Older people's understandings and perceptions of well-being: A grounded theory

by

Mandy Stanley

BAppSc, MHlthSc(OT)

UNIVERSITY OF SOUTH AUSTRALIA
23 JUN 2006
LIBRARY

A thesis submitted for the degree of

Doctor of Philosophy

School of Nursing and Midwifery, Division of Health Sciences

University of South Australia

February 2006

Table of Contents

Table of Contents i
List of Figures v
List of Tables ii
Summary iii
Declaration v
Acknowledgments vi
Chapter 1: Introduction 1
Well-being and older people: The demographic imperative 2
Emerging popularity of the word/ concept well-being 6
Occupational therapy and health and well-being 9
The potential afforded by a qualitative approach 11
Myself as the researcher 14
How the thesis will unfold 18
Conclusion 21
Chapter 2: Well-being and older people: A review of the literature 22
Introduction 22
Defining well-being in occupational therapy 22
Well-Being Literature Review 24
Search Process 24
Occupational therapy literature 25
Social science, medical and allied health literature 26
Well-being as a core concept within occupational therapy 27
Occupational therapy and older people 29
Ageing successfully 30
Measurement of well-being 32
Reconceptualising well-being 35
The missing older person's perspective 37
What is known about well-being and older people? 45
Conclusion 46
Chapter 3: Tenets of grounded theory 48
Introduction 48
Research paradigm 48

Position of the researcher....49
Grounded theory....50
Assumptions....51
Theoretical pillars....52
Data collection....53
Constant comparative analysis....54
Theoretical sampling....56
Memoing....56
Core category....57
Theoretical saturation and sample size....58
Critiques and trends of grounded theory....59
Application of grounded theory in occupational therapy research....62
Use of grounded theory within occupational therapy research....63
Occupational therapy practice....67
Occupational therapy education....68
Occupational science....68
Selection of grounded theory for my research....69
Chapter summary....70
Chapter 4: Method....72
Introduction....72
Selection criteria for participants in this study....72
Gender....72
Age....73
Community dwelling....74
Metropolitan....75
Selection of participants....75
Opportunistic sampling....77
Snowball sampling....77
Theoretical sampling....78
Data collection strategy....80
Choosing semi-structured interviews....80
Process of interviewing....83
Transcribing the data....84
Recruitment....84

Sample 84
Ethical issues 90
Analysis 93
Selective coding 96
Theoretical coding 97
Theoretical saturation 103
Data management 103
Strategies used to ensure rigour 109
Credibility 109
Transferability 110
Dependability 110
Confirmability 111
Chapter summary 112
Chapter 5: Articulating the theory: an overview and the core category 114
Overview of the theory to emerge 115
Core category: Maintaining perceived control 122
Routine 122
Having choices 125
Maintaining independence 127
Perceived control 132
Basic social problem: having the perception of not being in control 135
Chapter summary 138
Chapter 6: Articulating the theory: the categories 139
Challenge to equilibrium 139
Loss of capacities 139
Loss of relationships 145
Life is like a yo-yo 146
Gender imbalance 147
It came out of the blue 149
Summary of 'challenge to equilibrium' 150
Personal resources 150
Having good health and good fortune 150
Being engaged and active 154
Feeling needed and wanted 154

Being connected 158
Keeping busy 165
Up to me **169**
Up to me /Self-responsibility 169
Being realistic about capacities and limitations 170
Having to give up things/ accepting 173
Being positive 173
Feeling comfortable and secure **176**
Being comfortable 176
Feeling safe and secure 177
Financial security 181
Chapter summary 184
Chapter 7: Articulating the theory: the basic social process **185**
Basic social process: trading off 185
Trading off and links to occupational therapy notions of adaptation 191
Use of client centred practice to enable trading off 194
Chapter summary 198
Chapter 8: Implications for knowledge and practice **199**
Reviewing the aim 199
Implications for occupational therapy practice with individuals, groups and communities 201
Occupational adaptation 206
Person environment occupation models 211
Summary 215
Transferability 215
Application to a multi-disciplinary context 217
Concluding remarks 218
References **219**
Appendix A: Recruitment letter **236**
Appendix B: Information sheet **238**
Appendix C: Ethical approval **241**
Appendix D: Consent form **243**
Appendix E: Published journal articles **244**

List of Figures

Number *Page*

Figure 1 Examples of the growing popularity of well-being 7

Figure 2. 'Mud map' of analysis 106

Figure 3. Next iteration of analysis mud map 107

Figure 4. Further analysis 108

Figure 5. Diagram of relationships between categories, the core category and the basic social process 116

List of Tables

Number *Page*

Table 1 Occupational values statement adapted from Polatajko 1992 18

Table 2 Key occupational therapy theories with outcomes involving well-being 29

Table 3: Summary of Well-being literature 44

Table 4 Examples of initial open coding 55

Table 5 Summary of occupational therapy studies using a grounded theory approach... 66

Table 6 Summary of literature review of sample age 73

Table 7 Demographic characteristics of participants 85

Table 8 Sample of text from transcript with open coding 95

Table 9 Use of trade-off by participants 101

Summary

The proportion of the world's population over the age of 65 has increased significantly during the last century and is projected to keep increasing, with the largest growth in the sector of the population over age 75. With the growth in the population of older people it is more likely than ever before that occupational therapists will have contact with older people. Occupational therapy has much to offer older people and their well-being, ensuring that they live not only longer, but importantly, live well as they understand it.

Well-being is a core concept within occupational therapy. Achievement of well-being on the part of the client is a goal of therapy. However, examination of occupational therapy and other health related literature, reveals that the meaning or understanding of well-being in play is often not articulated and at times well being appears as a contested concept in the literature (Stanley & Cheek 2003b). The meaning of well-being is often assumed, or conflated with other concepts such as life satisfaction and happiness. Further, how people achieve well-being is unclear and in most occupational therapy literature the perspective of the older person with regard to well-being is missing. In light of this omission there is the potential for a lack of congruence between the principles of occupational therapy designed to promote well being, and the perspective of the older person as to what well being actually is. Such incongruence has the potential to make well-being an elusive goal of therapy. In response, this study uses grounded theory to explore how older people perceive and understand well-being.

Grounded theory was used in the study because of its ability to generate theoretical propositions in an area where little is known (Stanley & Cheek 2003a). Fifteen participants over the age of 75, living in the community in one metropolitan city of Australia, were selected by opportunistic, snowball and theoretical sampling. In-depth interviews were conducted and analysed using the tenets of traditional grounded theory.

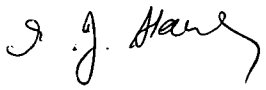
The central category to emerge was that to experience well-being older people had to perceive that they were in control. Participants in the study sought to avoid the perception of not being in control brought about by 'challenges to equilibrium', such as loss of capacities and loss of relationships. To perceive that they were in control participants used routine, needed to have choices and maintain independence. They used the basic social process of 'trading off' to increase their perception of being in control. 'Trading off' was used to exchange occupations

that were no longer within their capacity, for occupations that were, or for other people to complete those tasks in order for the person to perceive that they were in control. Other categories that supported perceived control and the ability to use 'trading off' were 'personal resources', feeling 'comfortable and secure' and an attitude of 'its up to me'. Thus well-being emerged as a dynamic interaction between the older person, their physical and social environment, and the demands of the occupations they wished to engage in order to have perceived control.

Given this new knowledge about the importance of perceived control to older people and their well-being, occupational therapists can look for ways of working with older people to ensure they perceive they are in control and are able to use trading off in order to attain well being. The major contribution that this study makes to occupational therapy knowledge is an explication of older people's understandings and perceptions of well-being, particularly given that well-being is a central concept within occupational therapy. Knowledge about the use of 'trading off' also contributes to the theoretical propositions relating to the process of occupational adaptation.

