiencing, they considered they were satisfied with, and even proud of their achievements in terms of maintaining independent living and engagement with their networks, as reflected in the comments from these two women:

“...of course I am older, but I can still help others and my opinion is that I am going along quite well” (S4/EW); and:

“Regardless of things not being 100% I am very contented; I keep busy, help my family and other friends... I think I do so well” (S4/LW/2b).

The women felt that despite managing co-morbidities, they were still able to contribute and give value to the things they deemed to be important. This could include: helping their spouse (if not widowed), their family (particularly if they had small children), assisting neighbours or relatives who were less able bodied, and being involved with organisations that make a positive contribution to those less fortunate, both in Australia and overseas. There were many references to activities in which they engaged in order to ‘feel’ better about their ability to participate and as two women expressed their opinions.

7.3.2.2 Well-being related to objective measures

The data analysed for this study were free-text comments offered at the end of the quantitative part of each ALSWH survey. Consequently, specified objective measures were only seen in the comments if the participant repeated test results, scores, and/or levels of attainment of a measured quantity by way of contribution to the overall message of the comment. Although there was no requirement or suggestion for women to contribute objective measures, women often combined a numeric score or result with an additional comment regarding their opinion about this. For example, a woman may have said that her blood pressure readings were ‘higher than usual’, and then added ‘my blood pressure was usually 125/85 but recently the doctors said it was around 140/95’. Following the taking of a prescribed medication, the women often added that they were ‘much better now’, the readings were ‘now in normal range’ or they ‘were happy the problem was under control now’. Some linked specific results such as blood pressure readings, blood sugar levels and other blood markers as now being in the normal range for their age, with the new readings added to the comment. The added comments that suggested the improvement(s) had come since they
had embarked on a specific lifestyle change, for example, doing regular exercise or altering their diet. Sometimes they showed evidence that they had ‘just decided something should be done’ or they ‘had taken advice’ from a doctor or another health professional.

Women relayed details regarding their conditions and surgeries, writing what they had done, were currently doing and/or what they were going to do to help manage the problem, or to assist in making improvements. The inclusion of actual measures or relevant survey scores, indicating they had accessed their knowledge resource, and they knew what was important and required for effective management for conditions such as diabetes, cardio-vascular disease and arthritis. Their comments frequently related changes in measures associated with medical conditions not merely as isolated facts. Rather, the comments showed that they understood the relationship between the actual measured score to improvements in objective function, for example:

“My blood sugar is now in acceptable range now that I have controlled my diet and I exercise for 30 minutes a day” (S4/EW);

“My blood pressure is now normal for my age since I started an exercise programme of walking 5 days a week if I can for 30-45’ (S3/LW/2b); and:

“I have begun going to hydrotherapy classes twice a week with the physiotherapist and my arthritis is better controlled. I have much less pain and do not need my walking stick as often now” (S4/M).

Over time, the women’s comments allowed the changes in disease status to be followed, for example, how they may have managed conditions such as Multiple Sclerosis (MS). One woman, who had MS, described first the use of a ‘four wheeled walker’ and the support of furniture in the home to help with her balance. In later surveys she wrote about the use of an ‘electric recliner chair,’ then a ‘wheelchair’. Although this comment does not describe that her mobility was tested in a controlled evaluation, her free-text comments described a trajectory regarding her ability to manage specified activities. For some women, comments about management of conditions also included a preferred plan of action that may have implemented in the future to maintain independence if changes in objective health measures occurred. Examples of this included: ‘if I cannot manage stairs in the future I may have to move’; ‘in the future I may need more help than my husband can offer so I may have to go to a hostel’; or ‘if I get worse, may have to get someone to accompany me to the shops for extra help’. It was of
interest that women reported that even in the presence of such stressors, they could adjust their goals and alter their expectations. For some, this may have been for a short while, while they recovered from a specific event, for example an operation. For others, the changes in goals were more long lasting, as the problem being faced was not going to improve. They expressed that that they had found new ways to cope, maybe with additional support, both instrumental and emotional.

Women sometimes changed their course of action intentionally, to assist them to age well. For example, some wrote they had trialled ‘recommendations’ from different practitioners to decrease their pain or improve their mobility. Sometimes they related that they had followed some advice as suggested, for example by a chiropractor. If this had not worked for them, they often wrote that they had ‘investigated other courses of action’ with other therapies, with results often included in the comment, for example:

“I was going to see (a practitioner) for some months. I was not getting any better and still could not walk enough to manage by myself at home. So I decided to see (another practitioner) and after a few visits my pain was reduced and I could walk in my house and as far as the letterbox to get the mail” (S5/LW/2a).

It was noted that women mentioned other specific scores such as Bone Mineral Density (BMD) results with knowledge about what they needed to do to either maintain or improve the results in order for them to be within a normal or healthy range. Deliberate choices to make changes as needed for conditions to improve were understood to be essential if the women wished to continue living with independence and involvement. One early widowed woman had noted in Survey 2 that she could only walk ‘20 yards’ without needing to stop. After some months of gradually increasing her regular walking regime to help control her weight and improve her knee pain, she wrote at Survey 4 that she could now walk ‘5km most days’. She described being in much less pain, and felt ‘so much better’. Over time, there were more reports where lack of mobility or strength presented significant challenges to managing physical activities, and possibly indicated that some women reported they were no longer feeling that they were ageing as well as they had been earlier. Some reported at early surveys that they were involved in a form of exercise or activity, such as ‘a pedal exerciser’, and included the length of time they could manage. They reported that their ‘balance was better’, they felt ‘stronger’ and could now ‘walk further unaided’, sometimes including the distance they could now walk. In addition, women included examples of specific activities could be
managed at home, although outside the home, were more ‘difficult’, if not ‘impossible’. Some examples of these were standing up from lower height chairs if there were not suitable arm supports, and the use of public toilets, where many women indicated that even disabled toilets were ‘difficult unless I have someone to help me’.

Married women wrote fewer comments regarding specific objective measures related to their health management and sense of well-being. If they did contribute a comment about a measurable score, their comments tended to be how the changes they were describing could affect the chances they had as a couple to continue to live together in an independent home. If they reported poor balance, for example as a result of Meniere’s disease, this could affect their confidence to walk specified distances without aids such as walking sticks, and included fears about how uneven surfaces could limit their ability to mobilise outside their home. Women then related how these problems could make it harder for her and her husband to care for their home together, to accomplish their own shopping.

Multiple co-morbidities, including poor vision, osteoporosis, and severely arthritic joints at times, limited the specific amount and type of activity. Women said they used to be able to walk a measurable distance, manage a specified number of stairs, and participate in prescribed amounts of activities such as dance and yoga. They also described the onset or worsening of problems that precluded or minimised activity levels they used to manage. Some could no longer be outside their homes after sunset as their vision and balance were poor and they felt ‘unable to go out at night’, and they could no longer drive ‘unless it is in the day. Such restrictions, caused by numerous conditions, were said to impact on their assessment of their ‘ageing well’ process. In addition to these comments, women who struggled to manage their health conditions over time, also added terms such as ‘not so good now’, ‘harder to keep going’ and ‘just can’t walk as far as I could, although I still try as hard as I can’, and ‘things aren’t what they used to be’.

Some women who were caring for their spouse did indicate that this impacted on their ability to devote sufficient time to their own health and activity needs. There were comments that helping to ‘lift’ and ‘care for all his physical needs’ had a negative effect on them. For example, women described back and shoulder injuries as a result of helping their husband, while others described how the care of the home now rested on them, once their husband could not assist.

Women usually reported that their physical condition improved, and felt they were aging better, once the burden of care was removed, although this improvement could take some
time. It was also noted that following spousal loss, there were other issues (both physical and emotional) associated with grief that required management. Transitions to a new life needed to be made and these were reported over time.

7.3.2.3 Physical function

Women related a story of trying to keep activity at a level that assisted them to keep their independent living and mobility, and thus contribute to ageing well. They often wrote about the fact that they enjoyed formal exercise groups, for example water aerobics and local community exercise groups. At times women were quite specific about the value of participating in specific programmes, by mentioning the names of groups that had provided opportunity to learn and enjoy a physical activity of special interest, for example bowls, tennis and dancing. They sometimes described that they could not do an activity or exercise following an event, for example, a surgery. They indicated they were planning to return to the former activity, or they were in the process of improving preparatory skills to facilitate a return to what they considered ‘normal’. Comments did not usually relate depth about quantifiable measures, for example, exact distances that could be walked and the relevant time taken, as would be reported if a health professional were reporting a test that was conducted. They usually wrote a comment linking an activity with skills that would be required to accomplish a practical task. For example, they may have written that just after surgery they ‘could hardly stand up by themselves’; then they progressed to how they were now ‘independently showering’ and ultimately they could walk outside their home to ‘potter in the garden’ or ‘get out to collect the mail’. They related activity levels to other tasks such as being able to ‘manage a trip to the shops’ to ‘do their own shopping’, to be able to ‘use the stairs’ to access certain buildings or to ‘be able to access public transport’.

The women were quite specific about tasks that they could still do (for example, light household cleaning such as dusting), and those they could no longer do (for example, bending required for gardening, mowing grass, vacuuming and other heavier household jobs that required lifting). Women did not write often about needing help with personal activities such as showering and dressing until later surveys. If this was the case, and the women were struggling to look after their personal needs, surveys were often completed by a family member on their behalf. At those times the family member may have added information about level of incapacity, such as the fact that the woman now ‘could not walk independently’.
and was ‘now in a wheel chair’, or that, due to worsening incontinence she may now have an ‘indwelling catheter in place’.

Most women wrote that they tried to stay well by keeping up their physical function. This included being active at home if they lived in a city, maintaining higher activity levels if their home was on a rural property, and/or by doing specific exercises, both individually and in groups. As time passed, more events happened in life that impacted on their physical function, and examples were provided. By the time the women were aged in their late 80’s, their comments reflected how hard it was becoming for them to maintain adequate physical function to be independent, as seen in three comments from one woman, who was widowed at Survey 4 (LW/2a), and made these contributions over 12 years:

“I feel I keep very good health for a person of my age. I exercise by walking on a machine at the club four times a week also I do water aerobics. (Number) years ago I had an accident which resulted in a back operation and which I try and keep under control by exercising. I still have pins and needles in my right foot. However on the whole I am in good health, of course like most people I have arthritis but I find exercise helps greatly” (S2);

“In (date) I broke my wrist on the way to water aerobics & then (number) weeks later I broke the top of my arm falling over a foot stool. However I am now feeling much better & I am able to do lots more. I do have help cleaning bathroom, kitchen & family rooms as I do have trouble after a back operation years ago that comes against me. My daughter mows my lawn for me & my son-in-law does any heavy work in the yard. I still have physio on my neck & shoulders every week, also I do exercises in a heated pool which is helping me greatly I do it at the physio’s & I find it helps me” (S4); and:

“Last year I had a car accident. My car was wrecked. I have not replaced it as I no longer feel confident. I had (number) fractures. I spent 1 month in Rehab & another five weeks going 2 times weekly for exercise which if I was able I would have liked to continue to do as I know it helped me greatly. The reason I need to have help by using a frame I have bursitis in both hips & with the osteo. I am in a lot of pain I cannot walk very far with the help of the frame I can get around so much better & I am not afraid of falling” (S6).
The stressors that were involved for such women, and the resultant stress they felt, indeed added poignancy to their comments. The ongoing effort the women described, to remain active enough to look after themselves, and perhaps a spouse, was remarkable. When the efforts failed to be sufficient, it was evident that for many women they had really given the best they could, for as long as possible. Sometimes, even persistent effort was not going to be enough to ensure safety and independence at home, without additional care being provided.

7.3.2.4 Quality of Life (QoL)

There was richness in the comments regarding the perception the women describe about their quality of life. Most comments related their assessment of QoL to family, friends and their community of interest, influence and involvement. Families were said to be ‘wonderful’, ‘loving’, ‘supportive’ and ‘helpful’. The women said that their families added so much value and pleasure to their lives by way of physical involvement and encouraging emotional support.

Across all marital groups there were countless references to the ‘blessing’ and ‘benefits’ that a close and caring family network offered to women. The ways that this may have been experienced altered according to the physical situations in which the women found themselves, and to the psychosocial changes that may have been occurring if the women were caring for an ageing spouse. Many women were generous in their praise of family, for example:

“...astounding kindness & generosity shown to us oldies by my family especially by my youngest daughter, but really they are all marvellous to me and it helps me feel so much enjoyment of my life, though old” (S6/LW/2a); and

“In great health, for my age 85yrs. wonderful family & friends. What a wonderful way to live...what more can I ask!” (S5/EW).

If women remained married, they may have included comments about the pleasure derived by both the husband and wife of involvement with their families, for example: “Our children and grandchildren visit and we love spending time with them all. Everyone is welcome and we have so many visitors. We think our life is GREAT!!” (S3/M).

Friendships added a great deal to QoL and the reported experience of ageing well. Women in the early widowed groups wrote extensively of how their friends filled the void in their life that the death of the spouse had left. With the support of friendship networks, the women felt that they enjoyed greater quality in their lives than if they had to only pursue solo activities.
Women wrote about the pleasure they derived from ‘helping others’, ‘having laughs’ ‘reminiscing’ with older friends and ‘looking at more than just my own circumstances’. For women who remained married, there were still comments about joint friendships such as: “My husband and I keep busy and have lots of interests and we share the company of many wonderful friends” (S5/M).

Women who remained married, or who were widowed later, wrote less about being active with friends in organisations outside the home and seemed to rely more on ‘phone calls’ which brought ‘joy’ and a ‘sense of gratefulness’, and visits to each other’s homes, if transport permitted. Some wrote that they or their husband could still drive to see friends in order to enjoy companionship and interests together; others wrote that ‘my family will drive me wherever I want to go’. Whatever the method used, association with long term friends added a dimension to life that was described as being ‘invaluable’ to women, as this woman said:

“I have known my oldest friend since we were in school together. We have shared so many memories. You just can’t tell other people how much it means to have known someone for most of your life….. especially now that I am 86! It is nice just to be yourself. And to really share so many things since we were just girls” (S5/LW/2b).

Being able to remain engaged with, and be active in the wider community brought yet another dimension to the concept of QoL. Women reflected on the ‘society their generation had helped to create’. They felt that their lives were enriched by knowing that they had made a ‘valuable contribution’ in the past, and to varying degrees, were still able to do by using skills and experiences to help younger people ‘just starting out’. Many felt that their lives were energised by conversations and activities that took them out of ‘mundane tasks’ and reminded them of the interesting things that happened outside ‘the four walls of home’.

Women also reported that they felt their QoL was improved because they could invest in the next generation through helping the family, by being involved in community service organisations and even through their contributions to the ALSWH. They used expressions such as ‘I feel that my life is still contributing’ in a worthwhile way ‘if I can help my grandchildren learn in some way from my life’, ‘if my experience can help someone else’ and ‘if the information you gather at the ALSWH will help others prepare better for ageing and all it entails’.
Not all women were able to report such positive experiences of ageing. These examples from two widowed women show the challenges that some faced as they found it harder to be engaged in ways they deemed to be enjoyable and valuable:

“I have gone from a travelling, active member of society, to feeling & being unable to participate in activities of most clubs & activities I was a member of. I now find my mobility inhibits me & I do not feel that I enjoy social functions and family gatherings so much. Mentally, I miss it all” (S3/EW).

“I feel that I have slipped in my life. Harder to enjoy activities now. I think I am just running out of energy. It’s been much harder having everything to manage by myself as husband can’t help just now; still we hope things pick up in the future. I find myself envying the people who don’t have so much work to do in their homes and gardens” (S3/LW/2a).

For some it seemed their energy levels became too depleted to access and utilise the resources that had formerly helped them to age well, particularly seen in their later years. As true as this ‘fading experience’ was evident for some, there were many women who used expressions such as ‘I am so grateful for all the good things in my life,’ ‘I expect to keep going with my good life for many years yet’, and the comments included these three memorable quotes:

“I enjoy life and will probably live to be 100!!!!” (S2/EW);

“....birthdays are lovely happy times, 89 in July. It is old but I don’t think I am old, it’s a state of mind over matter. My ambition is to stay on my feet as long as I can” (S6/EW); and

“I remain very well seeing as I am 86; I am rarely sick... you have to be awfully sick to die...it is the way of things!” (S5/LW/2b).

7.3.2.5 Social engagement

Remaining engaged in the wider community was mentioned many times as being beneficial to the experience of ageing well. Social engagement was reported by many women as being a contributor to their perspective ageing well. Findings from this study showed that women reported that by being involved in service organisations, churches and interest groups they were ‘never bored’, felt ‘mentally stimulated’, ‘valued’ and were ‘grateful’ that there were still
more opportunities ‘to be active and contribute’ to their society. By maintaining an ‘outward focus’, to which women often referred in relation to families, friends and the community, there was the opportunity to feel that the experiences of a lifetime were not wasted, unnoticed or unwanted. For many, the opportunities meant they could give back in terms of skills and abilities, and in addition, they felt enriched because they could still learn new things themselves, which made them feel accomplished and proud.

For many women, particularly those from a rural environment, the places they turned to for ongoing social engagement were churches and community groups where their families had been known at times for some generations. For example, one woman from a country town contributed:

“I have been a member of (an organisation) for 50 years and I am still there!” (S3/M); and:

“...my mother came from this farming area and our family still enjoy going to (name of place) to help with the church work, fetes and missionary groups. We still raise money from our raffles and we all feel proud of our work” (S4/M).

Women from both city and rural environments wrote that they did ‘voluntary work’, on a regular basis, and wrote that they only slowed down, or had to stop, if health, mobility and/or transport issues became too difficult for them to continue. They wrote that doing their ‘charity work’ helped them ‘cope’ by ‘keeping busy mentally and physically’ and that they felt that by ‘giving back’ in many ways they were more often the beneficiary of what was perhaps supposed to be a work of charity for others. They used words such as ‘being involved helps me keep on top of things’, which could indicate that the challenges associated with ageing required a management strategy. Being externally focused, intentional concerning activities and positive about the potential for the future all combined to produce the added benefits of an experience of ageing that was reported in terms of ‘ageing well’.

Some women described barriers that made it difficult for them to remain socially engaged. Lack of transport that was accessible and affordable was frequently mentioned, especially for women who had never driven a car, if the spouse, who had now died, had been the driver for the couple, or if they had reported having to hand in their driver’s licence. The anticipated sadness women described as they considered the loss of independence afforded by the use of a car was linked to the knowledge of how limited they would feel if/when this loss occurred.
The barriers could be eased if friends or family were able to step into the gap and provide convenient transport to community events, interest groups and church services. Other women used their cognitive resources, knowledge and control by looking for other means of transport that may have been offered through community services. These appeared to be more readily available for women who lived in larger regional or capital cities. Women who received the assistance of DVA could often access means of transport more easily, as this was one of the benefits extended to them. Rural dwelling women frequently reported the most difficulty, regarding access to community services such as buses. To counter this difficulty, many rural women described that they lived in a close-knit community; perhaps not close with respect to physical proximity, however ‘close’ with respect to community spirit. Members of that regional group were often reported to be open to offering help to those in need.

Women often were able to balance the thought that although they may not have been as ‘active and involved’ in activities outside the home as they ‘once were’ they could still gain satisfaction from reflections such as:

“Getting older does bring new insights into our living. It’s true I am more often on the receiving end of help but I think I still contribute within our family and I cannot be more grateful for all the blessings I still enjoy. Every day is a gift!”

(S2/LW/2b).

For women who were part of the later widowed groups, or those who remained married throughout the study, and who reported that they had responsibility to care for a spouse, they described that they had limited opportunities to remain engaged outside of their home. Some found this a barrier to their experience of ageing well for themselves, using words such as ‘no time for me’, they had ‘lost the chance to be involved’ and ‘I miss my older interests where I felt I could help’. Equally, there were women who felt that the opportunity to care for their spouse was ‘a privilege’, and ‘just what you do for your closest friend’.

For many of these women, the centre of interest and contribution for a period of time at least, became their home, and the people who came to offer help and support, whether of a personal or professional nature became their focal point of interest. It seemed from the free-texts comments that a great deal of strength was derived from ‘the wonderful people who help us’, who were involved in some aspect of care for the couple. Women wrote that this degree of support helped them not feel ‘so alone’ as they managed the ‘difficulties’ that accompanied ageing. The women also wrote that although life was not entirely as they would ‘have liked’,
and the opportunities to ‘be busy outside the home were missed’, the situation was made easier because the ‘burdens were shared.’

7.3.2.6 Cognitive function

Many women wrote about keeping mentally active, with comments such as: “My retirement village has opened up new activities for me (e.g. computers, and a choir) and I enjoy trying to keep up with learning things where I can” (S6/LW/2a). There were some who reported that they ‘struggled to remember things’, worried about their ‘failing memory’, and were concerned that they could get ‘muddled’. For women who wrote in a positive way about their mental acuity, they seemed to also feel that this impacted on the way they perceived how well they were doing with respect to ageing:

“We have had some challenges... nevertheless, both my husband and I are learning how to use the computer and have made progress. We enjoy the classes and feel that we are remembering other things better too, now we are trying to use our brains again”!! (S6/M).

Women used terms such as ‘I think my brain is ageing well’, and ‘if you don’t use it (your brain), you will lose it’. Some added that although they could remember things from their younger days they reflected that ‘sometimes it is my short term memory that is not so good’.

Many women wrote about cross words, puzzles, reading, and other hobbies that kept them ‘mentally stimulated’. Quite a few women wrote that they enjoyed contact with younger people, particularly grandchildren because conversing with them was ‘much more interesting than talking with old people about their complaints’. A quote from a woman contained more detail about this aspect of interaction with younger people:

“I have taught high school seniors for so long that I now find empty talk about bingo etc. from ‘us oldies’ tiresome. I love to be in the company of my 19 & 20-year-old grandchildren. More stimulating stuff about now and the future. Too many ‘oldies’ wallow in the past! And lots of my peers have died!” (S6/EW).

Being involved in informal teaching situations, where women could pass on their skills and interests to others was said to be rewarding and an effective way to keep their brains ‘busy, not idle’. Women seemed to recognise that new activities were ‘good for the brain’, and many women seemed to cope with some change with age as being ‘par for the course’ and were not too despairing despite ‘momentary lapses’. Some women wrote about ‘keeping the books’ for
a business, maintaining ‘an interest in the family business’, or assisting others in managing shops and libraries, and even ‘chairing body corporate meetings’. Many contributed these types of comments at numerous surveys, until quite late in life. All of these activities would have required the women to function at a reasonable level of mental acuity. Some women specifically mentioned that they were aware they had the capacity to ‘conduct the jobs’ they worked in. Others also said that their work was a means to remain active in the community and it stimulated them mentally. They used their ‘jobs’ to add value and enjoyment to life as they aged, by being involved and interested in tasks that challenged their cognitive abilities.

Overall, women did show that they had an awareness of the potential to develop dementia, with frequent mention being made of Alzheimer’s disease. This caused some concern if symptoms were thought to be evident. The realisation of the severity of decline that could follow impacted on the women’s perspective on their ageing. Many had already cared for a spouse who had exhibited cognitive decline, and women did at times express that they hoped their episodes of ‘not getting the words out right’ or ‘forgetting names’ were not imminent signs of dementia. The comments from some women at times showed evidence of cognitive decline with less coherence within ideas, and less adherence to commonly accepted syntax. Some women seemed aware that their comments were possibly harder to understand, with examples such as ‘I hope you can follow what I am saying’, while others did not seem to note that there was any confusion in what they were conveying. Over time, the decline in use of appropriate grammar and spelling was more noticeable.

Some carers, usually identified as being the daughter or daughter-in-law, wrote on behalf of the woman for whom they had responsibility, if physical and/or cognitive decline was a barrier to completing the surveys. Two quotes that shed light on this difficult matter were:

“I have filled in this survey for Mum answering the questions as I am sure she would have responded. I did not ask her the questions & write her responses as she becomes confused easily and is very impatient with a long task requiring a lot of thinking. Mum has many symptoms of dementia but has not been formally diagnosed. Her short term memory is very poor, she is easily confused and recently she has started making things up to fill in the gaps in her memory. She is rational in her thinking but has very poor insight” (S6/EW); and:

“I filled in this survey for my mother. She has been diagnosed with dementia & has virtually no short term memory. Although she is in excellent physical health,
she becomes very confused if anything in her ordered life changes. She can take care of herself, but needs help making decisions even about such things as what food to buy. She is aware of her bad memory - but we don’t call it dementia, as her husband is in a nursing home with advanced Alzheimer’s & we don’t really feel she needs to know she is heading the same way” (S6/M).

7.4 Women who age ‘less well’

Woven throughout the findings are the examples of women who find it hard to describe a positive, active meaningful process of ageing. It is acknowledged that for many women, they describe experiencing the ‘ebb’s and flow’s’ of life, whereby some periods are more challenging to negotiate, and others are more relaxed and enjoyable. Indeed, it was at difficult times that women often wrote about the resources they felt were available to support challenges, and contributed comments about how they were ‘trying to cope’, they were ‘looking for meaning’ and were searching for the type, and amount, of support that was ‘needed at this time’. The journey of ageing, whether or not it included spousal loss, is not undergone from a static, or necessarily extreme position. The experiences women described were not expressed as entirely as ‘good’ or ‘bad’; of being long periods of uninterrupted ‘excellent’ or ‘very poor’ health; and did not reflect prolonged ‘heights of happiness’ or ‘depths of despair’. Rather the iterations of life were observed to be the more common experience, where the rhythms of life were described, and both negative stressors and celebrations were included.

Some women, either for longer periods of time, (seen in comments over multiple surveys), or over a shorter time frame, (perhaps with only one comment about a particular challenge), described that they were struggling to adapt to the changes in their health and functional capacity. These women at times wrote that they found it hard to find understanding and predictability in their lives (comprehensibility); they perhaps found it hard to find resources to support the challenges that they faced (manageability) and/or they struggled to find sufficient purpose and hope to sustain them (meaningfulness). Many of these women also described that they did not feel that they were ageing as well as perhaps they had hoped. These more disappointing comments about the ageing journey strengthened the finding that as stressors occur, it is beneficial for women to have access to, and knowledge as to how to utilise sufficient resources that contribute to a strong SOC.
7.5 Chapter Summary

The definition of ageing well (sections 3.2.4 and 7.1) is a multi-dimensional concept that was richly described in the findings presented in this chapter. The conceptual model (Figure 4-12) was applied, with consideration having been given to other models of ageing that had been described from the literature, along with the framework of salutogenic theory. Six key concepts had been identified as the conceptual model was developed and they were applied, with separate analyses having been conducted on each one. The concepts were subjective well-being, well-being related to objective measures, physical function, quality of life, social engagement and cognitive function.

Women described their experiences regarding their assessment of subjective well-being. Overwhelmingly, the women contributed that even in their late 80’s they felt that there was meaningfulness in their lives and they felt they could describe their situation as fulfilling, happy and purposeful. This positive assessment was alongside comments that acknowledged challenges, some disappointments and a measure of losses in various domains. For most women, they used their comprehension regarding their situation to assess either that the positive experiences of life outweighed the negative. If this was not the case many had the capacity to recognise that there was a certain predictability surrounding this later period in life, and it would not be anticipated that it would be an entirely easy and enjoyable time. Opportunity to analyse the data over time gave insight into the orientation that women used to assess their well-being as being good, tended to persist, even as additional challenges may have occurred in their later years. In later surveys, there were more descriptions concerning the ways women approached age related decline. However, the use of resources such as resilience and positive disposition appeared to strengthen their SOC, and good subjective well-being was frequently described even in later years.

There was mention made of objective measures that women felt were an advantage to understand in order to manage co-morbidities well. In addition, many showed that a sense of comprehension regarding objective measures related to their health and well-being. Importantly, being aware of how to practically apply relevant knowledge assisted their overall sense of well-being. Women tried to gain knowledge from sources such as their general GP and other community health workers in order to show manageability of their situation, exhibiting independence and control. Family members also were reported to offer information about potential future decision regarding best choices to manage their health, and to support
the women in the choices they made. Women contributed steps they had taken as a precautionary and/or preventive measure to minimise the onset of illness and disability. If such negative events occurred many women also demonstrated an understanding concerning their occurrence and how these events could potentially compromise their chances of ageing well.

Linked to these objective measures was the concept of physical function. It was often the sense of comprehension, strengthened by the use of the resource of knowledge about medical conditions that were faced, that pre-empted the women to be engaged in as much physical activity as they could to improve their own situation. Women identified that it was good physical and mental health that supported their ability to remain living with independence, an important aspect to women making an assessment that they still had meaning and purpose in life, and assessed themselves to be ageing well.

Women often showed they had good comprehension about, and demonstrated manageability to, complete tasks associated with running a home, such as paying bills and organising home maintenance either by themselves, or with help. When they expressed that they still perceived they had control over their situation, they were more likely to assess their ageing as being more positive. They also felt that over time, as long as they could function with independence, they could still be considered to be making a meaningful contribution, not just accepting help.

The perception of QoL was often linked to the degree of social engagement that could be maintained. Being ‘able to do’, (both physical and cognitive activities), contributed to the belief women expressed about a ‘good quality of life’. Meaningfulness in life, associated with being appreciated and making a valuable contribution, was seen when women described how they were engaged with families and communities. The sense of manageability was strengthened when resources supported independence regarding choices about their health care and matters concerning appropriate housing.

Finally, in reviewing and summarising the way women described their ‘ageing well’ process, was the importance they placed on good cognitive function. Women were so appreciative if they retained comprehensibility regarding changes that may have occurred in their world. There hovered over some women a fear of the onset of degenerative diseases such as dementia and Alzheimer’s disease. Many women wrote of how they managed their fears by taking proactive steps to improve their chances of ageing well. They deliberately made choices.
to extend their mental acuity skills, and to remain associated with people who would support their cognitive endeavours, especially younger grandchildren.

Women applied their GRR’s of knowledge, locus of control, resilience and social networks to combat the stressors of common diseases, such as cardiovascular disease and arthritis. Women have shown that they value being independently able to contribute to managing health and well-being outcomes by minimising the impact of diseases and conditions, particularly on their later years. The idea that older women are a drain in terms of resources, and require constant external management to help them through their ageing process has not been supported in the findings of this current study. Many women described with some degree of pride and confidence that they were proactive and involved in directing decisions that related to their process of ageing. Social support as a resource was an important contributor, along with knowledge and resilience, to the SOC that was evident in the comments that were analysed.

SRR’s seen in this study included women being able to access local information and support groups if they were managing certain medical conditions, either for themselves, or for their spouse. In addition, the services that were particular to their area of residence were described. The availability of services varies to a great extent especially in regional areas and women needed to know what resources were being offered in their own geographical area to support their independence and mobility within that community. Women who had been exposed to less predictable events (for example, accidents, natural disasters), and/or specific medical conditions (for example, less well known conditions that were not generally widely understood) indicated that they had sourced specific resources to help meet their challenges. They may have had to access, and even develop, their resource of knowledge so they could make informed choices about the best way to move forward from a crisis or critical point.

The inter-relationship of resources was also a key finding, in that no one resource was sufficient by itself. As different stressors were felt by women, the use of different resources were emphasised for certain periods. For example, women may have tried to manage medical decisions themselves for some time. However, they may have had to access additional support resources to help during periods of greater stress, such as in post-operative periods, or after an emotional based difficulty.

With the use of GRR’s and SRR’s, such as those mentioned, women were able to exhibit a SOC. They could see their lives as more predictable when they felt in better control of health.
management. They had strategies in place to manage challenges that could accompany illness or decline. Being aware that as they aged, they may have needed to select which activities that were best suited to their current abilities was one way the comments revealed that women could make appropriate adjustments to their lifestyle. By identifying and using available resources, women strengthened their inclination to view life with a SOC. As a result, women described ageing well in terms of high mental and physical function and an active engagement in social networks.

Many women continued to show evidence of the use of many resources such as good subjective and objective health, and positive disposition, over many years. There was an increasing awareness over time that negative effects of ageing were real and they could not be stalled or ignored indefinitely. This finding was supported by the descriptive analyses seen earlier in the chapter. The overall trajectory was downward, and clearly the women who were part of later surveys were in their late 80’s, up to 90 years of age were aware that lifespan was limited and that their lives were going to be affected by at least some of the frailties of ageing.

Changes in marital status affected the way women reported ageing well, and these have been already seen in the findings on the stress associated with caring for a spouse and subsequent spousal loss (section 5.4.1.1 and 5.4.1.2). For some women who had been caring for a spouse, the changes associated with being freed from the burden of caring, was seen to offer an opportunity to be more active and engaged, physically and socially. If the marital change happened later in life, it appeared that for some others that it was too late in life for them to re-invent new directions of interest. This could have been due to their own ill health or lack of means to travel to the locations of potential activities. For women who remained married, the level of physical and emotional health for both them and their spouse would have had a varied effect on how they were able to report their ageing process. Where both husband and wife were active, there were findings of richness in their experiences together, as they observed and were participants in the growth and interests of their families. If ill health was a prevailing influence, the women were less enthusiastic about their later life experiences of ageing.

Whether women remained married or not, where illness and immobility were significant, there were more references to the diminishing presence of concepts that would be considered important to the process of ageing well. These included comments about not having as much interest in living, that they were less interested in staying in their own homes, and they had less desire to stay interacting with families and the wider community. This finding added
weight to the importance of being able to support and educate women to have a SOC for as long as possible, which can enhance the later life experiences. The more women know what resources are available to them, learn how to develop and use them appropriately, and for as long as possible, the better the experience of ageing can be for them. Ageing well into their latest years can then be something women will be more confident that it is a likely outcome.

The comments made by the women showed that all three of concepts that contribute strongly to the SOC, that is comprehensibility, manageability, meaningfulness, were seen in the way women related their experience of ageing well, even into their latest years. The evidence of SOC in the data showed differences in intensity in the way it was expressed. How the SOC was seen in the comments, regarding choice of responses and use of appropriate resources, altered according to the changing circumstances over time. Key circumstances where SOC was seen to be important included the times of spousal loss, and other significant losses, such as death and illness of family members.

The findings reflected the same trends as were seen in the plots that were presented earlier in this chapter (section 7.3.1). The early widowed women did report that they were experiencing more challenges to their HRQOL in the first survey, which was ≤5 years from when their spouse had died. In Survey 1, they often reported that they had dealt with physical issues to do with managing co-morbidities and mentioned two potential reasons. One reason was that they expressed that their health issue bore some relation to problems experienced while caring for their spouse (for example, injuries related to lifting). Another factor that was offered by both early and later widowed women regarding their HRQOL was that health issues they had experienced for some time had perhaps not been dealt with earlier, due to the focus of care having been on the spouse. This was described as being to the detriment of their own health. However, by later surveys, having dealt with spousal loss, women reported that they were feeling much more in control of their health. Many described that they had returned to being involved in more physical activities and interests external to their home, and these were seen to be similar levels to women of the same age from other marital groups.

7.6 The next chapter

The next chapter brings together the findings from the last three chapters, on stress, resources and ageing well. It reviews the relationships between these three concepts and evaluates the efficacy of the conceptual model that was applied to the data. The chapter will also review the
findings with respect to literature, in order to situate the findings within the current body of knowledge. The implications of the research, its limitations and strengths, are discussed along with concluding comments.

### 7.7 References


8 Discussion and Conclusion

“Great things are done by a series of small things brought together” (Vincent Van Gogh)

8.1 Introduction and review of study aims

This final chapter revisits the aims and scope of the research. Findings from Chapters 5, 6 and 7 are brought together and discussed, and the adequacy of the conceptual model from Chapter 4 is re-assessed for relevance and breadth against the study findings. Discussion will include how valuable the model was in terms of how it reflected women’s experiences of managing their experience after spousal loss, and how they operationalised ageing well. Finally, implications from the study findings are discussed in relation to how the voices of older women can be given due heed, and how future directions of policy and care provision can best address potential needs and concerns of older women.