Declaration

I declare that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge it does not contain any materials previously published or written by another person except where due reference is made in the text.

Mandy Stanley
[Signature] 

26th April 2006
[date]

Acknowledgments

An endeavour such as a PhD thesis completed over 6 years does not occur in isolation. I therefore want to acknowledge the contribution of the following people and offer my heartfelt thanks.

My principal supervisor, Professor Julianne Cheek, for her drive, passion for quality in research and research education, and her ability to change her supervision style according to the student's needs and the stage of the PhD. Julianne's ability to engage with the research study and to coach me in writing is exemplary.

My Associate supervisor, Dr Louise Farnworth. Although the role of associate supervisor was not as large as what we might have imagined Lou's contribution was invaluable and assisted me at some of those very crucial moments during analysis and writing, which will always be remembered.

My academic colleagues for their support and understanding over such a long period of time. For their additional support as friends thank you to Penny Westhorp, Pam Dean, Chris Chittleborough, Sue Gilbert Hunt, Angela Berndt, Mandy Seyfang, and Sue Hartshorne. And well beyond our collegial and friendship relationships, Christina Boerema and Mary Russell who gave so willingly of their time and considerable intellect. Without them the thesis would have been a different product.

My student colleagues who at many times were the only ones who understood what I was struggling with, in particular Candice Oster, Jenny Findlay, Jenni Adams, Carol Brooks, Jo Harrison, Denise O'Connor, Terri Gibson and Marlene Wiese. The many lunches and coffees with Marlene and discussions about grounded theory along with her gentle approach probably saved my sanity.

The general staff colleagues, who helped in so many small but significant ways, especially, Alex Hunter, Brad Jeffery, Netta Russell, Sandy Heading, Seanagh O'Loughlin and Bridget Garnham. Jacqui Howard, for her help in making my theory diagram look so professional. It would have taken me many hours of frustration and still not looked as good.

My wonderful friend and work colleague Sue Coyle who is always there for me.

My students who have always shown such keen interest in my research endeavours despite most of them not being fond of research themselves. And for putting up with my passion and joy in research education in my teaching of them.

My many occupational therapy colleagues throughout Australia and overseas who have followed my progress with interest. Here I single out Clare Hocking and Alison Wicks who would offer the email or phone conversation at just the right time, and Phil Maxwell and Jo McInnes for their continual support and interest.

Thank you to my mentors throughout my occupational therapy career who have all helped me to be the occupational therapist, educator, researcher and occupational scientist that I am today. They include Marg Jeffries, Elva Summerville, Catherine Delin, Professor Ann Wilcock and Peggy Farrow.

And I have left my family to last, yet they have made the most significant ongoing contribution to my studies and my life. To my parents for always encouraging me to be the best that I could be. And my husband, Jeremy and daughter, Erin who have lived through the highs and lows of the last 6 years and kept loving me anyway. Also to my late Kit-e-kat, and to Si Tao, our precious cats, for keeping me company in the long hours at the computer.

Chapter 1: Introduction

> A human being would certainly not grow to seventy or eighty years old if this longevity had no meaning for the species. The afternoon of human life must also have a significance of its own and cannot be merely a pitiful appendage to life's morning Carl Jung

Growing older happens. We might not embrace it, we might even rage against it, but it still happens. In a culture that reveres youth it is sometimes difficult to speak positively about being older or to think about experiencing old age as a time of well-being. Historically, stereotypical images of aging include those of decay, of aches and pains, of loneliness and decline inevitably into dementia and being dependent and frail (Feldman 1999). However, other images of older people and being old are emerging. These images portray the post-retirement period as one of freedom of responsibilities, a time to travel and do exactly as one wishes. We now see advertisements of older people carefree running through the surf, or driving off into the sunset as new retirees are being identified as a cohort with disposable cash to be spent or invested to ensure they have a good time. Whilst alternative positive images are welcome, the question must be asked, whether or not we are now creating a new stereotype, which Feldman, Kamler and Synder (1996) refer to as "super-ageing". What seem to be missing are the images and stories of "ordinary" older people. Surely there is a place somewhere in between these two extremes for the "ordinary" older Australian who wants to experience a satisfying meaningful life in old age. It is with the "ordinary" older person that my interests lie, in probing what they think about living well in old age, and what they understand and perceive as well-being. In this study, an older person is one who is 75 years of age or older. A rationale for defining the older person as being over the age of 75 is presented in chapter 4.

In this chapter I begin the exploration by introducing the reader to the concept "well-being" and the approach I have taken to studying it. I aim to establish not only that there is a growing general interest in well-being, but also the importance of considering well-being for older people given the growing numbers of older people in the population, and an increase in expectations of living a good life in old age. The growing numbers of older people in the population mean that occupational therapists, as will other groups of health professionals, will be more likely than ever to be working with older people. Occupational therapy practice with older people seeks to enable them to optimal health and well-being, through maximising functional abilities and enabling participation in meaningful occupations (Steultjens et al. 2004). Therefore, it will be increasingly important for occupational therapists to have a good understanding of what well-being is for older people. I argue that the exploration of understandings of well-being is well served by a qualitative research approach. Having established the rationale for a qualitative study of well-being in older people and its links with occupational therapy, I will then position myself as a researcher and what led me to ask questions about older people and well-being. The chapter will conclude with a description of the unfolding of the argument in terms of the way the thesis is structured.

Well-being and older people: The demographic imperative

The world's population is ageing. With the population growing at an annual rate of 1.7%, the population over age 65 is increasing by 2.5% per year (World Health Organisation 1998). While countries with some of the oldest populations are in Europe, rapid changes are also being seen in some developing countries. The numbers and proportion of the very old is also increasing, with the fastest growing population group in most countries being those who are 80 years and older (World Health Organisation 1998). With respect to Australia, the proportion of Australia's population over the age of 65 has increased significantly from 4% in 1921 to 12% in 1998, and is projected to increase to approximately 25% by 2051(Australian

Bureau of Statistics 1999a). Five percent of the Australian population is currently 75 years and older (Australian Bureau of Statistics 1999a). The prevalence of a health problem increases with age to the extent that at least one long term condition is reported for almost all (99%) persons aged 75 years and over (Australian Bureau of Statistics 2002).

As people are living longer, levels of morbidity are rising. This has resulted in growing numbers of consumers of medical and health services and numbers will continue to rise. With rising levels of morbidity people will be living longer but will be living with higher levels of health problems. The health problems may impact on the older person's ability to care for themselves, and to actively participate in their community. Because of the increase in occupational needs, that is, the ability to engage in daily occupations, of an ageing population it is likely that occupational therapists all over the world will have more contact with older people than ever before

In an international context, the United Nations' General Assembly endorsed a set of Principles for Older Persons (United Nations 2000) in the hope that governments will be encouraged to incorporate them into their national programs wherever possible. The principles emphasise the rights of older people:

- to maintain independence and autonomy;
- to be integrated in society for all ages and actively participate in policies that directly affect their well-being;
- to protect human rights and dignity for all;
- to pursue opportunities for the full development of potential; and
- to maintain the highest level of physical, mental and emotional well-being.

Of particular note here is the prominence that well-being receives, as a basic right for all older people. Well-being is also viewed in a very holistic way as encompassing the physical, mental and emotional aspects of life. It is interesting that these principles were put forward by the United Nations as part of an International Plan of Action in 1982 and yet are just as relevant today, some 20 years later.