The broad intent of the study was to understand how older women experience ageing, what stressors they identify, and what resources prove useful to deal with changes as they age and with respect to changes in marital status. In addition, there was an intent to explore women’s experiences for evidence of a SOC, as described in the theory of salutogenesis, particularly against women’s practices that contribute to ageing well. The following study aims were addressed:

1. To identify if the main themes described in previous research concerning the experiences of older Australian women persist over time (Chapter 4/Paper 1).
2. To identify the main stressors, and the reactions of stress, that women describe over time as they age, according to marital status (Chapter 5).
3. To identify the main resources that help women contend with, and minimise the negative effects of stressors (Chapter 6).
4. To assess if the resources alter over time as the women age, and according to marital status (Chapter 7).
5. To identify concepts that women report as being related to ageing well (Chapter 7).
6. To identify if SOC and GRR and SRR are seen as useful to counteract and manage stressors and stress (Chapter 7).
7. To identify if SOC and GRR and SRR alter over time and with respect to differing marital status (Chapter 7).

8.1.1 Review of the studies in this thesis

The first of the two studies used a sample of women who had been widowed for five years or less in 1996, and who had continued to contribute to the ALSWH over the following 15 years. The women had answered questions regarding the presence, and nature of life events and concerns experienced by them as they aged. Their age over the time of the study ranged from 70-90 years. Free-text comments provided by the women on a health-related survey were analysed in terms of how the events were described and managed by the women. Comparison was made between the findings from an earlier cross-sectional study of ALSWH data using data from 1996, against longitudinal data that was available following completion of five further surveys, conducted at three yearly intervals, until 2011. The findings of this study have been published, with the publication being included (section 4.11). The main themes that were described by the women, over time as they aged, were confirmed to be consistent with those reported at the first survey in which they had participated. However, changes were seen in the timing and nuances of the themes that underscored the importance of maintaining support for widowed women and their altering needs, well beyond the initial period of bereavement.

The women from the first study were then included as one of three sample groups, based on marital status, for the second study, a review of which now follows. The breadth of information that had been described in the data from early widows highlighted the diversity of personal experience and also the recurring nature of common themes characteristic of women and ageing in general. From the analysis for the first study came an awareness that the data that had been collected over 15 years was rich with observations, information, and insight into what life was like for an Australian woman, ageing without a spouse from the time they were 65-70 years.

The knowledge that was derived from the first study provided an ideal platform from which to build the next study. The second study was planned to include the same participants as the first, and to broaden the sample to also include later life widows and those who had remained married for the entire time that the data had been collected. The experiences of the three sample groups could then be compared and contrasted, to see how the process of ageing differed for each marital group, and also to see how time may have affected this process.
The second study examined data from three groups of women, (early widows from the first study, later widows and married women), and examined the free-text comments for each group multiple times. First, each individual concept proposed in the conceptual model (Figure 4-12), was applied to the comments from all the women in turn, from the sub-sample groups that had been chosen. Information was sought about the nature of various stressors, and women’s feelings of stress in response to the stressors.

Guided by salutogenic theory, answers were then sought regarding resources to which the women, they had the ability to utilise, and they had found effective to minimise the negative effects of stressors. Attention was paid to the way comments about resources changed over time and with respect to marital status. The comments were then reviewed to link the findings concerning stressors, stress, resources, and SOC, with how women reported managing their life as they aged. Evidence of the three key concepts of SOC, comprehensibility, manageability and meaningfulness, were noted for women who showed evidence of a positive, orientation to life. This study identified how older women described managing significant life events, alongside the process of ageing, noting the use of terms that related to the concepts of salutogenesis. Finally, this study sought, by using data collected over 15 years from women with differing marital status, to explore the differences in the experiences of ageing. The data from the three sample groups of women provided the opportunity to compare and contrast the experiences of those women who reported ageing well, with those for whom the outcomes were not so positive.

The premise of salutogenic theory rests on three intertwined concepts, the first being the inevitable occurrence of stressors in daily life. The second concept is that having resources can help manage stressors. The third concept is that positive responses are possible. For example, people can demonstrate an ability to regain physical strength and mobility after a health challenge, depending upon the variety and intensity of stressors (Antonovsky, 1979, 1987). Resources available to help manage stressors are different for each person and may vary over time. One of the key strengths of salutogenic theory is that it has a dynamic and flexible approach, which incorporates personal interpretation of the orientation to life. It is also consistently aligned with the focus that, universally, people have the capacity and ability to manage challenges (Lindstrom & Eriksson, 2005).

The women in the second study were divided into three groups according to their differing marital status (early widows, late widows and married), and it was seen that they described
variable stressors at differing time points in their lives. The loss of a spouse is considered to be the most significant personal stressor and social disruption factor that can be experienced (Holmes & Rahe, 1967; Trivedi, Sareen, & Dhyani, 2009). It was seen in comments contributed by the early and later widows that indeed spousal loss was described as being of utmost significance. The passing of a spouse described, with varying amount of detail, at the closest survey to the event occurring, and was also consistently included at subsequent surveys. The main additional stressors that women reported having to deal with centred on caring for their spouse, and other issues related to the spouse, bereavement (other than spousal), issues to do with the ageing process, health, social relationships, and financial and housing matters.

Rarely did any woman indicate that the stressors of life were entirely outside her capabilities to manage. Later in life, there were more references that women indicated that living alone, managing a home, organising medical support, difficulties with mobility and/or managing activities of daily living, had begun to feel overwhelming. Despite the challenges many comments reflected the resources which they found to be accessible and helpful. The result of appropriate use of resources to manage stressors was considered to contribute to a perspective of ageing well. ‘Well’ did not necessarily equate with being perfectly happy, healthy and living in ideal circumstances. Rather it conveyed the perceived satisfaction expressed by women who had done the best they could, given their opportunities and resources available to them. The study was driven by salutogenic theory to assess if there was evidence in the women’s free-text comments that evidence of a SOC was linked with experiences of ageing well.

8.1.2 Bringing together the findings

This research has explored experiences described by older Australian women, over a 15-year period. Particular attention has been paid to noting key events that have occurred over time, which events were considered as life stressors, how women accessed resources to manage these, and how women described their experiences in which they had utilised resources to manage stressors. This chapter brings together, and reflects upon, the relationship between the concepts of stress, SOC and ageing well. Then, further discussion will follow regarding the implications concerning the conceptual model that was proposed, in context with other paradigms of ageing and, finally future directions of research will be addressed.
8.2 The story of stressors, sense of coherence and ageing well

8.2.1 The development the Conceptual Model

The conceptual model (Fig 4-1) was formulated after a review of the literature, focusing on what was known about ageing as a process and how people had been reported to describe their experiences. In addition, information was sought about the way women described managing key events, for example, losses such as spousal bereavement in their older years. It was also a focus to identify how they recovered from, and made adjustments, to challenges that occurred in order to positively influence the process of ageing where possible.

Much of the literature had concentrated on conceptualisations that people involved in research and/or the medical/scientific communities had proposed to describe ageing. They seemed to fail to adequately capture the breadth of experiences and opinions that women had offered to the researcher, during interactions over the years of home visits for physiotherapy services (section 1.3). Some other literature indicated that to understand the term ageing well, consideration should be given to such concepts including: environmental factors (such as safe and affordable housing), purpose in life, meaningful social interaction, subjective well-being, and encompassing both physical and mental aspects that relate to health (Kendig, Browning, Thomas, & Wells, 2014; Osborne, 2012; Woods et al., 2016).

The researcher developed an interest to incorporate both theoretical and practical perspectives, to interpret how women experienced different stressors and yet consistently found resources to manage the stress. They appeared to have developed ways to adjust and cope, and as a result they described with satisfaction that theirs had been ‘a life well lived’.

Along with the interest of the researcher, there was also a discomfort regarding assessing how women were ageing by the use of prescriptive criteria as the main instrument. The researcher felt uneasy in considering the assessments of how women were ageing that used prescribed criteria as the main instrument. How would this type of assessment report those who had perhaps never been ‘100% healthy’, for example those who had suffered ongoing effects of childhood illness, those who had managed lifelong problems such as asthma, and/or who those had suffered a physical set-back at some point.

When applying prescriptive and mainly biomedical constructions to the process of ageing, the 90-year-old bi-lateral amputee woman the researcher visited each week could, in a quantitative study, be described as ‘unsuccessful’, ‘unhealthy’, ‘unproductive’, and ‘inactive’.
Placing this woman in these categories would occur because she could only live at home providing she continued to have extensive support of family members and medical professionals. She had no formalised centre of influence outside her home. She no longer helped care in any way for others. Her physical activity was limited on a daily basis to getting both her prosthetic legs to fit with some degree of comfort and to have short walks in her home with assistance.

However, this woman was considered by her family and friends to be inspirational and, as best she could, the woman herself felt she was ageing well. The researcher was always amazed and inspired by the woman’s ongoing zest for life despite frequent challenges. Her family adored her and various members of the extended network visited daily. They recalled many things she had done in past days for them. She knew all about their lives, and cheekily ‘required to be updated’ on information about any current ‘relationships’. She kept them all laughing as she recalled how she had fallen off her legs and had used her emergency call button to phone for help, and then described the ‘lovely young ambulance men’ who had come to help her back into the chair, and who really made the whole experience quite ‘worthwhile’.

Women such as this formed the personal background against which the literature was reviewed and the current position about how ageing was assessed. The question was asked, how broadly could existing literature provide a reasonable framework to adequately represent the many facets of ageing? Current findings suggested that keeping good health, physically and emotionally, was important and necessitated the uptake of preventive behaviours, and appropriate and timely medical support to be adequate. Social engagement was reported to enrich the lives of people who could continue to find groups of interest for interaction and involvement, providing they could access transport to take them to places outside their homes. Families and lifetime friends were important to most people, with whom to be able to have physical contact. If regular physical contact with families and friends was not possible, then other social networks could suffice to fill the emotional gaps. A model was sought that allowed flexibility regarding the concepts deemed most important to the age group of the participants, and that could represent older women more broadly in the process of ageing.

The conceptual model (Figure 4-12) drove the qualitative data analysis, with each concept in the model providing a different ‘lens’ through which the women’s comments were read. All available comments were reviewed again, in order to consider how the concepts may inter-
relate with each other, over time. In this way the process of ageing was followed through the medium of comments written by women, aged between 70-90 years of age.

The nature of the stressors described by women, the intensity of them, and the duration they may have lasted were varied. The orientation through which women viewed their experiences, was chosen in the model to be the SOC. This orientation to life is central to salutogenic theory and proposes that the presence of the concepts of comprehensibility, manageability and meaningfulness support the likelihood that the process of aging will be more positive, conceptualised in the current study as ageing well. The findings of the study strongly support most aspects of the conceptual model, which was driven by the theory of salutogenesis. The following section of this chapter re-visits the findings that were presented in Chapters 5, 6 and 7, and links them together in a discussion about their relationship to each other, their relationship to salutogenic theory and how the findings can be situated within the current body of literature. Aspects of the model that did not adequately support the findings are also discussed.

8.2.2 Linking examples of stressors and stress, use of resources and ageing well

Participants in the second study reported multiple stressors, over many years. This finding concurs with literature across time (Aldwin & Yancura, 2010; Angel, Jime’nez, & Angel, 2007; Bennett & Bennett, 2001; Byles, 2007; de Couto, Koller, & Novo, 2011; Lazarus & Folkman, 1984; Orzechowska, Zajączkowska, Talarowska, & Galecki, 2013; Rosnick, Small, & Burton, 2010; Selye, 1974; Stroebe, Folkman, Hansson, & Schut, 2006). The findings from the current study concurred with other research that has reported that the presence of long term and heightened stress levels was also associated with elevated blood pressure, disrupted sleeping patterns, poor decision making habits and other negative coping mechanisms (Aldwin & Yancura, 2010; Ben-Zur & Zeidner, 2012). Despite the increased risk factors that accompanied stress, there was an unfolding story of the use of resources to mitigate the effects of stress, and at times, creative ways to resolve the stressful situation by finding ways to address the factors that had been the initial cause the stress reaction.

The comments provided remarkable insight into the different stressors that were experienced by older Australian women, over 15 years. The data used for the study (free-text comments from six ALSWH surveys), contained insights from older women who had been given the opportunity to express their voice and opinion over a range of topics, none of which had been
pre-empted by defined questions. The discussion regarding the relationships between stressors and resources are presented with the stressors discussed in the same order as they were discussed in Chapter 5 (section 5.4).

### 8.2.2.1 Caring for spouse

Women from the early widowed group did not have a living spouse at the time they participated in any of the surveys. Therefore, any references to caring was only made as a comment about life in the past. There were some comments about the stress of caring for their spouse as it had been ‘hard to see him suffer’ and they did not want to ‘prolong’ this period. The described they had felt ‘tired’, had ‘suffered some injuries’ and felt ‘emotionally drained’ from the care-giving period. However, within this group of women who were widowed earlier there was clear evidence in the comments that they had very often found sufficient resource to re-build relationships, interests and hobbies, along with resuming active physical activities as well. Many of these women were able to function both physically and cognitively at a high enough level to transition to their new situation, to adjust and to be able to emerge from a period of grief to a new phase that still provided meaning and purpose. They also acknowledged that they felt a sense of satisfaction that they had done what they could for the spouse in caring for him when they could and this was reassuring to them as they recalled their lives together.

Caring for a spouse was described as a key stressor by women in the two later groups of widows, and by married women. Despite the negative aspects of the stressor, the strain was often balanced by a sense of gratefulness and appreciation that there was the opportunity to show kindness and concern to their lifetime partner. Other research concurs with these findings, suggesting that there are combined negative effects of spousal care on the care-giver’s health and well-being with positive benefits possible as well (Gray, Hahn, Thapsuwan, & Thongcharoenchu pong, 2016; Marnocha & Marnocha, 2013; Penning & Wu, 2015; Wittenberg-Lyles, Demiris, Oliver, & Burchett, 2014). In some population based studies it has even been found that about one-third of care-givers do not report that they feel strain, or other negative effects on their health (Schulz & Sherwood, 2008). The positive effects included feeling that there was meaning to life by offering care to another, the opportunity to learn skills related to health management and a sense of strengthened relationships with others (Brown, Nesse, Vinokur, & Smith, 2003; Peacock et al., 2010).
The degree of negative stress that women described was at times linked to the type of health challenge the spouse was suffering, the length of time that it was reported to have occurred and the relative state of health and well-being the woman felt at any given time. Where a spouse was in pain, where loss of memory or speech was distressing and where a woman felt that she could no longer offer the degree of assistance required, the subsequent description of care-giving reflected a negative reaction. Women used words such as ‘it is so hard that he cannot tell me how he feels’, ‘it is difficult for me to lift him all the time’ and ‘he no longer knows who I am’ and these were reflective of the heartache and suffering that could be felt both physically and emotionally. As time passed, whether the women were from later widowed groups or married, as they aged during the care period, there were more references to the strain that was felt in attempting to supply multiple care needs, while maintaining their own health and well-being.

For many of the women studied, the length of time of their marriage impacted on their decision to continue offering to care for the spouse. Women wrote that ‘you could not just walk away when needed most’ or that they could not ‘even imagine’ leaving the spouse in the care of others, for example, in a nursing home. The impact of time was seen to be significant as women could scarcely imagine a life without their spouse, considering the length of time of their most marriages. Despite the challenges involved most women did not want to ‘let their spouse down’, at such a critical and often emotionally charged period of life.

It has been found that if the primary health challenge causing the need for care is related to mental health, then one-third to one-half of carers can suffer significant psychological distress. This can be due to difficulty in being responsible for decisions regarding care, difficulties in managing health behaviours and the impact that the condition may have on opportunities to socialise (Shah, Wadoo, & Latoo, 2010). The comments of women whose husbands suffered dementia and other mental health issues was rich with evidence that living alongside someone with these problems offered many challenges. These included the ‘tiresomeness’ of repeating the answers to questions that were asked ‘non-stop’, instructions not being understood so the woman felt, due to safety concerns, she ‘could not leave the spouse unattended’, and issues to do with the stress associated with ‘broken sleep’ due to unusual sleeping patterns and spousal insomnia.

Where the main health challenge was primarily physical, there seemed to be evidence that when increased social support was needed, it was easier to access than when deteriorating...
cognitive health was the main issue. Women wrote how they realised they could ask for help not just from families but from community organisations. The knowledge regarding how to access this support, and the possible range of services offered was gained by women through their GP, allied health practitioners such as social workers and physiotherapists, and through their peer support networks. The way caregivers access help has also been the subject of research that supports the fact that women have to know when they need help and support in a timely manner, and from quality sources (Pinquart & Sorensen, 2006; Reinhard, Given, Petlick, & Bemis, 2008; Singh, Hussain, Khan, Irwin, & Foskey, 2015).

These findings add weight to the ongoing need to be aware of how an increasing number of older women will need support to care for a spouse, particularly as expected life span is increasing. Along with more people having added years to life, there is also an anticipated increase in the number of people who will have age while experiencing multiple comorbidities (Australian Government Productivity Commission, 2011; Cubit & Meyer, 2011).

8.2.2.2 Spousal loss and widowhood

From the reporting by Holmes and Rahe (1967), and including later studies on the significance of spousal loss, the findings are consistent that the loss of a spouse was the most significant stressor of a lifetime, and a source of ongoing stress for both of the sample groups for whom widowhood had occurred (Bonanno, Boerner, & Wortman, 2008; Miller, Smerglia, & Bouchet, 2004; Pruchno, Cartwright, & Wilson-Genderson, 2009; Williams, 2004). It has been well documented that the death of a spouse has far reaching effects on increased mortality and, at least for a period, contributes to diminished physical and psychosocial health (Naef, Ward, Mahrer-Imhof, & Grande, 2013; Young & Foy, 2013). In the conceptual model (Figure 4-12, section 4.12), spousal loss was considered as one of the most powerful contributors to stress in the lives of older women. This was borne out of the weight of findings reporting that almost every woman, who was a participant in one of the sample groups of widowed women, contributed comments regarding this loss in their lives. They contributed one comment nearest the time of loss, and also frequently made additional references at later surveys.

The words used to describe the response to the loss included ‘devastated’, ‘heart-broken’, ‘disinterested in life’ and ‘the worst thing that has ever happened to me’. After the death of husband, to whom many of the women had been married for 50 years and more, the extent of the loss was hard to convey for some. This finding agrees with other research that links spousal loss, for a subsequent period of time at least, with higher mortality, periods of depression and
lower mental health scores, along with decreased physical function and higher use of medical service and lower social engagement (Bennett, 2010; Bennett & Soulsby, 2012; Digiacomo, Lewis, Nolan, Phillips, & Davidson, 2013b).

Although the depth of the loss was undeniable, the women in this study provide a rich account of the resources that they accessed to counter this major life stress. Positive disposition was a key resource whereby women first described feeling ‘lonely and depressed’, and then added comments about having to ‘cheer up’ and ‘pull oneself together’ as they acknowledged that taking the initiative to act was something they had to ‘do for themselves’ as it was not in the domain of another to change one’s own outlook on life. The phrases that indicated a positive outlook were frequently inclusive of glowing accounts of how family and friends had offered help, how they were aware that there were others worse off, and how glad they were to still be able to look outward to help others. This finding was consistent with previous research, with evidence suggesting the presence of positive emotions, when expressed on a daily basis significantly reduces the magnitude of stress related depression (Ong, Bergeman, & Bisconti, 2004; Santos et al., 2013; van der Houwen, Stroebe, Stroebe, Schut, & Meij, 2010).

Protective factors which foster the development of positive responses do not necessarily mean that difficult events have not happened (i.e. that there has been a lack of stressors). Rather, it seems that the nature of positive attitudes and resilience can be consistently observed in the way people describe their responses to many events over their lifetime. They are particularly evident as strengths in those who, although they may have suffered some form of trauma and stress, can return to levels of well-being that were present prior to the occurrence of stress (Charles & Carstensen, 2010). In the current study, many women wrote with such warmth and pleasure about how much their family support had helped them re-orientate to a new stage of life, now without a husband. Women wrote about how ‘lucky’ they were, how ‘wonderful the family members’ were, how they knew that with the resource of resilience, that they ‘had managed difficulties before’ and, with help, they would ‘do so again’.

It is also known that after spousal loss there are effects experienced in both psychological and physical domains. A study by Utz, Caserta and Lund (2011) found that the health status of the bereaved person at the time of loss, may also affect the trajectory of health and well-being changes that may follow. Their study used data collected from the Living after Loss (LAL) study, which utilised questionnaires administered over four occasions, for up to 18 months, post spousal loss. Trends were sought in the relationships between known health status at the time
of loss and the level of grief and depressive symptoms that followed. The nature and amount of support that may be required, particularly in the first few years following spousal loss, may be better understood if the health status at the time of bereavement is considered by health professionals and those family and friends within supportive networks. Their study also emphasised the finding that there is a wide variety in the way feelings are expressed, and how these change over time (Utz et al., 2011). This finding adds weight to the potential need for, and benefits from, further longitudinal studies that extend past the first few years of widowhood.

It was described by women in this study, that there was a need for increased social support after experiencing the loss of a spouse. This has been documented in other research on stress (Ozbay et al., 2007; Scott et al., 2007). However, the type of support, how it is offered, and by whom, is significant. The women in the current study wrote almost exclusively about support coming from long term relationships and known networks such as close family and established friends. This finding concurs with research that indicates that most widowed women do not seek resources from formal bereavement and grief support groups. Other research has found that women benefit from forms of volunteering, both formal and informal. However, most of these opportunities provided an outlet for women to contribute in tangible forms to the well-being of others. Most of these activities did not exist specifically to enhance the well-being of the women, although that was seen as a secondary effect (Donnelly & Hinterlong, 2010; Scott et al., 2007). For women who were widowed later, an additional challenge was felt as their social networks, which could have been their preferred resource of strength and support, were also known to shrink over time, limiting this opportunity.

One point of difference in this study, compared to findings from other research, was regarding the use of SRR’s such the particular social support groups that exist to assist the wives of military veterans. Many of the widowed women in the current study expressed that organisations associated with Veterans’ Affairs, such as Legacy and War Widows, proved to be useful resources for support. These organisations offered help for women in the periods surrounding crises. They assisted women in dealing with care issues while the spouse was alive, and with matters concerning grief and loss after his passing. One reason that this finding was thought to be so strongly evident was that the members of these service related groups offered an understanding of specific problems associated with living with ex-military personnel who frequently suffered war related physical injuries and ongoing psychological trauma. In addition, these support groups also offered expertise to help navigate legal ramifications.
concerning legislation applying to members of the military and their families. With these insights, such groups could offer practical as well as emotional advice and support.

Support for the women associated with the veteran’s community also extended to financial assistance that was available for widows under specified circumstances. The contribution to ageing well for women for who received this benefit was that they could described being able to access timely and quality medical care. As a result, they could exercise independence of choice, irrespective of their own personal financial resources and whether they had been able to maintain private medical fund cover. The experience of ageing was also improved when the financial assistance received from DVA contributed to paying for help to manage the home for longer than they may have been able to do alone. Transport assistance, also offered by DVA, was invaluable because it allowed women to remain mobile, able to be engaged outside their home, and that benefit was so often reported as being enriching and meaningful to their sense of interaction and contribution. It also meant women could arrange, with some independence, to go to appointments, without feeling they were placing added pressure on family or friends. These types of support were reported as additional benefits that helped to reduce stress in women’s lives.

The findings from the first study, where the experiences of early widows, over a 15-year period, allowed for comparison to their baseline data. The early findings had indicated that financial and structural issues were among the most important areas of stress for women as they aged without a spouse. Developing knowledge about the benefits of the support that widowed women acknowledge has been given to them by DVA has highlighted the significance of this finding. When women feel that the stressors of finances, transport and home maintenance are lifted by additional support, their physical, emotional and mental health may improve. Other research has also found that health benefits are present when financial burdens are eased (Sullivan & Fenelon, 2014). Evidence that was seen more frequently in findings included reports that widowed women consistently experienced more financial challenges, increased risk of living in poverty, accompanied by lower self-reported health scores, and increased reports of dealing with health issues, both physical and psychological (Digiacomo, Davidson, Byles, & Nolan, 2013; Digiacomo, Lewis, Phillips, Nolan, & Davidson, 2015; Trivedi et al., 2009).

The strong connection with the veteran’s community was evident in this generation, given the widespread effects on the women of both WWI (through their parent’s generation) and of
WWII directly on their own lives, their husbands and their wider networks. The extent of this involvement may not be repeated in subsequent generations, if worldwide conflict that includes Australian involvement is avoided. However younger people, who are following in the military services, will report their own unique experiences.

In addition to social support, resources of locus of control and resilience were strongly evident among widows as a means to help the process of transition and adjustment after the loss of a spouse. They often wrote that they were happy they could still exercise control over decisions regarding medical management and their choices of type and location of housing. Where women wrote about the degree of change in their life that was precipitated by the death of their spouse, they indicated that they used past experiences of overcoming challenges with a resilient spirit and attitude. They described also using the advice of peers and knowledge networks through their long-time GP, and/or through visits of allied health professionals such as physiotherapists and occupational therapists.

8.2.2.3 Bereavement (other than spousal) and other significant life events

As time passed, there was an increased likelihood of more stressful life events being reported which included the deaths of people within the women’s social networks, other than spousal loss. For both married and widowed women, there were many reports of the failing health, and subsequent deaths of family members (notably siblings), and long-time friends. Reports of these losses were usually accompanied by a comment reflecting the deep grief and trauma they had felt. Women wrote that ‘you never expect to outlive your children’ and where the loss of a young grandchild was reported, it was said to have brought grief that ‘almost too hard to fathom’. The current study did not have the capacity to identify if pre-disposing factors that heighten the response to trauma, such as elevated depression levels, were present prior to the experience of loss. Some research has suggested that these are factors that affect the grieving process and the subsequent outcomes after loss (Shuter, Beattie, & Edwards, 2014; Stroebe et al., 2006; Stroebe & Schut, 2001). The findings from this study was consistent with other research where many women had described being able to move on from varied losses, having accessed resources to help strengthen their responses, and had found the ability to invest in new opportunities for interest, engagement and inclusion (Byles, Feldman, & Dobson, 2007; Digiacomo, Lewis, Nolan, Phillips, & Davidson, 2013a; Digiacomo, Lewis, et al., 2013b).

Significant events reported by the women included more than deaths of family and friends. There were frequent accounts of injuries suffered from falls, about motor vehicle accidents,
and about incidents concerning their homes, for example flooding and fire damage. These stressors required the use of multiple resources. Access to the resource of sufficient finances to cover rehabilitation costs, and repairs to cars and homes was needed for adequate recovery, potential housing relocation and to ease emotional anxiety that accompanied such events. Family support was often accessed as a valuable resource at such times as well, for example with transport required to appointments, for temporary accommodation to be provided, and for support to be available when key decisions may have had to be made, when the woman herself was under other pressures. Women wrote that they felt so glad they could ‘lean on others’ for a period of time.

Following major events, women described gathering information to help guide and support the making of large decisions that were often required. For example, women may have needed to choose where to live if a former home had been damaged, or if their home was no longer best suited to their needs as their physical capacity had declined. The resource of a formal education, being a foundation of knowledge that could help inform decisions was rarely mentioned. References to ‘knowing’ and ‘having learnt’ were more veiled allusions, and the source(s) of knowledge that was utilised was often unclear. Women did appear to have gained awareness and understanding from informal learning opportunities that life had afforded them, more than specific avenues of formal learning. What was consistent for many women in this cohort was that they described that formal education opportunities had often been denied them when they were younger, and this is consistent with what had been gathered from government sources (ABS, 2012).

The women who described how they ‘chose’ specific resources, in an ordered and considered way, to combat significant challenges showed evidence in their findings of using cognitive ability and informed choices. Some women used expressions such as ‘I have been discussing my options with my daughter’, ‘we have talked about what decision I might choose’, ‘we have been looking at different houses together’ and ‘I have been so glad to have somewhere to stay while I re-gather my strength after the accident’. Knowing how to access and use resources involving educated and appropriate choices, which could have been strengthened through formal education, or learned through more informal means.

The findings from the comments, demonstrated that the women frequently retained the ability to handle finances and other decision making processes, for many years. If over time, women lost their acuity to manage their finances, or reported that the speed of change in
some other area was proving too much of a challenge for them to continue, they usually mentioned that a member of their family had stepped in to give assistance. This step may have been accompanied by mixed feelings, with some women indicating that they felt ‘relief’ while others felt ‘sad’ they had relinquished some degree of control. Findings in the current study concur with other reports concerning a wide range of responses women make to approaching making decisions that are associated with asking for help, altering control of situations and finding the balance between adequate support and preferred independence (Brody, 2010; Charles & Carstensen, 2010; Eshbaugh, 2008).

8.2.2.4 Ageing

Stressors related to ageing were mostly linked to gradual decline in mobility and independence. Not seen widely in other literature were three stressors that women in the current study mentioned. The first was crowded social scenes, which lead to a feeling of isolation due to difficulty with hearing. Poor balance and failing vision were the other two stressors that contributed to the lack of confidence in new or unfamiliar environments, where women were fearful of ‘uneven surfaces’, ‘absence of rails beside stairs’ or ‘seating that was too low’ for women to get up from sitting.

Widowed women wrote more comments about some of the challenges they experienced to their mobility. They reflected on the common resources they applied within the network of social support. Sometimes they had asked younger family members to accompany them to social events, medical appointments and to the shops. At times, some of the family return to live with them, and to provide mutual help for each other. It was reported that the more able bodied younger people (often said to be their sons) did heavier chores, while the women shared other jobs where possible, such as cooking, cleaning and doing lighter jobs around the home, (and property, if that was mentioned). If financial resources allowed it, some women may have managed by paying local workers to assist with jobs they could no longer do.

These findings concur with another study which used a cross sectional survey design, with American participants aged older than 65. It was found that women have greater limitation on mobility than men (Shumway-Cook, Ciol, Yorkston, Hoffman, & Chan, 2005). The disparity between men and women’s later life mobility appeared to be explained by the increased presence in women of disability related health conditions such as osteoporosis, osteoarthritis, depression and fractures, findings that this current study would agree were described at length in many women’s comments (Murtagh & Hubert, 2004).
Many married women wrote that it was difficult to keep looking after the spouse when they both had to deal with issues of ageing. At times, the situation was reversed, and the comments described that it was the wife who was more frail or immobile than the husband. One stressor for women, who were the main carers of their spouse, was that they felt a sense of loss as they had neither time nor energy left to pursue their own interests anymore. They also described their social networks as being much smaller. They wrote that the degree of emotional strain of caring for a spouse meant they had insufficient reserves of energy to invest in other relationships and interests, despite their wish to do so.

Whilst their spouse was alive, women wrote about the stress of disrupted sleep and the drain of repeating instructions and conversations. This area of tedious repetition of information was described when a spouse suffered with dementia. The women wrote a great deal about how much these stressors depleted their resources, both physical and emotional. Other studies added similar findings related to ‘carer-stress’. Carers often suffer the stressors of sleep deprivation, of inadequate care of their own health needs and mental symptoms such as grief and sadness over losses. The effects of these types of challenges seemed to accumulate over the period of decline of a spouse, and may even last for some years after the spouse has died (Carlsson & Nilsson, 2007; Currow et al., 2011; Haley et al., 2008). Supporting carers of people with cognitive decline, and specific diseases with dementia as a symptom, is a key recommendation for service providers. Appropriate levels of support may help carers to minimise the drain on their own resources, and as a result, they can better manage their own needs.

8.2.2.5 Health issues

In the literature, one of the most commonly reported stressors for older women was that of health (sections 2.4- 2.6). Spousal loss and bereavement has been noted to be a common occurrence among older Australian women (ABS, 2007; 2012). Studies have shown that, particularly in the first few years following the loss, mortality was likely to be increased and physical and mental health were seen to decline (Elwert & Christakis, 2008; Stroebe, Schut, & Stroebe, 2007; van den Berg, Lindeboom, & Portrait, 2011). In a four year longitudinal study of men and women who had been widowed, using secondary data from the Changing Lives of Older Couples study, it was found that depressive symptoms were higher at six months post spousal loss, and non-communicable diseases, such as cardiovascular disease were higher at the last follow up at four years (Holley & Mast, 2007).
Co-morbidities such as osteoarthritis, cardiovascular disease and respiratory conditions, to
name a few, are conditions that are rarely considered curable, and therefore will always
require ongoing management. It is the very nature of such problems to need long-term
strategies to minimise exacerbations and further decline. To manage these chronic stressors
requires the use of most of the resources proposed in the conceptual model, in varying
degrees, at differing time points. Women from all marital groups in the current study wrote
comments about being educated in the best practice of disease management, whether that
was conservative measures or surgeries or a combination of both. They used financial
resources, often requiring discipline to save the necessary funds. They also accessed social
resources to provide both emotional and instrumental support. Additionally, they attempted
to retain control over their choices regarding medications, the health professional they
consulted, the procedures they chose to have, or to decline, and the rehabilitation
programmes they followed, both formally in specific health related centres and also on an
ongoing basis at home.

Pre-existing risk factors may increase the likelihood of increased negative changes to health
following spousal loss (van den Berg et al., 2011). The Longitudinal Aging Study Amsterdam
(LASA), found that those couples who suffered spousal loss in the time frame of the study, lost
12% of residual life expectancy after the loss of their spouse. This is of key interest as it was
noted that the healthy years of the remaining lifetime were replaced by chronic illnesses (van
den Berg et al., 2011). Prior to the death of the spouse women reported a wide range of
emotions that frequently impacted on their health. These included stress, anxiety and even
suicidal thoughts. Again, in a life course perspective, all of these feelings and reactions were
subject to change over the course of the husband’s decline from onset of a condition, or
diagnosis of a disease, through to the time of his death (Riley & Fenton, 2007).

The mortality rates of the women in the oldest cohort of the ALSWH were considered to be
representative of the Australian population (Byles et al., 2010). Although deaths in this age
group are also common to the wider population other forms of attrition (for example, loss of
follow-up to frailty or cognitive decline), possible biases that could impact findings. However,
these possible biases were examined and were not found to affect the generalisability to
women living in Australia, born in the years 1921-26.

As also seen in other research (Digiacomo, Davidson, et al., 2013; Digiacomo, Lewis, et al.,
2013a; Williams, 2004) some women reported that as they transitioned to living alone, their
health behaviours changed, daily routines, including eating patterns altered with fewer reminders to make positive health choices alongside the possibility of less assistance being received at home. Studies conducted over time concurred, if levels of physical activity were not maintained, physical and mental health will deteriorate. The Aging in Manitoba study, which used interviews conducted at 2 yearly intervals (Menec, 2003), over a six year period, found that health and well-being was positively affected by involvement in both social and individual activities. Whereas social activities may yield greater physical health benefits, more solitary pursuits may improve psychological benefits and a greater sense of engagement with life. These findings concur with a review of the literature that had been published over 30 years, between 1977-2007 (Allender, Hutchinson, & Foster, 2008). This review noted that there is a lack of longitudinal research linking major life events with their effect on physical activity and health, and proposed that further work in the area was warranted. The key reason for the need of further understanding was that declining physical activity, if linked strongly to adverse life events such as spousal loss, was an important area to consider for better supported health promotion initiatives.