In the National context, the Australian government has responded to the challenges of the future by setting four national priority areas for research, one of them being promoting and maintaining good health (Department of Education Science and Training 2003). Within that priority area, aging well and aging productively is named as one of the priority goals. The stated purpose of setting the priorities is to establish 'a vision where research can contribute to Australia's future prosperity and well-being'. Well-being is clearly established as a goal for all Australians particularly older people.

Taking a proactive approach to the demographic imperative, the Australian government has produced a National Strategy for an Ageing Australia (Department of Health and Aging 2003). The goal of the strategy is to deliver better outcomes for all Australians regardless of age. The strategy forms a framework for a national response to the following challenges and opportunities:

- An aging workforce;
- The need for adequate levels of retirement income to support retirement living;
- The need for positive individual and community attitudes to ageing;
- The need for infrastructure and community supports to enable older people to participate in society;

- The importance of healthy ageing to enable a greater number of older people to remain healthy and independent as long as possible; and
- The growing demand for accessible, appropriate, and high quality health and aged care services.

The document makes it quite explicit that the responsibility for meeting the challenges of an ageing population is a shared responsibility between all levels of government, private enterprise, communities and individuals. The strategy is organised around the 4 key themes of independence and self provision; attitude, lifestyle and community support; healthy aging; and world class care. A solid research base is identified as an action, which will help achieve the goals set within the strategy. This study is therefore in line with the goals and objectives of the National strategy.

At the local level, the South Australian Department of Human Services, in setting its research agenda for 2002-2005 named population health, well-being and quality of life as one of the major social research themes, and older people as one of the priority areas within that theme. In 2004 the State government released a strategic plan with 6 objectives (Government of South Australia 2004b). The second objective is to improve well-being and specifically lists the goal of addressing the challenge of an ageing population. Specific targets for the objective include increasing life expectancy as well as quality of life and participation in sport and recreation, at the same time as decreasing psychological distress, smoking, obesity and crime rates. The overall aim is to improve the quality of life and well-being for all South Australians by being healthier, fitter, having less crime and feeling safer.

Thus, it can be seen from considering the local, national and international context that it is timely to investigate well-being and older people. This study will therefore be contributing to

not only meeting the challenges of larger numbers of older people in the population, but also to improving the quality of the years that people are living.

In the introduction to their recent gerontology text, Bevan and Jeeawody (1998) state that "It is essential that professional providers of care to elderly people and political decision makers, as well as society in general, understand clearly the relationship between ageing, health and well-being" (p. XXI). The aim of this study is to find out more about the concept of well-being and older people, which is the first step to being able to explore relationships between concepts. Use of the word well-being is increasing as can be seen in the previous section in government documents and gerontology texts. I will expand on this point in the next section.

Emerging popularity of the word/ concept well-being

The concept of well-being has become quite fashionable in the popular media as well as a focus within occupational therapy and the health field more generally. Magazines dealing with the home and family contain articles about well-being. There is even an entire magazine dedicated to the topic (see fig. 1 for examples of everyday use of well-being). Most of these items seem to be concerned with alternative medicine, exercise, diet and relaxation as a means to achieving well-being. In some there is almost the rejection of traditional Western medicine as people seek to be more involved in their health care and wrest back some of the power from the medical profession. From reading the material one can detect a promotion of the values of self-determination and self-responsibility.

In the time that I have been interested in well-being the growth in popularity and increased usage of the word has been considerable, and one that goes beyond being interested in a topic

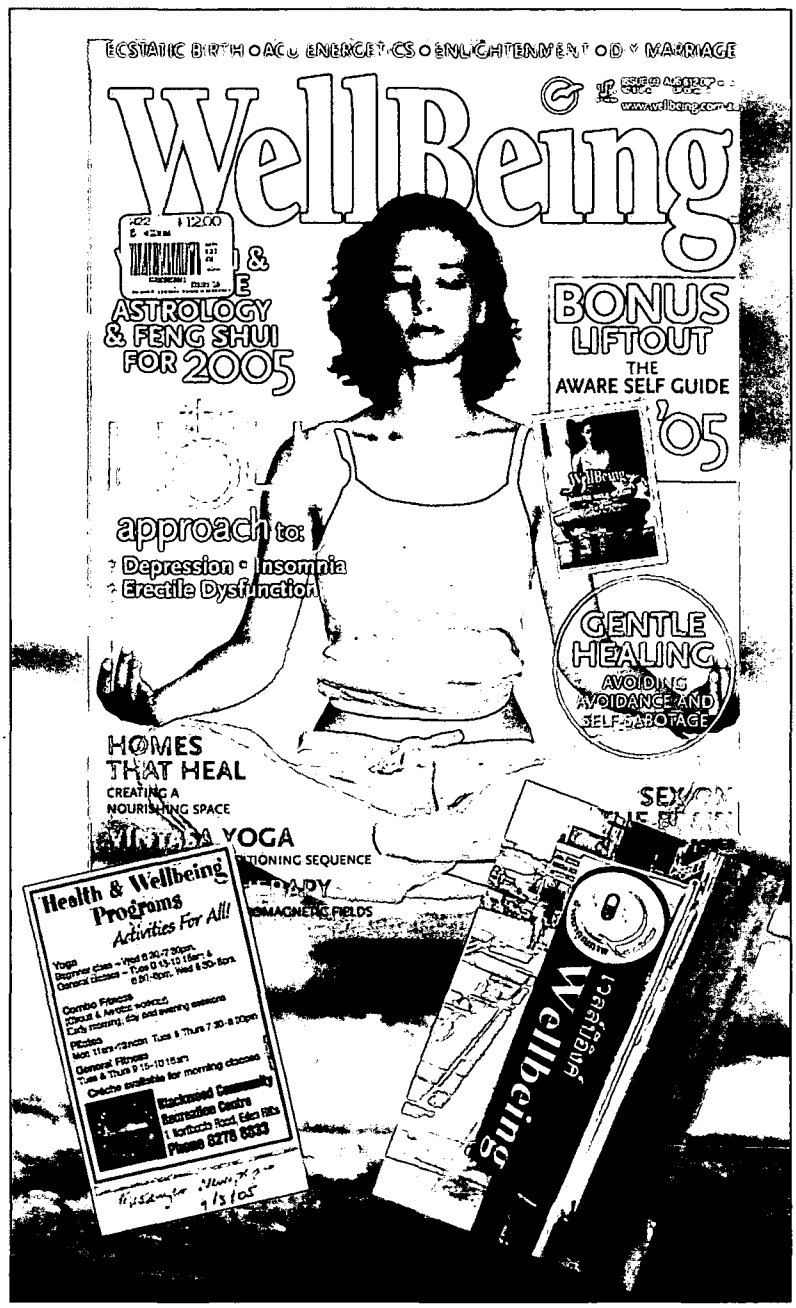


Figure 1 Examples of the growing popularity of well-being

and having a heightened sensitivity and awareness. As well as a magazine, there are television shows, and specialist sections in daily newspapers as well as alternative health practitioners advertising that they promote well-being. The Tetley tea company has even capitalised on the popularity of well-being and advertises the Tetley well-being website which includes tips to improve health and well-being (Tetley 2004).

The website for the newly created Department for Families and Communities (Government of South Australia 2004a) includes the strap-line "Enhancing the well-being of individuals, families and communities". Further evidence for the growing interest in well-being comes from the decision in 2003 made by the Community Cultural Development Board to commission research into how the sustainability and well-being of communities can be improved by engaging local communities in arts projects. The subsequent publication, Art and Wellbeing (Mills & Brown 2004) presents a number of case studies from around the country to demonstrate the effectiveness of involvement of communities in arts projects in contributing to individual and community well-being. Whilst the general interest in well-being appears to be growing, there is particularly a growing interest in well-being for older people driven by the demographic imperative and a growing interest in the 'good life'. Despite the growing interest in well-being it appears that there is lack of clarity as to how it is defined, and lack of consistency in how it is used. The concept of well-being appears to be embedded into the mainstream; however it is assumed that we know what well-being is. This thesis seeks to address that gap in knowledge, specifically in relation to what older people believe well-being to be.