The women in the current study continued to function in roles they had identified as being suited to them, at times needing help and support of others, while also pursuing interests of their choice, where possible. Combined with the resource of resilience, women in all three marital groups continued to devote energy to, and to devise innovative ways to not give up when circumstances were difficult, and the levels of stress were perceived to be high. The use of words such as ‘it is harder to be active but I want to stay involved in my groups’ or ‘I want to keep caring for my husband even though I have had some health challenges myself’ and, ‘finding a way in tough times is not easy but it is what we women do’, added weight to the notion that women of this age group showed considerable strength and creative use of resources in order to age well. These findings were consistent with a report based on American women, aged 65-101 years, who participated in the Women’s Health and Aging Study. They identified that the components of frailty, co-morbidities and disabilities were complex to understand. The findings also suggested that further exploration of these components would assist in better management of health needs of the older population who present with multiple health challenges (Fried, Ferrucci, Darer, Williamson, & Anderson, 2004).

8.2.2.6 Social issues

In Australia, ageing is not usually experienced in total isolation, a finding that was well documented in this current study, and consistent with previous research (Feldman, Byles, &
Beaumont, 2000; Kendig et al., 2014). Social support and networks were reported to be a valued resource. However, for the women in this study, there was a significant stressor experienced when social networks diminished, a finding seen in other research as well (Digiacomo, Lewis, et al., 2013a; Digiacomo, Lewis, et al., 2013b). Whether it was associated with the loss of family and/or friends, it was very common for women to report that they were the ‘only ones left’ of their siblings, of a friendship network or within a neighbourhood that used to be filled with familiar faces, all of whom were people who had shared their life experiences. To manage this stressor, women wrote that they had relied on their resource of a positive disposition to attempt to see brighter options amidst the shadows cast by multiple losses. They used words such as being ‘grateful to have such wonderful memories’, ‘lucky to have so many years of shared friendship’ and ‘happy to have been blessed with so many good people around me for so long’. Security gained from networks that did remain was evident too in comments using words such as ‘I am glad there are still other people I can call when I am lonely’ and ‘glad I still have interests that keep me busy where I can help others’ and ‘I am glad I have so many good times I can still remember. I have been blessed with a lifetime of good friends’.

Women reported that caring for their spouse was taxing on their physical and emotional health. They had frequently not given sufficient attention to managing health conditions, and to add to this pressure, they found it hard to ask for help. This finding is important regarding the need to educate the response required from health professionals. Many different service providers and social networks can be involved in assisting with care for older people. There would be great benefit for differing service groups to communicate better with each other. Communication could raise early awareness of any potential concerns that may have arisen. If issues regarding health and safety for older women are reported, then appropriate interventions can be implemented. This matter lies within the area of ‘duty of care’ that rests on those who provide medical and social services, and who may be legally required to share information with others in the support network.

Numerous studies that were evaluated in a review conducted by van Der Houwen (2010), indicated that social support does not necessarily reduce the feelings of emotional loneliness, rather, it was found that good health and self-esteem were more likely to be associated with lower levels of emotional loneliness. Similar findings were reported by Drennan and colleagues (2008) who found other risks that were associated with heightened loneliness were: poorer health, rural dwelling, lower income and less contact with friends. More research in this area
was recommended as being important considering spousal loss can be accompanied by higher levels of loneliness for years following the husband’s death.

One area of contrast between the comments of the women in this current study and the results of other studies, that may challenge the efficacy of the conceptual model (Figure 4.12), was the role of different aspects within the concept of social resources for widowed women. The assumption that support for women, from people within their family and community networks, would be a source of comfort was questioned in earlier research (Morgan, 1989). However, findings since then have not been conclusive, largely because the perspective of perceived support relies on the subjective opinions of the people involved and this has led to high variance in the findings. It may be that perceived social support was more beneficial than received or actual support (Lee, 2013; Miller et al., 2004; Scott et al., 2007). It is proposed that actual support may actually threaten the identity, the ego or the self-efficacy of widowed women, particularly if there is any perceived negativity and pressure to conform to suggested behaviours or choices.

Although the comments of the women in the current study largely described that support from families and friends was an important resource, the findings also showed that the conceptual model cannot adequately represent the intent behind types of support offered. In addition, it was not always clear whether every type of support that was offered, and the timing of such, were actually considered helpful by the recipient. What can be said is that the women in the current study did not write that they felt that the support they received was inadequate, inappropriate, or worse, controlling or abusive.

A recent literature review of changes associated with bereavement suggests that daily social activities were frequently disrupted, especially in the early period of grief (Naef et al., 2013). This loss and disruption was associated with increased loneliness. During this time of adjustment, a widow had to re-establish herself as a single person, no longer part of a couple. Associated with the personal challenges related to the emotions of loss of a lifetime partner, a woman also had to re-negotiate roles and relationships within the family and friendship networks, and this had been found to evolve, with further processing, over time (Bennett, Stenhoff, Pattinson, & Woods, 2010; Cheek, 2010).

The support offered by friends may be perceived as being more beneficial than that offered by families because it may be better linked with women re-joining friendship networks, an aspect that is absent from family support (Scott et al., 2007). More qualitative studies, could add
depth to the understanding of the lived experiences of older widows. The taxing nature of the period of caring for an ageing spouse, and their subsequent death, is seen to contribute to the wide variety of responses that are possible within such a diverse group (Digiacomo, Lewis, et al., 2013b).

With this in mind, Bennett (2010) showed that 81% of older widows found issues of their identity to be important as they reconstructed their social support and position within their personal world and wider society. Finding the right amount of social support in new ways, once a spouse has died, was a challenge that can cause stress (Bennett, 2010). The perceived needs of support may fluctuate over time. Over-reliance on support early in the bereavement process, which may be withdrawn or lessened over time, by families and friends, may cause women to suffer the additional stress of feeling isolated and lonely (Stroebe et al., 2006).

8.2.2.7 Financial and structural issues

It has been reported that women who were widowed suffered financial loss, with reduction in income, following the death of their spouse (Burkhauser, Giles, Lillard, & Schwarze, 2005; Corden & Hirst, 2013; Digiacomo, Davidson, et al., 2013). The death of a spouse can be preceded by inadequate preparation and guidelines as to how finances may change at the point of spousal death. Therefore, in addition to managing the grief associated with such a significant life event (Holmes & Rahe, 1967), women may also have to adjust to the stress of a rapidly diminished income with uncertain means of how to recover from this position (Lee, 2003). Research into the psychological aspects of widowhood has found that the economic situation of widowed women is significantly worse than for men (Angel et al., 2007) and that the effects on women, regarding poverty and vulnerability are sadly neglected in reports, with women appearing at times to be “invisible” (Trivedi et al., 2009, p. 38).

Many women who were born in the 1920’s did not have significant levels of paid work, outside the home, throughout their marriage. This is particularly true for women who spent many years based at home, bearing the responsibility of being the primary care giver for children in their family. Their ability to manage on reduced income has been expressed as a concern (Donnelly & Hinterlong, 2010; Feldman et al., 2000). Their financial situation had been dependent on how well they had saved, especially in their husband’s post-retirement years, along with potential access to government-funded schemes such as superannuation funds or other investments. If the women were a member of a minority group pressure, on finances,
and on physical and emotional health, would most probably be even more evident (Angel et al., 2007).

In Australia, government-funded pensions are a key source of income for older people. The average total time on income support from the aged pension is 13.1 years, and the single rate of pension is only 60% of that for a couple (Australian Government Department of Social Services, 2008). The rapid decrease in income, especially if women are mostly dependent on the aged care pension, will occur within three months of the death of the spouse, despite the fact that living costs for a single person do not drop significantly. Australian women traditionally also have far less accumulated assets in schemes such as superannuation (ABS, 2012). In addition to reduced income, there may have been increased medical costs accumulated in the last two years of the life of the spouse who died. This problem may have caused a reduction in savings, and even resulted in an acquired debt that required repayment, and this may have added to the financial stressors (McGarry & Schoeni, 2005).

These factors are amongst those to be considered by further research to offer findings that can promote education, help and support to a vulnerable group within our society. This finding is linked with other findings from older non-institutionalised Americans who were studied biennially for 30 years. A large disparity was seen between older married people, aged over 70 years, compared to same aged widows. In this study the poverty rate for older people was said to be 10%, with that of widows being 17% (McGarry & Schoeni, 2005). Economic disadvantage experienced by older widowed women was also supported in other research. Findings have accentuated the importance of addressing, and reducing, this inequality between men and women (widowed women in particular), with respect to future planning within the aged care networks (Davidson, Dracup, Phillips, Padilla, & Daly, 2007; Digiacomo, Davidson, et al., 2013; Lee, 2003).

The stress associated with the difficulty of paying for items such as private health funds and costs for medical procedures and prescriptions were key barriers for both married and widowed women reporting that they were ageing well. Women who were ageing while remaining married made fewer references than did widowed women regarding financial concerns associated with managing their health. Married women made some comments about waiting periods for medical services for either one of the couple. They described this problem as being deleterious to their well-being as there was constant worry as to when the situation
could be resolved. Chronic, unrelieved pain was also a persistent stressor if either of the couple were waiting for needed medical procedures.

For widowed women, the first two to three years following spousal loss is known to be a period when they reported increased use of health services (Shah et al., 2012; Williams, 2004). The findings from this current study concur with that of other research (Fasoranti & Aruna, 2007; Trivedi et al., 2009). The current study also extends the understanding that the risk of poorer outcomes (specifically health related) is heightened due to economic deprivation. Outcomes of poorer QoL and lower mental health scores have also been linked to lower financial resources, along with lower physical function (Tajvar, Arab, & Montazeri, 2008). In addition, evidence of gender specific outcomes, which relate the fact of being a woman to the experience of greater poverty and financial strain, is an area that will benefit from preventive measures in the future (Vlachantoni, 2012).

With respect to structural issues that have been proposed as contributing to economic stress, both married and widowed women in the study referred mostly to stress in two areas. The first was regarding a decision to re-locate where they live, as was often needed, as significant events occurred over time. There was the emotional aspect to this stressor. Leaving long established networks was a big challenge for most women to consider. Moving home was more frequently reported by women who had lost their spouse. It was common for a married couple to remain living in their home together, at least up until the spouse died, possibly with added support at home from family and nursing services. The current study found that women used the resource of locus of control in retaining the decision making position where possible regarding the potential housing move. They preferred to be able to be involved, if not totally in control, of the process. However, they did report that making these decisions was taxing on their emotional resources and demanding of their cognitive skills. This finding highlights the importance of retaining resources in the emotional and cognitive health domains, for as long as possible. Women also showed the use of the resource of resilience in the way they adapted to the new housing location, indicating that they realised it would take time to ‘settle in’ and ‘feel at home’, and most of them felt that the outcome of their choice would ultimately be to their benefit.

The second structural issue that caused stress was related to transport, and although this was particularly relevant after spousal loss, it also applied to married women. The stress usually occurred when either one of the couple, or the widowed women could no longer drive, or had
never been licensed to drive. The problem regarding access to forms of transport other than their own car, centred on the expense or unavailability of options. The outcomes in this area were generally reported as being poor, as women expressed that they often could not afford vehicles for hire, such as taxis. Others wrote that a transport service was not offered at suitable times, if at all, in their area. Further research into how transport barriers could be resolved, or greater support could be offered, is recommended. Ways to help keeping older drivers on the road in a safe manner, by more education and support schemes is also suggested (Dickerson et al., 2007; Oxley & Whelan, 2008).

Feeling that they can be mobile and safe within the local community is fundamental to the ability of older women to lead dynamic and independent lives (WHO, 2007). Other research has also found that restricted access to the wider community, whether for pleasure and social interests, and/or for medical reasons, is linked with lower health status and quality of life (Groessl et al., 2007; Yeom, Fleury, & Keller, 2008). The findings of this study also concur with those reported in a review of mobility frameworks that emphasised the importance of maximising mobility as people age (Webber, Porter, & Menec, 2010).

Rural women were considered at most at risk of reporting unresolved stress, where transport issues were also linked to possible isolation. One third of Australia’s population live outside the major urban cities. Of these, 13% are aged over 65 years (ABS, 2006). There has been frequent identification of reduced fundamental services available to the rural community, which makes it difficult to age in place, and stay engaged in their communities.

Transport was an issue of concern, along with access to telecommunication services which can be inconsistent across many rural areas in Australia (Davis & Bartlett, 2008). While it was true that as a couple aged it was harder to stay independent on a property out of town, it was a more serious problem if a woman was widowed and living alone. Isolation and safety were barriers for women to remain on farming properties and even in regional towns. Concerns about safety and isolation were linked to precipitating a decision for older widows to move to a larger city. Rural dwelling women in this current study mentioned the expense involved in keeping in touch by telephone with families when they were all separated by distance. They were also concerned about the regular breakdowns in technical services and mentioned that many areas received inadequate telecommunication coverage, despite the high costs they paid for telephone and Internet services. This finding extended the knowledge of the personal experiences of older women who usually cannot find a person who will pay heed to their
concerns, given that most individuals, let alone older women, feel it is difficult to have a voice that can be heard when trying to get assistance and support within larger corporations, for example, telecommunication companies.

Considering that social support was described as an important resource for women, they often had to consider moving closer to family in order to facilitate more frequent and perhaps more tangible interactions with each other. Alternatively, women creatively found other ways to access social support. They described utilising other resources, such as community transport and home help services, so they could remain in their home of choice, in a familiar area, participating in managing their homes, (and even larger rural properties at times) for as long as they could. Use of such resources contributed to women describing that they were ageing better, with enjoyment of friends and family, and an increased sense of still being valued and engaged.

8.3 Eustress

The concept of eustress was introduced in Chapter 3 (section 3.2.1.1). It was acknowledged that although stress is usually described as having a negative connotation, with links to ‘harm’ and ‘distress’, some aspect of stressors can actually be considered positive, and can have uplifting benefits to health and well-being (Selye, 1974). To deepen understanding of this field of research, Selye (1974) coined the term eustress, a beneficial form of stress, the term being derived from the Greek prefix ‘eu’ meaning good. Eustress can be said to occur following an occurrence of psychological, physical and/or biochemical challenge where the force(s) experienced cause a reaction of motivation and the subsequent results are perceived as being beneficial. One common example of eustress, in the physical realm, could be the effects felt by people when they put their muscles under load in forms of exercise, and the result is seen as increased strength and capacity for that person.

For this current study the effects of stressors have been largely portrayed as having negative effects. However, it is important to acknowledge the ‘upside’ of the effects of some stressful events. Women in the current study contributed rich comments about key life events, such as family weddings and births of grandchildren, as being times of great joy and celebration. Associated with the coming together of family and friends to participate in significant moments, women described the pride they felt in the descendants who were following behind. They felt included, valued and grateful as they wrote about being ‘surrounded by wonderful
grandsons’, feeling overwhelmed at how ‘beautiful their granddaughter was’ at her wedding, and the ‘pleasure of holding little babies’ born to subsequent generations.

In addition to considering the aspects of eustress (i.e. positive stress), there is also an awareness that although stressors, for example care-giving, can encompass difficult experiences, there can be a positive side to the experience as well. The findings of this current study concur with other research, where the people offering care receive a sense of satisfaction, and feel a strengthening in their identity as a result of helping a loved one (Gray et al., 2016). People usually feel better by expressing kindness and care to others, and it has also been seen that sustained positive emotions themselves reduce the unhealthy effects of stress and improves physiological systems, including heart rhythms (McCraty & Tomasino, 2014).

8.4 Evaluating the salutogenesic model against ageing well

The salutogenic model has a central concept of SOC, described as the presence of three concepts: comprehensibility, manageability and meaningfulness. Discussion about these three concepts is presented in the next section with evidence being sought of their presence in the free-text comments. Following this discussion, a review of the study will assess if the conceptual model was competent in the way it framed the relationship between the stressors, the use of resources to manage stress, and how women then described their experiences of ageing. With the passing of time, future changes in society and medicine may alter the way the concepts of SOC may be expressed and ongoing research into younger cohorts may be able to reflect these changes.

8.4.1 Comprehensibility

There was strong evidence that women used the concept of comprehensibility as they considered what resources would be effective to manage the stressors that confronted them. The definition of comprehensibility that uses the expression that ‘life’s events are perceived to have structure and predictability’ is not always easy to reconcile with the fact that unexpected events do happen, and that the routine associated with structure can be disrupted. The dynamic approach of the salutogenic model offers the possibility that the wise, practised and reasoned use of available and appropriate resources can herald and support the re-building of structure. In addition, it can bring some degree of predictability and order back into a situation. This restoration process can be considered to be a part of ageing well.
For example, women in the current study reported how they used the resource of social support to help bring a sense of familiarity and strength to a period when they felt dislocated, deeply upset and/or weakened in physical and emotional domains. This action showed that they had first had an understanding that help was required outside of their own efforts, which then led to evidence of managing the stressors, an area that will be expanded on further in this chapter. The findings from the comments that women had written over 15 years revealed how they had repeatedly demonstrated this pattern, whereby the disruption of stressors first had to be recognised before the use of suitable resources, could help manage, and if possible resolve the problems.

Key resources that support this concept of comprehensibility proposed by Antonovsky (1979) included knowledge, self-esteem, traditions, and view of life along with commitment and cultural capital. These resources can be applied in a flexible way, that are not linked to mastering strategies and applying prescriptive coping methods (Antonovsky, 1993). The cognitive component is essential in this concept as there is a need for people to be able to recognise what is happening in their situation. A requirement to problem solve is advantageous to promoting better outcomes when confronted with an uncertain situation. However, the outcomes will proceed more effectively, and with logical progression, if the problem is first appraised and a plan formulated (Lindstrom & Eriksson, 2006).

The presence of comprehensibility improved the likelihood of ageing well where women reported ‘feeling better’ about a situation once they ‘had an idea of what options were available’, and a recognition that the available options were likely to be helpful to restore normal order and/or function. One example of this in the data was the way the concept of comprehensibility strengthened the manner in which women described their recovery from injuries and accidents. Undoubtedly a disruption to normal function had occurred, yet women who aged well described the situation with words such as ‘something that could be dealt with’, and they expressed hope that the situation ‘would return to something more like normal’. Women wrote that they were ‘thinking about what were the best decision for the future’, how they applied ‘common sense’ and ‘reason’ to planning a way forward.

Other research has supported these findings whereby if women lacked the resource of comprehensibility, particularly if it was due to cognitive decline, there was evidence seen that this made the experience of ageing more challenging (Bherer, Erickson, & Liu-Ambrose, 2013; Gajewski & Falkenstein, 2016; Williams & Kemper, 2010). Where there was a lack of
understanding and/or the ability to bring about structure amidst difficulties women found it hard to find positive aspects to report. This could also have ongoing effects on their ability to find manageability and meaning.

8.4.2 Manageability

The behavioural aspect of SOC is manageability, and refers to the use of resources that can be accessed either from within or through access to other external sources (Lindstrom & Eriksson, 2005). There are many resources that contribute to manageability, for example locus of control, resilience and a sense of identity. As time passed, and physical and cognitive declines became more likely, it was harder for some women to feel they could manage to retain a sense of control, both with respect to events that happen to them, and their reactions to these events.

The stressors of shrinking social networks, combined with added physical challenges, could contribute to women feeling it was difficult to maintain energy and skills to keep in control in many areas, with no spousal support if widowed. Other research has examined the effects of control on aspects of health and ageing. Grotz, Hapke, Lampert, and Baumeister (2011) found that being able to access the resource of control with respect to health related decisions was associated with better health behaviour. A study of older adults from Russia and Sweden used a cross sectional comparison method that showed that where levels of perceived control were higher (in this study it was found in Sweden, not Russia), this was associated with 20% higher self-rated health (Lundberg, Bobak, Malyutina, Kristenson, & Pikhart, 2007). One important aspect of salutogenic thinking is that it promotes the power of the individual to help retain a locus of control within their own situation, instead of having to relinquish it to others, who were formerly considered more powerful in the interactive process (Lindstrom & Eriksson, 2006).

Women described that they had to manage caring for a spouse, for the length of time that he lived, managing the aftermath of his death, if that occurred, and managing their own health and their homes. Other research has added to this concept of what resources women may need to use to bring manageability to their situation, for example accessing both instrumental and emotional support (Digiaco, Davidson, et al., 2013; Digiaco, Lewis, et al., 2013b). The findings from the current study concurred that women used a wide range of resources to increase the sense that their situation could be managed. The appearance and frequency of support resources varied over time, and depended on other concurrent events such as health
challenges and changes in social situation. It is suggested that people involved with offering help and care towards older women should be aware that their needs will fluctuate, and to be cognisant that differing types and amounts of assistance will be required over time. Women in younger cohorts have already been seen to not report the same predominance of the long marital relationships that was common to women born in this cohort. In addition, among younger cohorts there are more divorced women, and women who do not choose traditional marriage relationships. These factors will most likely influence future findings.

It was noted in the current findings that some women actually reported that one of their resources for managing also came from their spouse, as it was not always the case that the woman cared for the husband. At times the support was offered for a short while recovering from some set-back in health, and at times it appeared that the support was required for a longer period. Other research has also shown that men are perhaps less avoidant of hands-on care than had previously been reported (Russell, 2007). Although many men may feel less equipped to provide care due to socio-cultural stereotyping, it can be more difficult for them to offer care in the long term as in western cultures, men are typically older than their spouse. This can lead to them dealing with issues of their own age-related frailty which impose a barrier on their ability to function as a carer (McCann, Donnelly, & O’Reilly, 2012)

Some types of GRR’s that have been mentioned that contribute to manageability include social and financial resources, positive disposition and resilience. The current study reported findings where the uses of resources were tailored more specifically to meet the individual’s needs. For example, quite a few women reported that they had ongoing responsibility for adult children who had some form of ‘disability’. They wrote about their ‘concern’ about ‘how to manage this problem in the long term’. They used expressions such as ‘I can manage him at home but what will happen to him when I am gone?’ The realisation that the child would most probably outlive them, required a plan to be devised in order for that individual situation to be managed. This again showed the link between first being cognitively aware of the stressor, processing through potential options that could have good outcomes, and then putting a plan in place. This example sheds light on a different aspect of ageing well, in that it does not concern the health and well-being of the actual participant. However, by association the situation about a close family member would most likely have impacted the emotional health of the woman over time, if a solution was not found.
For women who remained married there was a shared sense of ‘managing’ their stressors. Unless the spouse was very frail, and possibly in an aged care facility, there were references to how they ‘got along together sharing tasks’, for example, describing how if one could not manage a situation, then the other did their best to ‘fill the gap’. Women wrote how they discussed necessary future ‘financial planning requirements’ together, which alleviated some of the burden by sharing responsibility. As time passed, for some women, disagreement with their husband about what future plans were needed for late life, caused additional stress when they could not agree on what the management plan may have been. The use of expressions such as ‘he is stubborn and getting worse’, ‘he still thinks he is the boss’ and ‘he is used to getting his own way’ highlighted the problem. The ability to negotiate a suitable way forward to manage the issue impacted on whether the outcome could have been contributed to an overall sense of satisfaction that, as a couple, they were ageing well or not.

A related concept to manageability is that of self-efficacy, defined by Bandura (1994) as being the person’s beliefs to produce levels of performance that can exert influence over events that effect their lives. Linked with self-efficacy is the concept of locus of control, whereby people can use different strategies to exercise some control over their own fate (Lefcourt, 2014). The commonalities of these concepts centre on the importance of managing resources. It is the effective management of resources that help to create and support health and well-being, and how people can more than just survive, but flourish, even with the presence of stressors (Eriksson & Lindstrom, 2010). Despite similarities in content with other related terms, the concept of SOC remains as having the broadest evidence base. As such it is able to facilitate health promotion, within a salutogenic framework, that can be implemented at the individual and societal level (Lezwijn et al., 2011).

8.4.3 Meaningfulness

It has been said that the first two concepts, comprehensibility and manageability, inter-relate and have a dependency on each other to be able to contribute with most strength. This can be equally said equally about meaningfulness. Each one of the concepts was not seen alone in the findings although at any one point in time one may have been more obvious than another.

Without understanding what may contribute to a meaningful life, it would be very difficult for women to describe what aspects of their lives were subjectively satisfying to themselves, and that could be assessed by an external evaluating person process, as ageing well. The data revealed that women conveyed strong opinions about the high value they placed on people
and events in their lives. The meaningfulness they derived from their interactions with families and communities was clearly and frequently expressed.

Antonovsky (1987) had proposed that meaningfulness was the most significant of the three concepts that comprise SOC. He thought that meaningfulness would be the key driver to bringing reasoned explanation and understanding to the events that were occurring in a person’s world, and to finding accessible resources. However, this has not been found to universally be the case (Bergman, Malm, Ljungquist, Bertero, & Karlsson, 2012; Saravia, 2014). It does appear that in some circumstances the need for comprehensibility becomes of greater importance, particularly if people are gathering information as to how best to manage a critical health issue. Evidence was not found in the current study, or other literature, that the three concepts within SOC function independently of each other. The comments at any one survey for each woman in this study tended to emphasise different concepts within SOC, according to the required or chosen response to life circumstances.

When women wrote in the comments how much they valued their family, their homes, their relative state of health, it was often accompanied by expressions that showed they had positive outlook on life. They managed to focus on what they did have and not what was absent. It was not that they did not recognise the absence of key people in their life, particularly the spouse if he had died. They may have also missed their old homes, their former friends who had either died or moved away, and their youthful levels of activity and energy. However, they often reflected with words such as ‘I feel I am the luckiest person in the world’ and ‘I could not be more grateful’. These women also usually described a good sense of subjective well-being, a high quality of life and high levels of social engagement. The findings from this current study supported that these resources were frequently bound together within comments, and were also reflected consistently over time. It would seem that the women who expressed that they were lucky and fortunate at 65, when first surveyed, still reported the same opinions until later surveys, when they were in their late 80’s. On multiple occasions, various women expressed the optimism that they were ageing so well they ‘may possibly live to be 100’.

The resource of positive disposition used by many older women concerned a positive attitude to life as it currently was seen, and also how it may have appeared over time, as the ageing process unfolded further (Levy, Slade, Murphy, & Gill, 2012). It was a key resource to understand as a positive disposition seemed to add a greater sense of meaning and well-being.
to life, and to increase the general feeling of happiness. It has also been linked in findings from other research to longer life, lower blood pressures and better health status (Charles & Carstensen, 2010; Wiesmann & Hannich, 2014).

The concept of spirituality was also seen to contribute to the concept of meaningfulness. A general awareness of a spiritual dimension in life was frequently seen in the expressions of women who had a positive disposition, and it seemed to be linked to uplifting the emotions, particularly in harder times. A Greek study, by Anyfantakis and colleagues (2015) found that there was a strong relationship between high SOC, high religious involvement and a low score on depression (Anyfantakis et al., 2015).

Women who describe a faith more specifically than just having a positive view on life, often included examples of how their faith was expressed in daily life. They frequently included descriptions of how they were involved in mainstream church services and organisations. The experience of faith, and spiritual beliefs, was reported by both married and widowed women to add a sense of peace, purpose and strength to their experience of ageing, with the use of terms such as 'I don’t know what I would do without my faith' and it is 'such a comfort to have my faith... perhaps even more as I get older'. Some women added that if the faith was shared by their children, that too brought pleasure if they were able to enjoy shared opportunities that church communities offered for worship and service.

As the culture in Australia has evolved, there is already a greater representation of faiths other than those based on Christian values, such as Buddhism and Islam. For many Australians, there is also less adherence to formal structures of religion that were such a corner stone of the communities that the women in this study have experienced and described. The former dominance of Australians being involved in orthodox Christian churches and organisations is already less prevalent, and future expressions of faith, and the support offered by these communities will most likely be seen to alter the way the resource of faith and spirituality could be expressed over coming years (Bouma, Cahill, & Zwartz, 2011). Ongoing research may need to develop and adjust models to adequately express how the resource of spirituality may be utilised for women as they age.

The resource of social engagement was a key contributor to meaning in life as women aged, and there could be greater potential for less opportunities for engagement. Women needed to maintain their efforts to stay involved or they could gradually become more isolated, and could feel a reduced sense of purpose for their lives. In the light of other research, social
engagement for this study has been considered to be an activity that was conducted outside the home, on some form of regular basis, and without financial remuneration (Charles & Carstensen, 2010; Morrow-Howell, 2010). A positive affect from the resource of interacting with others and volunteering outside the home has been seen in the way it has helped promote psychological well-being and self-reported health (Anderson et al., 2014; Tang, Choi, & Morrow-Howell, 2010). It does appear that to best benefit from volunteering and social engagement people need to have a positive view of others (Goetz, Keltner, & Simon-Thomas, 2010), and this resource was often found in people who found meaning and purpose in the activities they chose and from the people with whom they associated.

Social engagement is a wider concept that merely having social interaction with family members, such as care-giving and informal opportunities. Understanding more about the resource of social engagement is critical because it has already been seen to have potential benefits to reduce functional decline and onset of dementia. The findings of the very long running Harvard Study of Adult Development and the research of Vaillant (2002) concurs with other longitudinal studies such as the Health and Retirement Study (HRS) and The Longitudinal Study on Ageing (Morrow-Howell, 2010) that, when seen over time, volunteering attracts people with a higher level of well-being, who in turn experience positive effects because of their volunteering (Hao, 2008). Social participation is another concept that is related to, yet is wider than just social networks, in that its accepted inclusion criteria is inclusive of both formal and informal interactions (Utz, Carr, Nesse, & Wortman, 2002).

Despite the different nuances and emphases in meanings of these related concepts of social resources, it has been seen that maintaining continuity in participating with friends, family and the wider community contributed to how women describe meaningfulness in their lives. As was mentioned in the discussion regarding the resource of faith and spirituality, the changes in the structure of what was considered the ‘normal nuclear’ family in Australia will also need to be addressed in future research models to reflect changes in society, with for example, more single parent families and same-sex relationships being seen (Australian Institute of Family Studies, 2016).

8.5 Revisiting the Conceptual Model

In relation to the reported findings of the current study, the data were found to be overall mostly consistent with the conceptual model reflecting well the process of life, specifically
related to ageing. Stressors will happen, resources are available, to varying degrees, and good outcomes are possible, given the ability to recognise that this is a time related process that requires cognitive skills, emotional and physical resilience and sufficient purpose to make the effort be considered worthwhile. Although the thematic analysis was based on the concepts indicated in the model, at all times there was an awareness that if themes were seen that were not accommodated within the proposed model they should be documented and given due consideration. However, although there were differences in the strength and timing of some themes being seen, variations between marital groups and over time, there were no significant omissions seen in the data that the conceptual model did accommodate.

A further issue in considering the model is how much it may have influenced the analysis and interpretation of the results. The main concepts of the model were broad in their scope and this was intentional at the outset of the study. As was outlined in section 4.12 the model was developed deductively, largely from literature and professional experience, and inductively, primarily from the first readings of data from the large group of women in the first study. When the later analyses were conducted, the concepts that were proposed were the result of lengthy efforts to understand the literature combined with the descriptions that had already richly informed the understanding of the women’s experiences.

However, it remains possible that if a different theoretical model had been applied there would be have been a different emphasis given to the findings in the data, and in the subsequent interpretation and analyses. For example, if a pathogenic model had been applied, the emphasis would have been on disease and disability. While these states were noted in the data, they were not given primacy. Consistent with salutogenic theory, the analysis probed for women’s descriptions of stress, how they reacted to the tension that ensued and what resources they accessed to enable better outcomes. The depth of analysis and subsequent discussion of each concept, for each of the three marital groups provided the opportunity to evaluate changes that may have been seen within each of the main concepts of the Conceptual Model. These changes are discussed in the following part of this section.

There were no significant new themes that emerged from the data that were so significantly different that they could not be accommodated within the larger concepts that formed the structure of the conceptual model. In keeping with the TA method that was described as being used for this study (section 4.5 and 4.8.5.2), there were repeated patterns of meaning, recurring themes and similarity within results. As a result, the researcher was satisfied to
conclude that the model offered enough structure, yet sufficient flexibility to accommodate different nuances of expressions within the women’s comments. The model allowed for comments to be analysed, and the findings presented, with evidence of the presence or absence of potential stressors and stress, of the presence of absence of contributory concepts to SOC and to the experience of ageing well, or not, with consideration all many of the subtle nuances in between.

One strength of the model was its ability to indicate the relationship between the three main concepts, (which are stressors, resources and SOC), and ageing well. One aim of the thesis was to allow the many voices of women, with different experiences, yet a commonality within expressions, to be expressed, listened to with intent, and to be validated within the wider community. The model has provided a framework to guide the large amount of data that was available for analysis, and to try to bring a reasoned and honest report back to the readers that would adequately reflect the content of the women’s comments.

It is acknowledged again that with respect to the understanding of stressors and the reaction of stress, there was an implication within the model that stressors and stress were largely negative. Section 8.3 addressed the aspect of ‘eustress’, whereby it is noted that not all stress has negative effects. With opportunity to broaden the understanding of stress, this discussion chapter has drawn attention to the fact that some stressors can be positive in nature. In addition, stressors can have multi-dimensional aspects in that although a stressor can at first be interpreted as negative, (for example, illness of spouse) some of the associated reactions (for example, kindness and care) can produce positive and health promoting reactions. One other consideration about the positive aspects of stressors is that if the stress is not too prolonged, and/or if there is a supply of resource that can withstand the amount of accessibility that is required, then irrespective of the exact nature of the stressors, they will not necessarily have a negative and ‘stressful reaction’ within the person(s) concerned.

8.5.1 Social support

It was possible that with such a wide variety of experiences that women contributed, not every aspect of the concepts contained in the model may have been adequately conveyed. For example, some areas that surrounded the understanding of the resource of social support could not be entirely explained. The main reason was that, as the research used secondary analysis of data, no further information could be elicited from others within the women’s networks to give added external insight and assessment regarding the women’s needs and
preferences. The findings from this current study would contend that the model represented what the women wrote, in that they perceived social support as a firm and valued resource. However, not all literature supported the model without some qualification of the term social support (Miller et al., 2004). This could relate to who was offering the support, what form it took and if there is any possible underlying conflict of interest. Some people who offered forms of social support and intervention could possibly have had a desire for personal gain or influence. It is recommended that qualitative studies should be conducted in the future that may allow widowed women to give further voice to their opinions about other aspects of social support that analysis of this data provided.

8.5.2 Financial resources

The conceptual model proposed that financial resources would be a contributing concept to a woman’s SOC by way of offering stability to the economic situation and by offering them an ability and flexibility when making choices in financial matters, and not being burdened by debts. It was true that women wrote about the benefits they felt from the security of having essential needs met, for example, having their medical treatments paid for by adequate health cover (private health funds preferred) and being able to make choices regarding comfortable and suitably located housing. However, the results did not show that the accumulation of objects that are often assessed as contributing to as assessment of economic status and wealth, for example, multiple properties, boats, later model cars, high-end fashion and jewellery, were important to the women in the current study.

8.5.3 Knowledge

With respect to the concept of knowledge, it was acknowledged that formal education is a valid and valuable contributor to the resource. The role of education is said to positively affect quality of life as people age, and there is an awareness that there is still gender inequality in the opportunities for education, and subsequent employment opportunities, for older people, particularly women (Radovic-Markovic, 2013). The women in the current study were affected by the inequality in educational opportunity far more than is already being seen in following generations (Pruchno, 2012). For the women in this current study, formal education was not seen in these findings to be available to any extent as a valid source of strength of the SOC. However, studies on subsequent generations may see the appearance of the role of formal education as a stronger resource, contributing to the overall concept of knowledge for women. Younger women will likely have more opportunities than the participants in the current study.
to pursue higher education and a career path outside other roles within home and family. The term ‘knowledge’ taken for this study has accommodated that women write about acquiring skills and information about subjects that have been learnt outside formal educational opportunities such as those offered in schools, colleges and universities. It is noted that there is ongoing need to emphasise the importance of equality of educational opportunity for women. It is recommended that developing educational objectives earlier for women will help them to age well, as they have an opportunity to have better understanding concerning their rights, their position and their potential power base as a significant part of their community that honours and values their contributions (Turcotte, 2011).