In this thesis I will be using the form of "well-being" as two words separated by a hyphen in contrast to the usual Australian spelling of "well being". Whilst this study is set in the Australian context I prefer to use the more widely accepted International spelling. This

choice can be supported by my experience of searching databases for literature on well-being. When I entered the search word with well being as two words the result was a good number of articles but I knew there was more. I then tried "well-being" and was inundated with thousands of references. Therefore if I want my work to be accessible to readers in the future who will be searching databases I believe I need to use a more universal spelling. Moreover it is more than a simple spelling issue, as I want my work to be connected to and contribute to a wider international body of knowledge.

Occupational therapy and health and well-being

The most recent definition of occupational therapy from the World Federation of Occupational Therapists (2004), confirmed at the council meeting in South Africa April 2000, highlights the centrality of the concept well-being to occupational therapy practice. The definition is as follows:

> Occupational therapy is a profession concerned with promoting health and wellbeing through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of daily life. Occupational therapists achieve this outcome by enabling people to do things that will enhance their ability to participate or by modifying the environment to better support participation.
> Occupational therapists have a broad education that equips them with skills and knowledge to work collaboratively with individuals or groups of people who have an impairment of body structure or function due to a health condition and who experience barriers to participation.
> Occupational therapists believe that participation can be supported or restricted by physical, social, attitudinal and legislative environments. Therefore, occupational therapy practice may be directed to changing aspects of the environment to enhance participation.
> Occupational therapy is practiced in a wide range of settings, including hospitals, health centres, homes, workplaces, schools, reform institutions and housing for seniors. Clients are actively involved in the therapeutic process, and outcomes of occupational therapy are diverse, client-driven and measured in terms of participation or satisfaction derived from participation.

The philosophy of the profession of occupational therapy was built on the ideas of people such as Meyer, who observed that engagement in occupations was a powerful force in

maintaining well-being (Meyer 1922). Occupational therapists working with older people focus on what older people can do, whether they can do what they need to do, and whether their lives are meaningful and satisfying (Bonder 1997). This focus on *doing* is based on the assumptions that:

- Occupations with meaning to the person contribute to well-being;
- Occupation is an important determinant of health and well-being (Law et al. 1997); and
- A positive sense of self-efficacy is essential, to enable engagement in new challenges and the experience of mastery that contributes to well-being (Baum & Christensen 1997).

Well-being is thus an important concept in the philosophy underpinning occupational therapy, and subsequently the clinical practice on which it is built. Given this, it is important for occupational therapists to consider what understandings of well-being are in play in the way they construct their practice. Furthermore, it is important to explore whether there is congruence between understandings of well-being held by health practitioners such as occupational therapists and the clients with whom they deal. If the concept of well-being is not well understood, or if there is incongruence between what is understood as well-being on the part of the occupational therapist with the understandings of the client, then it may be an elusive goal of clinical practice. Clarity about what the concept well-being is necessary before occupational therapists can effectively enable their clients to work towards a goal of well-being. Further, given the increasing proportion of older people in many countries, it is even more imperative to understand what well-being is for older people. Therefore, it is important that therapists explore what is understood by well-being to ensure clinical practice is founded on clear evidence based principles.

The potential afforded by a qualitative approach

In exploring the potential afforded by a qualitative approach to this study and my reasons for its choice, I begin by considering the question of how I came to be interested in well-being? Originally I was interested in the concept of life satisfaction for older people. My coursework Masters minor thesis was a quantitative study (Stanley 1995) using time budget methodology. I wanted to test the hypothesis that there would be an association between the occupations that people engaged in and the score on the life satisfaction measure. I hypothesised that as time spent in valued occupations increased, life satisfaction scores would also increase. Although the data did not support the hypothesis I was fascinated by the data collected about people's daily lives and frustrated with the limitations of the instruments used. During the aggregation of data from the time diaries I lamented the loss of much of the richness of the data. Some of the diaries provided such a vivid picture of what the person was doing, who else was present at the time, and the orchestration of the person's occupations. For example, one participant wrote "*had tea, washed up, watched tv, but no good news, only bad*" and in the coding process this was reduced to a number of minutes spent in personal care, domestic activities and passive leisure. I knew therefore that to access the richer data I would need to explore the use of qualitative methodologies.

Besides the loss of richness of data there were also numerous problems with the coding of occupations as written in the time diaries, including the necessity to make assumptions about the type of occupation. For example, reading was coded as passive leisure, however unless the participant recorded what they were reading I didn't know if they were reading Tolstoy, a Mills and Boon paperback or the bible (which would be coded as religious/ spiritual activity). I was uncomfortable with the decisions I had to make in coding occupations, particularly basing the coding of leisure around the amount of physical activity involved. The only way

of coding more accurately would have been to ask the older people themselves as to how any particular occupation they engaged in should be coded. For example, only the older person themself could have told me if gardening for them on the particular day recorded, was leisure rather than work or vice versa. The methodological problem of coding the time diaries was another pointer towards a more qualitative approach to exploring what occupations older people engage in to experience well-being.

The life satisfaction measure in the time diary study was very carefully chosen, as it was fairly short and had been used with older people before. Despite that, many participants found it difficult to complete. That led to missing data rendering the results less useful. I began to ask questions about the use of scales to measure concepts such as life satisfaction and well-being and to question their content validity, that is, are they really measuring what they purport to measure?

The conclusion I reached from evaluating the limitations of my study was that further exploration of the concepts that I was interested in would best be served with a qualitative research design. A qualitative study design would enable me to access the richness of data to be analysed that was lost in the time diary study. Therefore this study will be situated within a qualitative paradigm. In addition, a qualitative study would enable older people to give their views in their own words.

Having decided that a qualitative approach would best suit the field of study I had to be clear about the concept for exploration. In re-examining occupational therapy core concepts I decided that well-being was a better descriptor for the concept I wanted to explore rather than life satisfaction. I wanted to find out how individuals achieve well-being, believing that if we knew more about the process of how older people achieve well-being then occupational

therapists will have better ideas about how to facilitate and assist in enabling well-being for their clients. At this stage I thought that the meaning of the word well-being was pretty clear and that there was consensus on the meaning within the professional literature. One of my first tasks in beginning this study was to define well-being. It was only then that I discovered what a difficult task that was, a difficulty I had certainly not anticipated. This point is returned to in the next chapter when I review the occupational therapy and gerontological literature in my search for a definition of well-being, and explore how it is conceptualised. I was also interested to see if the literature included representations of how older people conceptualised well-being. Surprisingly very little literature is available that presents the perspective of older people on what well-being is. A qualitative study of older people's perceptions and understandings of well-being would address this gap in knowledge. Qualitative research is appropriate when the research question seeks to understand the point of view of the study participants.

Common to all qualitative theoretical perspectives are a number of underlying assumptions:

- human behaviour goes beyond what can be observed and measured, incorporating subjective meanings, values and perceptions;
- human behaviour, actions and ideas can only be understood in context, not separated from the environments in which they occur; and
- people perceive and interpret reality differently, based on the context of their past experiences, there are no 'objective' truths (Hammell & Carpenter 2001).

Qualitative research is recognised as having a good 'fit' with occupational therapy research (Kielhofner 1982). There is resonance between the concerns of occupational therapy and the paradigm and methods of qualitative research as both focus on everyday life and appreciate the richness of living. Occupational therapy researchers are interested in studying the

complexity and embeddedness of occupation in everyday life and qualitative research designs provide the approaches to do just that.

Myself as the researcher

In qualitative research the researcher is an integral part of the research process. Hammell and Carpenter (2001) suggest that the researcher engages in an intellectual process through which the knowledge and experience of those within the study is juxtaposed with the knowledge, sensitising concepts and experience of the researcher so that the outcome of the research is a joint construction. Throughout the study I have employed reflexivity which is 'the process of self examination' (DePoy & Gitlin 1998), that is, thinking critically about what I was doing and why, bringing to awareness and challenging my assumptions, and recognizing the extent to which my thoughts, and decisions shaped the research. The use of reflexivity enabled me to achieve a far more intense insight. Therefore, in keeping with the reflexive process, before going any further I will describe my background and myself as a researcher.

Whilst appropriate strategies were employed to ensure a rigourous study (these are described in detail in chapter 4), there is no doubt that the research will be influenced by the experiences, both personal and professional, that have brought me to this research endeavour, along with my professional background and its associated philosophy and values. I became an occupational therapist 25 years ago in 1979 and my first employment following graduation was in a newly opened day therapy centre for older people. Subsequently in the clinical arena I have worked for major aged care providers in their nursing homes, hostels (now high and low care facilities) and day therapy centres, in an inpatient psychiatry ward of a public hospital where the majority of the clients were over the age of 65, and in an inpatient geriatric assessment unit. I also served on the Board of Management of a large aged care organization for 9 years. This organization is one of the major players in the aged care

industry in South Australia and prides itself on being innovative in terms of the services and the quality of care that it offers. During that time I was able to contribute to the growth and development of the organization and make sure that a client-centred approach was taken in Board decisions and in setting the strategic directions for the organisation. By the term client-centred I mean that each time the Board was required to make a decision I worked to ensure that the decision wasn't only made on financial grounds but also took into consideration the potential impact of the decision on the residents and the staff.

My work in recent years has been educating occupational therapy students at both under-graduate and post-graduate levels. I am often asked if I miss clinical work, but I still consider myself to be an occupational therapist and 'doing' occupational therapy as I am working at enabling the occupational therapy students whom I have contact with to develop their occupational potential as future occupational therapists. By occupational potential I mean, "future capability, to engage in occupation towards needs, goals and dreams for health, material requirement happiness and well-being" (Wilcock 1998a). Being an educator has given me more insight, knowledge and exposure to the theory of occupational therapy and current debates in that area.

I count myself as fortunate to have witnessed the development and evolution of a new area of knowledge, that of occupational science. Whilst Betty Yerxa is known as the creator of the term occupational science before her retirement from an academic position at the University of Southern California, Professor Ann Wilcock was, and is, the key person in Australia. Wilcock has an international reputation for her work on an occupational theory of humans, but for me she has a more personal connection in being firstly my lecturer when I was an occupational therapy student and then later a work colleague. I studied occupational science as a post-graduate student and am heavily involved in the development of occupational

science through official positions on the Journal of Occupational Science and the Australasian Society of Occupational Scientists. This has strongly influenced the way I view the world in that I can't help but see the world through an 'occupational' lens. The occupational aspects of what I read and see are fore grounded for me. For example, in watching the popular movie "The Full Monty" I am reminded of the despair and loss of hope of having nothing to do. Being an occupational scientist impacts on the way that I approach research, as the questions that I am interested in and passionate about pursuing are in the realm of trying to increase understanding about humans as occupational beings. There is so much we don't know or understand about the relationship between what we do and our health and well-being.

The occupational therapy profession can view occupational science as a threat or an opportunity. The notions of occupational science excite many people; however there has been considerable debate in the occupational therapy literature about the relationship between occupational science and occupational therapy. Whilst the debate does re-emerge every now and then, there is generally wider acceptance of occupational science by the occupational therapy community. Consensus on the relationship has not yet been reached, and there still exists a range of views. For example, some occupational therapists believe that the development of occupational science will detract from occupational therapy (Kielhofner, G. 2002), whilst others warn of the danger of occupational therapists taking over the tasks of occupational science (Mounter & Ilott 2000), and still other occupational therapy authors consider that occupational science is now an accepted science that contributes to the knowledge base of occupational therapy (Lunt 1997). My personal view is that occupational science is the foundation science that underpins occupational therapy knowledge and practice. I take the stance that occupational science can be informed, developed and indeed enriched by the participation of other disciplines such as sociology, anthropology, human geography and others, and that the discipline of occupational science is not the unique province of

occupational therapists. What is unique to occupational therapy is how the knowledge gained from occupational science is applied in therapeutic practice with clients. That is the view that will inform my approach in this thesis.

Thus I came to this study with a strong background in aged care from acute hospital to residential and community settings, both from a practice and management perspective and with a passion for ensuring that older people experience a high quality of life, together with a passion and drive for developing the occupational therapy profession. Being both an occupational therapist and an occupational scientist, and an educator in both areas, I bring to the study a particular set of values and beliefs. In searching the occupational therapy literature I came across a set of occupational therapy values that had been constructed by a group of Canadian occupational therapists. An adapted set of these values is included in table 1 as they succinctly capture the values and assumptions that I bring to this study. In attempting to articulate those beliefs it enables the reader to understand my perspective, and to determine its influence on the outcomes of the study. More importantly it enabled me to engage reflexively with my values and assumptions and their impact on the study throughout.

Occupational therapy values statement
As occupational therapists we value: the individual, human life, occupation. We believe that humans are occupational beings and that: • Every individual has intrinsic dignity and worth • Every individual has the right to autonomy • Each individual is a unique whole • Each individual has abilities and competencies • Each individual has the capacity for change

- Individuals are social beings
- Individuals shape and are shaped by their environment

We believe that occupation is a basic need, that:

- Occupation is an essential component to life
- Occupation gives meaning to life
- Occupation organizes behaviour
- Occupational has developmental and contextual dimensions
- Occupation is socio-culturally determined

Table 1 Occupational values statement adapted from Polatajko 1992

How the thesis will unfold

Thus far in this chapter I have discussed the importance of considering questions about well-being, in particular for older people. With growing interest generally in well-being and with growing numbers of older people it would be useful to have a clear idea about what older people understand well-being to be. I have highlighted that well-being appears to be a concept that is accepted by the lay mainstream and occupational therapists, yet does not have a clear definition, its definition being assumed or taken for granted. I have also indicated why I was drawn to a qualitative approach in this study. Having discussed how I came to be interested in exploring questions about well-being and older people, and my use of reflexivity throughout the study, I turn now to discuss the organization of the thesis.

In chapter two of this thesis I review the literature related to well-being and older people. It is my contention that well-being is a contested concept with authors assuming the reader has a shared understanding of well-being or using the word interchangeably with other terms such as life satisfaction. I will also argue that there is very little evidence of the older person's views on what well-being is in the literature. In the last section of the chapter I aim to establish that well-being is a central concept to occupational therapy. Given the centrality of

well-being it is important that research is conducted to further our understanding of what well-being might be for older people. Furthermore, if occupational therapists are working with older people to achieve well-being then it is imperative to have an understanding of the older person's view point.

In Chapter 3 I describe the research approach chosen for my study, grounded theory. I describe what grounded theory is, its theoretical orientation, and the various elements that make up a grounded theory approach. There are a number of versions of grounded theory emergent as the approach evolves and is modified by different researchers. I have chosen to follow a traditional 'Glaserian' approach and I provide a rationale for my choice. I also present the argument that grounded theory is a research approach suitable for occupational therapy researchers aiming to derive theories to underpin occupational therapy practice. It is timely for the occupational therapy professional body of knowledge to have more of its own unique theories that are supported by empirical research.