8.5.4 Future iterations of the conceptual model

Over time, future iterations of this conceptual model will need to be re-visited and re-evaluated. The expressions and utilisation of the concepts that it represented may change in keeping with developments in society, and in the way ongoing medical developments will impact the way ageing can be experienced. Women in this cohort were largely occupied at home for many years, with primary responsibility for raising a family, within a family unit that modelled the accepted structures of their time, among a largely Caucasian social fabric. They did not usually pursue advanced formal education and were largely adherent to Christian-based ethics. In general, they were less likely to travel widely, and more likely to live in one area for long periods, particularly as their families grew up. All of these factors will influence the way the concepts within the model may alter in the future, and therefore interactions with each other will also vary as further research is conducted.

8.6 Evaluating the effect of ‘time’

One of the key reasons for analysing longitudinal data was that it was considered that the process of ageing could be better understood if the concept of time was built into the study design. The very nature of ageing is a time-related process. In addition, the researcher’s professional experience had seen that women described their situation very differently according to the key events that occurred over time.

The first study that was completed, took the opportunity to compare the findings from earlier cross-sectional research, with data available from five more surveys, over 15 years (Feldman et al., 2000). The key difference in findings was not that the main issues that women reported in their lives changed. Rather, by introducing the element of time into the design of the study,
the ebb and flow in the intensity and frequency of areas of concern could be observed. This finding aligned with the need for people who are involved with older women to continue to pay attention over time to what women are actually saying, regarding how they feel their needs can be best met and how assistance can be offered appropriately.

The findings strengthen the case that prescriptive criteria, attributed at one point of time, are of limited benefit in being able to assess how women describe their ageing process. Depending on when the assessment is made of how well a woman is said to be doing, the findings may alter, so due respect needs to be paid as to what other event(s) may need to be considered. Event(s) may be occurring concurrent to the time of assessment, or there may be lingering after effects of a past experience.

In both the first and second studies within this thesis, findings were reviewed with attention being paid to concepts that may have increased or decreased over time. In addition, the analysis included an awareness of the concepts that appeared to be constant, or those that were cumulative, none of which can be observed from evaluations, of any kind, at one point in time (Saldana, 2003). Social support was a concept that was seen to generally increase over time, yet also changed in the way it was seen according to circumstances. After key losses were described (particularly spousal loss), women often mentioned that the emotional support from family and friends was invaluable. As time passed, more instrumental support may have been mentioned, where women may have needed extra assistance, for example around their homes to manage if physical abilities had declined, or if the strength of a younger and/or male person was required.

Families provided a central resource for support for women. If women mentioned that they had a dynamic and involved family unit early in the surveys, reports about ongoing support tended to continue and cumulate. For women who reported in early surveys that they had keen interests outside the home, whether it was helping care for others, volunteering in community organisations or hobby groups, the references to this part of their life remained strong. Over time, care for a spouse, or their own decline, at times saw the forced reduction, or even cessation, of their activities. This finding strengthens the need for older women to be encouraged and educated in the related benefits to their health and well-being of maintaining interests in a social environment as much as possible. Also, it promotes the need for awareness of extra support to be offered during times of spousal care, particularly if the care period is protracted. Having additional support can allow a woman to retain interests and
activities for longer than if little or no additional external support was offered. It also adds to the knowledge that there is a mutual benefit experienced between maintaining good physical and mental health and social engagement and activity outside of the home.

The concepts that tended to decrease with time were linked to combinations of declining physical and emotional health and lack of opportunities to interact with people and interests outside the home. Over time there were fewer comments about being able to help others, the networks that were described were smaller and the variety of outside interests waned for some women. The better health that was reported, and the greater levels of activity maintained seemed to help negate the shrinking of social interactions and engagement, and as such forms a strong recommendation for ongoing efforts regarding health education and promotion.

Overall SOC is reported in the literature as a fairly stable orientation to life, allowing that some changes can occur depending on individual experiences of life. The findings from this current study concur that where women report high levels of comprehensibility, manageability and meaningfulness in comments at early surveys, they tend to continue to report ongoing high levels of these concepts over time. As has been recommended in other literature, more work needs to be done to ascertain how SOC is developed over time, how stable it is, and what can be done to assist people to both develop and maintain SOC over their life course. Some recent research has examined SOC over time, and it has been seen to contribute in many areas of life satisfaction and to the feeling of having made the most of opportunities. In addition, a strong SOC allows people to both access and utilise resources in an appropriate way for the best possible outcomes (Helvik, Engedal, & Selbæk, 2014; Langeland et al., 2013; Tartas, Walkiewicz, Budzinski, Majkowicz, & Wojcikiewicz, 2014).

8.7 Evaluating the choice of sample groups with different marital status

A key decision in designing this study was the inclusion of three different sample groups of older women, with the different marital groups being early widows, later life widows and women who remained married. This decision was validated in the findings considering there were very different experiences described over time, particularly regarding the effect of the significant event of spousal loss.
When women were widowed younger there were more frequent comments regarding immense shock at the loss, although this was countered over time with the younger widowed women making the adjustment to a new life with more enthusiasm and energy. First, it appeared that they had less challenges regarding their own health issues, at this younger age. They made frequent references to driving and, with this mobility, they could access friends, and to go to places of interest. They were able to help their own families in active ways with matters such as baby-sitting and offers to assist in their families’ homes. As was mentioned, many of the younger widows had associations with veterans’ organisations. In addition to social support and friendship with women who had similarities in past experiences with ex-servicemen, the financial support offered by DVA added a sense of security in terms of paying for key items such as health cover and transport.

The later widows described a different situation. They were older when they suffered their spousal loss, and associated with this, they often commented on the length of time that their marriage had lasted. Many of this generation described being married for 50, or even as many as 70 years. The degree of upheaval, socially and emotionally, surrounding this loss was difficult for the women to capture. While possibly caring for a spouse for more years than the younger widows, and in that process, suffering reduction in opportunities for social interaction and interest groups, the older widows found it harder to renew a life outside of their homes. This was often compounded by their own health challenges and also by difficulty in accessing transport. Fewer of these women wrote that they were still driving, and even fewer reported taking friends to places, in the way younger widows had described. It was true that some wrote that it was a relief to have the burden of care eased. However, it appeared for other women, that the period of care giving had so depleted their emotional and physical reserves that it took more time and effort than they could find to try to renew a life external to home and family.

The women who remained married for the length of time they remained in the study described more joint activities and less pursuit of individual interests. The women often wrote that as a couple they drove to visit family, and at times they included reference to also visiting long term friends. They appeared to describe activities outside of the home more in their earlier surveys, and these reports tended to diminish over time. The length of time of the marriage partnership was often mentioned, and this effect was hard to measure and evaluate from an outsider perspective. The depth of commitment to their marriage and the value they placed on companionship was a key point that was found as a result of the findings from the
married women. In this way the marriage relationship was for many a resource that strengthened their ability to manage the stressors associated with ageing. The older married women made more references in the later surveys to either one of the couple needing increased care, possibly requiring placement in an aged care facility. This brought about comments as to how hard it was to see a spouse decline, whether that was primarily physical or cognitive. There was the area of guilt that arose for comment as well, when women described how hard it was for them to no longer be able to care for the husband, and/or to no longer be able to live in the same accommodation. Again it was seen that there was a juxtaposition of the enjoyment of a long marriage against the pain of losses after such a long period of relationship.

By utilising data analysis from the different marital status groups, the findings were enriched in the greater discovery of the key areas of challenge experienced by the three groups. In the sample groups chosen, there was a rich variety of experiences described that reflected in detail and breadth the many ways that changes in marital status can affect how women age. However, although the differences that were outlined above were clearly described, there was the ongoing commonality of experiences as well. The pattern of the occurrence of stressors, utilising resources and the description of the experiences that followed was repeated, with difference in the exact nature and timing of stressors, and the varying needs regarding appropriate use of resources.

8.8 Evaluating the choice of random sampling in Study 2 and 3

The background to the decision to analyse a smaller sample for the second study than was completed for the first study was discussed earlier (section 4.8.1). The initial decision to select a random sample of 50 women for each group in the second study was made against the background of earlier analyses of a larger sample (N=162) (section 4.8.2). This decision, taken at the outset of Study 2, allowed for further sampling if it was felt that the data had provided a lack of breadth of comment, with insufficient detail, or where unexpected information of interest needs to be further explored (section 4.8.3 and 4.8.4). On reflection after the analysis was conducted, the sample size was considered to have been sufficient to produce a rich source of data that appeared to adequately reflect the opinions of the women. There was a diversity of response within the sample of 50 women in both of the later widowed samples, and the married women, that allowed for a variety of experiences to be explored. This
concurred with the suggestion by Patton (2002) that common patterns that emerge from the variations in data add an element of interest and value to capturing and understanding the experiences that are being described.

There were common issues reported by the women, which contributed to a pattern of meanings, and relationships between the concepts. In addition, there were experiences that were less frequently reported that illustrated further about the heterogeneity of ageing as well. The comments about the more unusual events in women’s lives were considered as thoroughly for inclusion as those that concerned a more repeated subject. The sample size of 50 women from each of the three marital groups provided sufficient breadth and depth in the opinion of the researcher and the team that provided support to the study.

Again, it is worthy of note that the larger sample size that was used in the first study (N=162) had allowed the researcher to evaluate early in the research process what areas were covered in comments contributed by a much larger group of women. As the data from the smaller size (N=50 for the subsequent groups) was analysed the researcher felt confident that comments from 50 women/marital group was revealing a depth and variety of information that equalled what had been seen in the larger group. No significant new themes were being identified by the time all the comments from the 50 women in each group were read, coded and analysed. It is also noted, as was addressed in earlier chapters (sections 1.3 and 4.6), that the data that was available in the comments from the cohort being studied, resonated deeply with the experiences from 40 years of clinical work that the researcher has already acknowledged. In keeping with these factors, being aware of the need to continue the process of reflexivity at all times during analysis, and with respect to the time and resource that was available to the thesis of this type, the researcher was satisfied that no further sampling was required to provide a trustworthy account of the experiences of the women in the oldest cohort of the ALSWH.

8.9 Trustworthiness

The issues regarding how to present ‘quality’ in qualitative research continue to be persistent and pervasive. When studying the experiences of women, told as narratives, the very subjective nature of the inquiry can appear to resist the assessment of quality of findings against strict boundaries or specified criteria (Thomas & Magilvy, 2011). However, the researcher understood that it was also of importance to establish rigour that leads to trust and
confidence in a qualitative study. As suggested by other research (Loh, 2013; Silverman, 2010), the steps that were taken to pursue best practice, that could be confidently defended, yet suit the subjective nature of the study that was chosen, were documented (section 4.8-4.10).

In the past it had been thought that free-text comments were not generalisable across populations due to the fact that responses are unstructured and the participants who contribute may not be of equal representation of the total numbers surveyed at any one time (Garcia, Evans, & Reshaw, 2004). However, Rich and colleagues (2013) completed a recent study on the comments collected across the three cohorts of the ALSWH. They reported significant findings which indicated that a high standard of quality, usefulness and rigour was present in the free-text comments from the ALSWH when applying the criteria suggested by Kitto et al (2008). It was also evident in the findings by Rich and colleagues (2013) that analysis of free-text comments, providing due processes were applied, provided justifiable research that has been seen to offer valuable contributions to literature.

Considering that the ALSWH is a longitudinal study, and analysis of change in meanings and experiences can be performed over time, findings from this current study have inherent value in the future in assessing the health and well-being of older Australian women. The possibility of this approach being able to add understanding to women’s experiences has been corroborated from other studies as well as indicating there is significant value to be found in qualitative studies that employ the analysis of free-text comments (Garcia et al., 2004; O’Cathain & Thomas, 2004; Riiskjær, Ammentorp, & Kofoed, 2012).

Kitto and colleagues (2008) presented the case for the need for researchers to adhere to suggested standards in the use of criteria for assessing the quality of the work. The key terms are clarification and justification; procedural rigour; representativeness; interpretive rigour; reflexivity; and transferability. The way the standards were addressed in the current study are outlined below.

**8.9.1 Clarification and justification**

This criterion asked for an appropriate fit between the aim of the study, the questions asked and the qualitative method design. The aim of the current study was to better understand the experiences of older Australian women, as they aged, and with respect to marital status. In addition, the study aimed to identify evidence of SOC in the experiences of women who described ageing well.
The design of the study, guided by a salutogenic framework, was appropriate to capture the wide range of experiences of older women. The choice of free-text comments contributed by the women was well suited to capture the voices of the insiders, that is, those women who were able to describe from their personal experience how they had managed the challenges of their older years. The need for this research has been justified, as there has been little prior research that has examined the experience of ageing for women in this age group and from their own perspective.

The theoretical framework that has underpinned the questions that were asked was outlined (section 3.2) and the methods that were proposed for the current analysis were detailed (section 4.8). The need for longitudinal research into understanding the experiences of older Australian women was also discussed (section 2.3).

8.9.2 Procedural rigour
This criterion asked for a clear explanation of how the research was carried out, recruiting of participants, methods of data collection. A systematic and thorough approach was taken from the outset of the current study. The steps outlining how the data were chosen, how it was prepared for analysis and then, how the analysis was carried out have all been followed and documented (section 4.7-4.9). The process had been made clear in order for the steps to be repeated by another researcher, on another sample group, should it be required. The idea of data saturation was considered frequently during analysis, and again as the findings were being presented. This was to ensure that there was confidence that the sample sizes for the three groups were adequate to convey the depth of information that was available, the range of opinions representing the issues, and that the information was relevant to deepening the understanding of the questions that had framed the study. Consideration was also given to the limitations of time and resources to completing this particular study. This concurs with research that recommends that a researcher using a qualitative method needs to allocate sufficient time and resource to analyse a large amount of data, while limiting excess and repetitious data (Bowen, 2008; Guest, 2006; Guest, MacQueen, & Namey, 2012; Mason, 2010; O’Reilly & Parker, 2012).

8.9.3 Representativeness
This criterion related to the recognition of the type of sampling frame that was used, with comparison and evaluation of the differences that were seen between participants being made clear in the findings. The sample groups were appropriate to the research aims. Older
Australian women were the participants, and smaller sample groups were selected according to specific criteria that allowed studies to be conducted on women of different marital status, early and late widows, and married women. There could be some bias in that only women who stayed in the survey, and who commented more than once were represented.

The details of the sampling framework, including the reasoning behind the choices of sample groups, were made clear in Chapter 4 (section 4.8). The comparison and evaluation of differences in the experiences of participants can be seen in each of the findings chapters, 5, 6 and 7.

8.9.4 Interpretive rigour

This criterion related to the research drawing on more than one researcher and/or using differing methods in order to give as full an interpretation as possible of the data. In this study, rigour was achieved first, by regular meetings between the researcher and the supervisory team, where all aspects of the study design and methods of analysis were discussed, in detail. This allowed for a better understanding of the experiences of the women to be developed as multiple opinions were discussed and evaluated.

Thematic analysis was chosen as the method used for all analyses. This allowed for a consistency of method to be applied to analysing different concepts that were underpinned by a salutogenic framework, and were supported by the conceptual model that was developed.

This study has been approved by relevant ethic committees (section 4.9). These analyses, and the subsequent findings are the subject of chapters 5, 6 and 7.

8.9.5 Reflexivity

This criterion asked that a researcher is aware of, and discusses the influences that the relationship between the researcher and the participants may have on the overall outcomes of the study. The researcher outlined the possible effect on the study brought about by past professional interactions with similar aged women (section 1.3). In addition, there was a full explanation of the process that the researcher undertook as the analyses took place, with handwritten memos, reflective summaries and detailed notes in document form as each analysis took place (section 4.8). These additional notes that were made during the analytical process were often referred to as decisions were made about the data. The information contained in the documents helped provide a balance between initial impressions of data, along with appropriate attention being given to comparison with other comments that were
read by all women in the particular sample group. The information also served as a reminder of data that was read at various times. Given the intensity of the process, and the time that was required in the period of analysis, all the background notes served to provide a stable referral basis for the process of reflexivity to continue throughout the period of the research.

**8.9.6 Transferability**

This criterion requires the researcher to suggest how the findings of the study could be transferred to inform other similar contexts, practice or policy. The relevance of the findings from this study will be considered in the following sections (8.9 to 8.12).

**8.10 Implications of the research**

The study has identified that there may be barriers that prevent SOC developing to its full capacity. Early recognition of risk factors could minimise the negative impact that having a low SOC can have on women as they age. Educational interventions could support the development of a strong SOC as, although it is a relatively stable concept, it was shown that it has the capacity to develop even into older age. A better understanding of the benefits of a high SOC would encourage the support being offered to women at key periods of change in their lives, particularly around the time of spousal loss, when stressors are at a peak, and strength and ability to apply resources may have ebbed to lower levels than may have been usual. Given the challenges that have confronted those who manage contemporary public health issues, when considering the effect that stress has on mental health, there would be benefit in supporting the development of SOC across the spectrum of health care, promotion and health policy (Lindstrom & Eriksson, 2005).

The current study has also identified the importance of understanding the lived experience of older women. So much can be missed when only prescribed numeric answers are used to assess the process of ageing. The ebb and flow of life’s events have an ongoing effect on how women view their situation at any one point. The key life change of losing a spouse remains an enduring theme in many comments, considering it is such a common stressor to which older women have to adjust. Women reflect on this loss, to varying degrees, and the presence of physical and emotional effects are detected, usually for many years. Considering how frequently this event is reported by women, and understanding something of the depth of the loss, suggests that ongoing study would be well served if it continued to develop further understanding as to how best support and help women through this critical transition.
There is evidence that women were remarkable in their creative use of resources, in varying amounts, at differing times, in pursuit of the most appropriate response that can be applied at any given time. The implication is that the wider network of people who offer care, support and educational tools to older women, need to be aware of the factor of personal experience. It may be difficult to keep the individual perspective in view when the larger group has to be considered in key decisions. However, research such as this current study has shown that the voice of the one, joins with the many, and bears consideration at all times.