Building on the discussion of what grounded theory is, in Chapter 4 I describe in step-by-step detail how I conducted the study. To this end I describe the selection criteria for participants along with the sampling approaches and details of how participants were recruited. My choice of data collection approach, semi-structured in-depth interviews, is presented together with a rationale for this choice. Ethical considerations prior to the study and those arising during the study are discussed, in particular the ethical issues related to interviewing potentially vulnerable participants who would not directly benefit from being involved in the study. The process of analysis is detailed along with the strategies used to ensure a rigorous study.

The findings of the study are presented in chapters 5, 6 and 7. I found it quite a challenge to present the findings in a way that is logical and with a minimum of repetition given the inter-related nature of the emergent theory, particularly given the linear structure of a thesis. So I begin by giving an overview with a diagrammatic representation of the theory that depicts the basic social problem, the core category and how all the other categories relate to it, and the basic social process. A second copy of the diagram is included as a pull out card at the rear of the thesis. If pulled out while reading the analysis chapters, the reader is able to consult the diagram as they read the discussion, thereby providing a ready road map to assist with navigation through the material presented. I begin chapter 5 with a descriptive overview of the theory, and then I present the core category 'perceived control'. Chapter 6 presents the categories 'challenge to equilibrium', 'personal resources', 'up to me' and the remaining category 'feeling comfortable and secure' together with a description of their properties. This is followed in chapter 7 with a description of the basic social process 'trading off'. I argue that use of the basic social process 'trading off' enables the older person to experience well-being. I begin to consider how occupational therapists might use this information about 'trading off' in their clinical practice with older people.

In the concluding chapter, chapter 8, I pause to reflect on the aims of the study and how I have worked to achieve them, along with limitations of the study, before drawing together implications of the findings from this study for occupational therapy knowledge, practice and education. Particular focus is given to how the theory generated about well-being and the use of trading off contributes to an understanding of theoretical conceptualisations of occupational adaptation, and theoretical models incorporating the person, environment, and occupations. Implications for practice are applicable at the individual, group and community level. Specific attention is given to the notion of how occupational therapists can contribute in

occupational ways to building social capital to further support older people to achieve well-being, before offering some concluding remarks.

Conclusion

In this chapter I have laid the foundations for my thesis by presenting a background to the study and a description of the broad context in which the study took place. I have addressed the questions: Why well-being and why older people? To answer these questions I have begun by arguing that there is a growing interest in the concept well-being as people increasingly seek the 'good life'. At the same time there are growing numbers of older people in the population increasing the likelihood that occupational therapists will be working with more older people in the future. Therefore understanding well-being from the point of view of older people is very important for occupational therapists. I outlined the genesis of my interest in the study and the previous work I have done in the area, which led me to undertake this qualitative study. I provided a discussion of what the reader can expect in subsequent chapters. I turn now to review the literature to explore how well-being is conceptualised and how the perspective of the older person is represented.

Chapter 2: Well-being and older people: A review of the literature

Introduction

In the introductory chapter I established that there is growing interest in the concept well-being. I highlighted the need to better understand what well-being is for older people given that the numbers of older people in the population are growing, and many older people are living longer post-retirement, and from an occupational therapy point of view, well-being is a potential desired goal of therapy. I argued that a qualitative research design will be best suited to exploring well-being with older people, and in keeping with the reflexive approach used throughout the thesis introduced myself as the researcher. In this chapter I explore what definitions of well-being are used in occupational therapy, and establish the gaps in our current understanding. I argue that well-being is a core concept within occupational therapy justifying the need to develop our understanding. I describe the results of a search of the occupational therapy and gerontological literature to explore and/or answer the following questions: What is well-being, how is it conceptualised, with a particular emphasis on occupational therapy, and does the conceptualisation include the perspective of the older person? I will begin that exploration by considering how well-being is defined.

Defining well-being in occupational therapy

According to the Merriam-Webster's Collegiate Dictionary (2002), well-being is 'the state of being happy, healthy, or prosperous' (p. 1971). In The Original Roget's Thesaurus (American Heritage Dictionary 1980), well-being is associated with words like happiness and euphoria. Another logical port of call when looking at how well-being is defined and understood in occupational therapy practice is the texts conveying and teaching about that practice. Surprisingly, few precise definitions of well-being can be found in occupational therapy texts.

(Christiansen & Baum 1997) in their glossary define well-being as 'a subjective sense of overall contentment, thought to be defined by affective state and life satisfaction' (p. 606). Reed and Sanderson (1999) identify well-being as a central concept for occupational therapy, and they state that well-being is 'feeling good'(p. 72). However, there is no further expansion of the concept in their text.

In her text explicating the relationship between engagement in occupation and health, Wilcock (1998a) states that the feeling of well-being 'is as intangible and amorphous a concept as charm and style'(p. 98). It seems somewhat incongruous that a leading occupational therapy theorist finds it difficult to define well-being. Given the centrality of the concept to occupational therapy, this alone strongly points to the need for more research. Wilcock suggests however that there are three aspects of well-being, in alignment with the World Health Organisation's definition of health (World Health Organisation), which are, physical, mental and social well-being. The occupational theory of human nature described by Wilcock proposes that people need to make use of their physical capacities in order to enjoy physical well-being, and that this can be through engagement in individually motivating and ongoing occupations. To achieve mental well-being, individuals need to experience a range of occupations that will enable each person to be creative, with a balance of occupations that provide intellectual challenges, spiritual experiences, emotional highs and lows, and relaxation. Social well-being results when the range of each individual's occupations and roles enables maintenance and development of satisfying personal social relationships. Within her theory, physical, mental and social well-being cannot be easily separated, as they are part of an integrated system. Wilcock cites some empirical evidence to support her theory; however, some of the evidence cited comes from studies on happiness or life satisfaction. I contend that the concepts of happiness and life satisfaction cannot be directly equated with well-being, yet it is apparent that these words are used interchangeably in the

professional literature. There does not appear to be a clear definition of what occupational therapists mean by well-being.

Well-Being Literature Review

Search Process

Having searched the standard occupational therapy texts for definitions of well-being my search moved to other literature. Using the key words wellbeing or well-being, in the English language, the following bibliographic databases were searched: Sociological Abstracts, Medline, CINAHL, Ageline, Psychlit, Current Contents, Expanded Academic ASAP, and AMED. In the larger databases, this resulted in many thousands of citations, so the search was then further limited to the years since 1990, with the inclusion of the key word, elderly. Despite the limitations on the search some databases still returned approximately 2,000 records. The search did not include well-being from a macro-economic perspective, or caregiver well-being as that was considered beyond the bounds of this exploration. The focus of this search was on well-being for individuals, which is usually how the concept is used in occupational therapy (Reed & Sanderson 1999). It was not feasible to obtain every journal article, but as many as possible were obtained and read. For those not able to be accessed the abstract was used. Some articles published before 1990 were included, as they appeared to be seminal articles.

It is acknowledged that limiting the review of the literature to the notion well-being may have led to the omission of relevant related literature. The decision at first was pragmatic, however as the review progressed it was evident that the term is often conflated with other terms such as life satisfaction or happiness. The decision to focus the scope of the review on well-being only was confirmed by this discovery so as not to further "muddy the waters".

On reviewing the literature 3 key points emerged. First, the definition of well-being is usually assumed, or is lacking in clarity, and a range of similar terms are used interchangeably. Second, well-being has often been measured in research using various scales, which may not capture the complexity of the concept. And third, the perspective of the older person is often missing in discussions of well-being. Each of these points will be explored more fully in the discussion to follow.

Occupational therapy literature

In the occupational therapy literature, an Australian study by Wilcock et al (1998) is one of the few examples of an attempt to ask people for their definition of well-being. They surveyed 7 groups of people (N=138) asking them how they would describe well-being. The convenience sample consisted of high school students, residents of a retirement village, members of family units, residents of a suburban neighbourhood, shoppers in a city shopping mall, churchgoers, and 4th year occupational therapy students. The four most common responses described well-being as having a sound mind, having a physically good body, being happy, and feeling good about oneself. Half of the sample said that they experienced a feeling they would describe as well-being frequently. The subjects associated feelings of well-being with environments or situations, with 56% associating well-being with relationships and 37% with surroundings. The majority of those in the sample were women who were fit, single and young, and the authors recommended that the study be replicated with a more representative sample of the general population.

Law, Steinwender and Leclair (1998) conducted a review of 22 studies that examined the relationship between occupation and health, and well-being. The authors state that well-being refers to the integration of a person's physical, mental, emotional, spiritual and social characteristics. This definition has some resonance with that of Wilcock (1998a), in that it

acknowledges the combination of physical, mental and social elements. The authors drew on the nursing literature and used Orem's (1995) definition of well-being as: 'a perceived state of harmony in all aspects of one's life. It is a state characterised by experiences of contentment, pleasure, by spiritual experiences, and a sense of happiness' (p. 83). However, how Orem's definition of well-being guided the choice of studies for inclusion in the review was not clear; for example, the authors appear to include the term life satisfaction in reference to the same construct as well-being. They concluded that there is moderate to strong evidence that occupation has an important influence on health and well-being, yet we are still left with the view that well-being can be used interchangeably with other concepts.

Social science, medical and allied health literature

As in the occupational therapy literature, the majority of the studies reviewed in the social sciences, medical and allied health literature did not specifically define well-being, other than to explain how it is measured in the study. In the psychological literature well-being is referred to as subjective well-being with the topic gaining considerably in popularity over the last twenty years judging by the numerous studies. Lawton (1983) suggests that psychological well-being is made up of four domains: perceived congruence between desired and attained goals, sometimes referred to as life satisfaction; positive affect; negative affect; and happiness. The domains offered reflect how, in the literature, the words well-being, life satisfaction and happiness are often used interchangeably, which again leads to a lack of clarity of the concepts including that of well-being. Before examining other similar terms that are used in the literature to describe well-being I turn now to establish that well-being is a central concept within occupational therapy.

Well-being as a core concept within occupational therapy

Over recent decades there has been a resurgence of interest within the occupational therapy profession for the value of everyday occupations. As Kielhofner (1997) states 'Occupational therapy seems to have rediscovered the centrality of occupation to human life and well-being' (p. 85). It is increasingly acknowledged that people need to engage or participate in occupations to experience the "good life", in other words, well-being. Or to quote Bing (1986), 'The grand tasks of occupational therapy are to attend to the multiple, complex, interrelated, and critical human activities of not just living, but living well.' (p. 671)

Reed and Sanderson (1999) in their text introduce the reader to the core concepts in occupational therapy. They chose to organise their list according to recommendations by Golledge (1968) by examining the concept in relation to its characteristics, the focus and the relevance for occupational therapy. Well-being is included in that list, with characteristics of 'feeling good', the focus being on the client, and in terms of relevance to occupational therapy, well-being is named as a core concept.

One of the major occupational therapy texts by Christiansen and Baum includes well-being in the title of the 2nd edition, with the structure of the text being organised around a model of occupational performance leading to well-being. This reflects the significance of well-being as an outcome of therapy, however the concept receives only cursory attention in the text. In the 3rd edition only recently launched on the market well-being is still in the title and includes a chapter by Wilcock on occupations and health and well-being. In an Appendix Reed (2005) offers an annotated history of key concepts within occupational therapy. Well-being is included as a concept relating to the outcome of therapy. Reed suggests that well-being began to emerge as a concept in the occupational therapy literature in the 1980's. She cites definitions of well-being by Johnson (1986), Christiansen and Baum (1997) and Wilcock (1998a). Reed also connects the concept of well-being with the International Classification of

Impairment, Disability and Handicap-2, which defines well-being as 'a general term encompassing the total universe of human life domains including physical, mental and social aspects, that make up what can be called a "good life"'. (p.163) The short section on well-being is concluded with the statement that the concept does not appear to be well developed in the occupational therapy literature, yet acknowledges that Wilcock (1998a) has provided some direction.

Wilcock tends to discuss the concepts of health and well-being together because of her use of the WHO definition of health as " a state of complete physical, mental and social well-being not merely the absence of disease or infirmity" (World Health Organisation 1999). Wilcock goes so far as to suggest that this definition of health is one of the most important definitions ever created. She suggests that if we take it seriously then it demands exploration to find out how to achieve a state of complete physical, mental and social well-being. The WHO definition of health is widely accepted within the occupational therapy profession, thus it becomes important to understand what well-being is and how it relates to engagement in occupations. Therefore this study aims to develop the understanding of the concept of well-being with a particular focus on older people.

Well-being is noted as the outcome for a number of occupational therapy practice models. An adaptation of a table in a chapter written by Bonder (1997) summarises the key occupational therapy theories that have outcomes involving well-being (refer to Table 2).

Occupational therapy theory	Outcome
Model of Human Occupation (Kielhofner 1985),	Well integrated behaviours lead to well-being
Occupational adaptation (Schkade & Schultz 1992)	Effective adaptation leads to mastery and well-being
Person- environment- occupational performance (Christiansen and Baum, 1991, 1997)	Occupational performance, well-being and health

Table 2 Key occupational therapy theories with outcomes involving well-being

It is quite striking that so little is written or known about such a core concept within the profession. Well-being is noted as the outcome of occupational therapy practice yet it seems that as a profession there is a lack of clarity about what it is, and whether it is the same or different to health. This clearly points to the need for research to be conducted to articulate the process involved in achieving well-being.

Occupational therapy and older people

Literature on aspects of occupational therapy practice and older people abound and it is beyond the scope of this review. Any occupational therapy studies of older people and well-being have been included already. It is however important to include two recent reports on the effectiveness of occupational therapy for older people. The first study by Carlson, Fanchian, Zemke and Clark (1996) was a meta-analysis of 15 publications and found that occupational therapy services for older people produce positive results across a wide range of treatment contexts. The positive results covered a range of domains including activities of

living, daily functioning, and psychosocial well-being. The meta-analysis did include a number of studies of older people in nursing home settings.

This brings us to the second study, a systematic review of occupational therapy for community dwelling older people (Steultjens et al. 2004). The review concluded that there is some evidence for efficacy of comprehensive occupational therapy on functional ability, social participation and quality of life. Steultjens et al also concluded that there was insufficient evidence for the efficacy of counselling the primary caregiver of clients with dementia about the maintenance of the client's abilities. For further reviews or meta-analyses to be conducted to contribute to a more evidence-based practice occupational therapists need measures that have good face validity and are grounded empirically. Currently such measures do not exist for well-being. Further knowledge gained from this qualitative study from the perspective of the older person will contribute to the development of better ways of measuring complex concepts like well-being.

Having established that well-being is a core concept within occupational therapy and the need to explore understandings of well-being I now discuss a similar term that has gained some recent popularity, successful aging, to clearly differentiate it from well-being.