Incorporating the element of time into the descriptions of experiences also has implications for future directions of study. The generations that follow these women also will report their own unique journey, and this needs to be documented. If the lessons learnt from the changes over time that these women described, preparation for potential changes in the future can be made in relation to communities, service needs and infrastructure.

8.11 Limitations and strengths

All research has limitations and strengths, although care was taken to minimise the limitations where possible. One limitation of this study is that the participants were women only, and as such no comments regarding comparison with men in the population can be drawn. However, the choice of participants was considered appropriate considering the primary intent of the thesis was to deepen the understanding of the experiences of older Australian women, as older women form a very significant proportion of the older population (sections 1.1-1.2). This fact, combined with the professional experience of the researcher that drew her to this study, made the decision to choose women participants to be appropriate.

Another limitation was regarding the use of secondary data of the ALSWH. Given the nature of the data there was no opportunity to ask for more specific detail, to gain a greater understanding of other experiences, to ask for clarification about certain matters. It was possible that some issues, maybe from younger days, may have remained unaddressed, and yet may have been significant in their unspoken, forgotten, or unidentified effect on the later lives of the women in this study.

It is of importance to note that only women who contributed free-text comments to the surveys could be included in the analyses. The responses were not directed in any way and were not elicited for any specified topic, although it is acknowledged that the opportunity to make comment came at the end of a survey that was largely about the health and well-being
of women. As such, it can only capture the experiences of women who feel strongly enough about their opinions to take the time and effort to write in the section provided. However, it is suggested that many women felt their experience of ageing was worthy of the time and energy investment to contribute extra information to the ALSWH.

The age of the sample used in the study was both a limitation and a strength. The older women have had a set of life experiences that will not be replicated within the younger cohorts, and as such their experiences may not be generalisable to the upcoming groups of older women in Australia. The strength came from the wealth of available data from the age group of key interest to this study, which was older women, from various marital groups.

There can be a bias within the qualitative data set, whereby the women who wrote comments at multiple surveys describe a perceived relationship with the ALSWH. They at times personally addressed directors and/or staff at the ALSWH with whom they had correspondence. They would virtually pick up the story from the last time they contributed to the ALSWH with words such as “as I told you last time...” and then continue to expand on their experiences of the past three years. They expressed gratitude that someone was listening to their stories, and felt hopeful that they were making a contribution to improving life for future generations. It can be said that most of the participants did not add these personal greetings and references, thus the degree of this bias was limited in its appearance.

Despite the potential differences between this cohort and younger participants in ALSWH, it was considered that there was sufficient commonality in the ageing experience to generate valuable information. The findings from this current study could inform people involved in the area of aged care services and provision currently, as well as having benefits to improve insight both now, and in guidance of direction for the coming years. The number of participants available was also more than what is considered sufficient to generate valid and worthy data.

At the outset of this study, there was yet to be any other significant study examining what a broadly representative sample of older Australian women themselves had to say about their ageing process, over a considerable period of time. This thesis has helped to address this gap. There have been other longitudinal studies such as the long running Melbourne Longitudinal Studies on Healthy Ageing (MELSHA). However, at its outset in 1994, the participants, men and women aged 65 years or more, were residents of Melbourne (Browning & Kendig, 2010). Similarly, the participants in other studies such as the Dubbo Study of the Health of the Elderly (Simons et al., 1990) and the Sydney Older Person’s Study (Broe et al., 2007) were all residents.
of the area that gave its name to the study. Some studies were much more specific in their areas of interest, such as adjustment to life when paid professional work ceases, as was the case in The Healthy Retirement Project (Wells, de Vaus, Kendig, Quine, & Peteralia, 2006). Other studies had a specific focus on ageing, and not seeking understanding other issues that may contribute to health and well-being in older people. For example, the Stories of Ageing study (Feldman, Kamler, & Threadgold, 1998), and The Canberra Longitudinal Study of Ageing, which in addition, was Canberra specific (Christensen et al., 2004).

The ALSWH offers a unique research opportunity. With its large number of participants, it is representative of the whole of Australia, not just state or region. The data collected from ALSWH has proven to be reliable and can be confidently used in subsequent analyses. Given the large number of women in Australia who are aged 65 years and above, the potential vulnerability for these women who are ageing, with many also facing the loss of their spouse, their experiences were important to investigate from their perspective.

A strong sense of national pride was engendered in these older women from the experiences of two world wars, first as it affected their parents, and then, on their own generation. Significant social change has impacted the role of community and the disruption of the traditional nuclear family since these women were raising their families. These ongoing social changes will affect how the next generations of women will report aspects of their lives, both personally and professionally, including their ageing experience.

Recent research has already noted the health demographic of participants in the oldest cohort of the ALSWH who contributed free-text comments compared to those who did not. The women who have contributed comments tended to have lower physical functioning, general health and social functioning scores (measured using the SF-36). They also had higher educational levels and reported more significant life events (Rich et al., 2013). Notwithstanding these characteristics, the comments can still provide information that is valuable in gaining insight into the experiences of health and well-being of older Australian women.

8.12 Future directions

There are multiple reasons we should develop better frameworks to understand salutogenesis. One is that the pathogenic paradigm is unable to explain the variations that are seen in morbidity and mortality (Lamprecht & Sack, 2003). Another reason for expanding the understanding of frameworks is that a better understanding of health inequalities will facilitate
more effective cooperation across academic faculties, service providers and health practitioners. Approaches that are aimed to increase SOC include being able to increase the availability of, or ability to uptake, resources such as self-management skills and community networks. Increased meaningfulness and order can be promoted by increasing the perception the individual has of control of their situation (Harrop, Addis, Elliott, & Williams, 2006).

Additional findings from the study by Harrop and colleagues (2006) suggested it was possible that, if the external environment did not change, and stressors remained unaddressed, adverse effects could be seen, for example, in increased levels of frustration, a sense of powerlessness and ill-health. Protective factors that could improve the SOC included the development of positive self-concept, self-esteem and strong social and ethnic identity.

A review of literature on ageing found that the lack of qualitative studies that had a focus on the perspectives of the older person limited the understanding of what actually constitutes good health and ageing well outcomes (Dionigi, 2015). It was suggested that the stereotyping of the ageing process in research led to assumptions being further embedded in the attitudes to older people. In contrast to negative stereotyping of ageing, it is suggested that if older people can view ageing as a time where social engagement can be pursued, activity and growth can be encouraged rather than decline. If this positive view of ageing can be supported, better mental and physical outcomes would be likely, when compared to people who have expressed a pessimistic view of ageing (Levy, Zonderman, Slade, & Ferrucci, 2012; Nelson, 2016).

Reversing negative stereotypes about ageing can contribute to reducing the accompanying unhealthy side effects of that attitude (Levy, Pilver, Chung, & Slade, 2014; Levy, Pilver, & Pietrzak, 2014). Changes in attitudes by individual and by society in general are needed to improve the adequacy of policy and infrastructure that will ultimately benefit the aged people themselves. Benefits could be seen in the way that society pays attention to the needs of the older people within the population and gives due respect to their valuable contributions and participation.

In the future, is anticipated that the pool of traditional family care-givers will lessen. The health effects of care-giving need to be understood better in order to target evidence-based services to those who offer to fulfil such caring roles (Roth, Fredman, & Haley, 2015). More research in this area is recommended in order to provide clarification and education about the
negative and potential positive effects that can be associated with informal care-giving in the extended family environment.

Regarding the future of research using the salutogenic model, it is noted that more important than the presence of the actual resources themselves, is the ability to use them (Lindstrom & Eriksson, 2006). Resources function to promote a better and more informed response to stressors, which in turn strengthens and promotes a strong SOC. This is relevant to ageing because a strong SOC can be one of the most important assets older women can have to help adjust throughout a time of change, stress, and potential decline. The flexibility of a SOC to adapt to any situation, across time, age and culture is a key benefit when the area of future education, support and health promotion is considered (Antonovsky, 1993).

The specific areas that require the close attention of aged care providers and those in policy making roles that have been reported as findings from this current study centre on the provision of affordable and comprehensive health insurance, telecommunication networks to be upgraded to cover far more of our vast country, and be accessed at affordable rates, and the provision of communities that are considered safe and accessible for an older person, with due respect to some of their physical limitations. The types of research that are best suited to studying ageing are those that incorporate longitudinal design. Significant events occur as the process of ageing unfolds and incorporating time into the study’s methods allows for a more complete understanding of how the process can result in ageing well.

The study has validated the use of free-text comments. Comments are frequently called for, and collected, as part of surveys, however they are rarely evaluated and analysed as research data. The data used in this study have provided valuable evidence of the experiences of health and well-being of women as they age. This study proposes that data sources such as free-text comments be used in other fields of research, and this study has made a contribution that advances the use of qualitative data analysis.

8.13 Final comments

At the conclusion of this study the researcher felt an overwhelming sense of gratitude that so many older Australian women had provided access to vital contributions they had made to record their journey of ageing, through the ALSWH data. The women from the ALSWH also served as a reminder of the memories of the wonderful patients the researcher had been
privileged to know in her professional capacity. And over and above that, they represented the age group that included her own mother. It was a privilege to give voice to them.

It was an honour to try to tell their story with integrity and enthusiasm, and in a way that will benefit future Australian women. The researcher has never taken lightly the responsibility that sits on a person who attempts to report with integrity, what was found in the data. In addition, it was hoped that support, information and encouragement would be offered to future generations of women with the insights that have been gained.

For each one the journey was personal, and yet there was much to be learnt from the commonality of the experiences that a generation reported. This thesis sought to honour the voice of the individual, to validate their opinion as being true for them, yet to situate the story of one within the collective stories of the many.

“Speak up and speak clearly.
I want to hear what you have to say because it matters.
Let’s listen to each other and respect one another’s opinions.
Although, they may be different,
Wisdom allows us to be responsible for our own feelings and actions.”
Felicia Johnson

8.14 References


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Australian Bureau of Statistics. (2007). *Lifetime marriage and divorce trends (Cat. no. 4102.0)*. Canberra: ABS.


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Qualitative processing protocols

Introduction

This document was compiled to clarify and extend upon current protocols that are employed in processing qualitative data collected by the Australian Longitudinal Study on Women’s Health (ALSWH). The qualitative data are primarily the comments included by participants in response to the final question on each survey (Have we forgotten anything?) and also include responses to open-ended questions that may be asked in the future. These guidelines were referred to the ALSWH Steering Committee and the ALSWH Data Management Group and were first revised in accordance with decisions reached during the Steering Committee meeting 5/5/2005 and DMG meeting 15/6/2005. The guidelines have since been revised by the Qualitative Research Group, formed in 2008 in response to increased use of the qualitative data. The Steering Committee approved the revised guidelines 18/02/2009 and University of Newcastle HREC approved the changes 09/07/2009. These guidelines were again reviewed in May 2014 by the Qualitative Research Group. The Steering Committee endorsed these changes in August 2014.

Qualitative processing 1996-2004

The following steps were undertaken with data for the first (“Survey 1”) surveys:

1. Potentially identifying comments (eg. someone’s name, addresses etc) were whited out.
2. The data, without this information, were entered into Access by ALSWH project assistants
3. At the same time, the data were coded into the main themes and keywords that arose according to the frequency of topics made in Survey 1
4. To check the reliability of these themes and keywords, about one in twenty surveys were checked by another operator.

Data from Surveys 2 and 3, and Survey 4 of the 1946-51 cohort, were entered in the following way:

1. During the editing process, potentially identifying comments were whited out.
2. The data were scanned and entered by the data company (with the exception of Old 2, which was entered by ALSWH staff), without the whited out material. The data were then read into Access. There has been no consistent notation to indicate the presence of omitted material.

Surveys 2 and 3, and Survey 4 of the 1946-51 cohort, were not coded.

In 2004 concerns were raised over the difficulties that were experienced with being unable to access data that had been whited out. Whitening out was stopped at this time.

Current qualitative processing

As of June 2005, and starting with Survey 4 of the 1921-26 cohort, data were being processed as follows:

1. All qualitative comments were left as is except for names and addresses. Changes of names and addresses were whited out and replaced with [change name] and [change address]. Where women include their own name and address for other purposes, these were whited out. Names are replaced with [name], and addresses with [address].

2. Data will be scanned and entered by the data company without whited out names and addresses. As in previous years, the data will then be read into Access.

3. In terms of online surveys, raw qualitative data is downloaded from the online surveys and imported into an MS Access database. ALSWH Project Assistants review the data and anonymise using standard ALSWH protocols. The data are then forwarded to the Data Managers for distribution to researchers as required.

Anonymising procedures

In this document, the term ‘anonymise’ is used to describe the process whereby qualitative data (i.e. participant comments) are altered so that participants are unlikely to be identified.

Anonymising of all qualitative data, including those collected prior to 2005, will be the responsibility of the ALSWH liaison who is named in the Memorandum of Understanding. The collaborator in consultation with the liaison may nominate a member of their team who will deidentify the data, but the responsibility for ethical procedures and compliance with these guidelines remains with the ALSWH liaison.
Outputs
All outputs must be vetted by the ALSWH liaison prior to publication in any form (presentation, journal paper etc).

Data security
All electronic copies of the data must be password protected.

If any data are to be printed they must first be anonymised. Raw data are not to be printed. Any printed data must be held securely in keeping with NHMRC guidelines; in a locked cabinet on the premises of their institution.

Suggested general guidelines for anonymising
Anonymising procedures may differ depending on the focus of particular research projects. The following guidelines are suggestions as to how data may generally be anonymised.

Dates must be removed.

All names, places and potentially identifying information can be replaced as follows:

Names can be replaced with the person’s relationship to the participant or their title. For example:

{son}
{mother}
{family member}
{friend}
{family doctor}
{solicitor}

Town and suburb names can be replaced with short descriptors as per the five RRMA categories. Place names can therefore be replaced with:

{capital city}
{other metropolitan}
{large rural}
{small rural}
{remote}
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Place names can be replaced by a short descriptor in braces. For example:

Royal Newcastle Hospital replaced by (regional centre hospital)

Sydney District Courthouse replaced by (capital city courthouse)

Other less general potential identifiers have been noted, such as unique characteristics (eg. awards) and specific disabilities involving multiple family members. These types of identifiers can be anonymised by changing the characteristics involved, family make-up or other details that do not affect the nature of the analysis being conducted.

Where potential participant recognition occurs the ALSWH liaison officer must be consulted. The liaison will ensure that the participant’s data are removed from the dataset.

Where a participant is very transparent and specific in their comments, in consultation with the ALSWH liaison, the analyst must decide if the data can be anonymised without losing meaning.
Access to ALSWH Data Flowchart

Analysis of ALSWH survey data
Contact an appropriate ALSWH Liaison person from the list available on the ALSWH website to discuss the proposed project & invite them to become ALSWH Liaison for the project.

Submit expression of interest (EoI) using the online submission form
Data linkage applications: submit the data linkage variable request form via the online EoI submission form.

EoI is checked by project staff for scientific validity & appropriateness of data use
Note: For the majority of data, overlap protection is only provided for six months with the exception of student projects which are protected for the life of the project.

If overlap is found or if it is deemed that the EoI is not an appropriate use of data - applicant invited to submit a revised EoI

EoI circulated to Publications, Substudies and Analysis Committee (PSA) for review & comment - as per the schedule of reviews
Data involving linked data will also be circulated to the Data Linkage Committee (DLC) for review & comment.

PSA Coordinator to respond to applicant

Approved

Further information required

Application not approved

Approval email sent

Statement Governing the Analysis, Use & Publication of Data & Confidentiality Statement sent to collaborators for signing

Once all of the signed documentation has been returned the project is made active and data delivery will be arranged
Dear Ms. Kennaugh,

I am sending our gratis permission for the use of your article in your dissertation with stipulations.

Article title:

Beyond Widowhood: Do Prior Discovered Themes that Describe the Experiences of Older Australian Widowed Women Persist over Time?

Article DOI: 10.1080/03630242.2015.1118731

Thank you.

Mary Ann Muller – Permissions Coordinator, US Journals Division

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www.taylorandfrancisgroup.com
Information about SF-36 Health Status Scales and the interpretation of low and high scores (Ware and Sherbourne 1992). 7

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<th>N of items</th>
<th>N of levels</th>
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<th>High</th>
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<td>Limited a lot in performing all physical activities including bathing or dressing</td>
<td>Performs all types of physical activities including the most vigorous without limitations due to health</td>
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<td>Role of limitations due to physical problems</td>
<td>4</td>
<td>5</td>
<td>Problems with work or other daily activities as a result of physical health</td>
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<tr>
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<td>2</td>
<td>9</td>
<td>Extreme and frequent interference with normal social activities due to physical and emotional problems</td>
<td>Performs normal social activities without interference due to physical or emotional problems, past 4 weeks</td>
</tr>
<tr>
<td>Bodily Pain</td>
<td>2</td>
<td>11</td>
<td>Very severe and extremely limiting pain</td>
<td>No pain or limitations due to pain, past 4 weeks</td>
</tr>
<tr>
<td>General mental health</td>
<td>5</td>
<td>26</td>
<td>Feelings of nervousness and depression all of the time</td>
<td>Feels peaceful, happy, and calm all of the time, past 4 weeks</td>
</tr>
<tr>
<td>Role limitations due to emotional problems</td>
<td>3</td>
<td>4</td>
<td>Problems with work or other daily activities as a result of emotional problems</td>
<td>No problems with work or other daily activities as a result of emotional problems, past 4 weeks</td>
</tr>
<tr>
<td>Vitality</td>
<td>4</td>
<td>21</td>
<td>Feels tired and worn out all the time</td>
<td>Feels full of pep and energy, past 4 weeks</td>
</tr>
<tr>
<td>General health perceptions</td>
<td>5</td>
<td>21</td>
<td>Believes personal health is poor and likely to get worse</td>
<td>Believes personal health is excellent</td>
</tr>
</tbody>
</table>

7 The SF-36 that was used for the ALWH study was adapted from the original shown (Ware & Sherbourne, 1992), to ensure relevance and understanding of terms for Australian women (Mishra & Schofield, 1998).