Ageing successfully

Successful ageing is a term that is used interchangeably with that of well-being, having emerged in the gerontological literature of the late 1990s. In writing about successful ageing, Bevan and Jeeawody (Jeeawody & Bevan 1998) suggest that 'the notion of wellbeing rests on a fulcrum which creates a balance for individuals to enjoy life to the full, irrespective of the conditions which affect them or the situation in which they find themselves' (p. xxv), and that successful ageing implies an optimum level of well-being. In a 12 year longitudinal study,

Roos and Havens (1991) defined successful ageing in terms of positive self perception of health, independence in self care and mobility, competent cognitive function, and minimal receipt of home services.

Jorm et al (1998) commented that a major problem in researching successful ageing was that the concept could be operationalised in different ways. Some researchers have defined successful ageing purely in physical terms, while others have included both physical and cognitive dimensions, and still others have only included psychological dimensions. Rowe and Kahn (1998) in reporting the MacArthur Foundation Study of Ageing defined successful ageing as 'growing old with health and vitality' (p. 23), in contrast to usual ageing which is older people who are functioning well but who have a heightened risk for age associated disease or disability. They suggested that there are three characteristics of successful ageing: low risk of disease and disease related disability; high mental and physical function; and active engagement in later life. Feldman, Kamler and Snyder (1996) warn against the creation of impossible stereotypes of what they call super-ageing. The use of the term "successful" can be viewed as value laden and implies that some older people are ageing poorly or unsuccessfully and are therefore failures.

Differentiating between concepts such as well-being and successful ageing is difficult; however, it appears that successful ageing implies an external evaluation on certain criteria, whereas well-being is a state experienced by the individual. The distinction is subtle, and there is currently not enough information to distinguish the terms further.

It is evident, from the literature reviewed thus far, that agreement is lacking in the literature on what well-being is; and at times there is a lack of clarity about how the term is being used, particularly with respect to its seeming interchangeability with other terms. It is also

frequently assumed that the reader will share the same definition as the author. This lack of clarity on what well-being is gives cause for concern. If the term is not well defined, how will occupational therapists know when their clients achieve a sense of well-being? That leads us to consider how well-being is measured as a way of exploring how the concept is defined.

Measurement of well-being

Well-being is usually measured using one or more quantitative scales, either as a single item global measure, or as multiple item scales. All of the single item scales ask participants to respond to a single global question about how happy they are, or to rate how satisfied they are with their life, on a certain scale. Single item scales have obvious appeal because of their brevity and ease of administration; however, there are also disadvantages. Scores tend to be skewed, with most answers falling in the happy categories (Andrews & Withey 1976). Single items cannot cover all aspects of subjective well-being; however, Diener (1984) suggests, 'they are adequate if a very brief measure of global well-being is required' (p. 544). Euler (1992) argued that simple measures of life satisfaction only moderately correlate with deeper measures of well-being among older people. Single item measures such as the Cantril ladder are a weak measure yet it is often assumed to measure a deeper level of well-being. This means that researchers often turn to multiple item scales in an attempt to overcome the drawbacks of the single item measure.

Of the multiple item scales, there are some that measure well-being, while others measure happiness, morale or the balance between positive and negative affect. It is not the intention of this chapter to provide a critique of the psychometric and other qualities of the scales of well-being; that is provided elsewhere (for example, see (Larsen, Diener & Emmons 1985). However, it is evident that there is little agreement about what subjective well-being is, apart from it seeming to be conceptualised as having two main dimensions, that is, (a) a cognitive

judgement of one's quality of life (life satisfaction), and (b) the affective experience (happiness) (Andrews & McKennell 1980; Chamberlain 1988). Scales of happiness or affect balance are often used in combination with scales of life satisfaction. For example, Christiansen et al. (1999) used personal project methodology to explore the relationship between occupation and subjective well-being, by summing the scores of the Affect Balance Scale and the Life Satisfaction Index (Form A) to obtain a single score of well-being. Other examples of combining an affective measure with a measure of life satisfaction can be found in Bowsher and Gerlach (1990), Friedman (1997), and Heidrich & D'Amico (1993).

The single and multiple item scales included in this discussion are the most frequently used for the measurement of well-being, according to the literature reviewed. Simply because of their frequent use, they have become acceptable and recognised ways of measuring well-being, and researchers are likely to continue using them in the future. However, there are disadvantages in using a scale to measure a concept like well-being. One has to question whether the scales have content validity, that is, are they measuring what they purport to measure? The response bias has already been noted for single item scales, and may also be present in the multiple item scale. In many studies, the assumption is made that, if a person's life satisfaction scores and affect scores are both measured, then the researcher will obtain a measure for their well-being. Is this really the case?

A surprising finding from the review was the number of studies that included a measure of depression as a measure of well-being, where psychological well-being appears to be measured as it relates to the reported absence of pathology (Bennett 1997; Graham & Schmidt 1999; Miller & Lago 1990; Silveira & Ebrahim 1998; Takahashi, Tamura & Tokoro 1997). Presumably it is assumed that, in the absence of depression, the individual must be

experiencing well-being. That seems to be a somewhat limited and unsatisfactory way of conceptualising well-being for older people.

A large number of studies use various life satisfaction scales to measure well-being (see, for example, (Bennett 1997; Bisconti & Bergeman 1999; Ducharme & Rowat 1992; Searle et al. 1995). Euler (1992) states that the use of life satisfaction scales exceeds the use of deeper psychological measures, such as depression, by a ratio of roughly 4 to 1. The most commonly used scales are the Life Satisfaction Index, Form A (Neugarten, Havighurst & Tobin 1961) and Form Z (Wood, Wylie & Sheafor 1969), and the Satisfaction with Life Scale (Diener et al. 1985). Factor analysis of life satisfaction scales indicates that the measures all seem to be tapping a shared "satisfaction" construct, which seems to be a somewhat shallow approach to well-being for older people. Euler (1992) argued for the use of measures of a deeper level of well-being and in his study used scales based entirely on Erkison's life cycle theory. These scales do not appear, however, to be widely used to measure well-being, but it is unclear why (Euler 1992).

Lo (1996) studied the relationship between daily occupational affective experiences and subjective well-being, with a sample of 60 students of occupational therapy and physiotherapy. The students recorded their daily occupational activities in a time diary, and completed two measures of happiness and two of life satisfaction. The results of the study partially supported the hypothesis that the levels of subjective well-being were related to daily occupational experiences, though only the scales that measured the affective component of well-being gave significant correlations. Generalisation from the findings of this study is limited, given the homogeneity of the sample in terms of age, education and socio-economic status. Similar studies of older people have not been found, apart from that reported by myself (Stanley 1995) in which I attempted to correlate time spent in daily activities with a

life satisfaction measure rather than a measure of well-being. I did not find any significant relationship between time spent in valued occupations and life satisfaction, and concluded that qualitative methods would be more useful for accessing information on how older people feel about what they do, and how that contributes to concepts such as life satisfaction or well-being.

Reconceptualising well-being

In examining how well-being has been measured it has become evident that there is a lack of consensus about what well-being is. Concern about the quality of existing scales of well-being led Ryff (1989) to publish a critique of the indices of well-being, concluding that the most popular and most commonly used scales were lacking in theoretical grounding. Having examined the literature on what Ryff prefers to call positive functioning, she proposed that the concept of well-being was made up of the following aspects:

- self-acceptance representing a positive evaluation of oneself and one's past life;
- positive relations with others;
- a sense of self determination or autonomy;
- environmental mastery, being the capacity to manage one's life and surroundings;
- having meaning and purpose in one's life; and
- a sense of continuing development as a person or personal growth.

She went on to define each of these aspects, operationalise them, and conduct a study comparing the new measures with six previous measures of well-being (Ryff 1989). Results revealed that four of the measures, positive relations with others, autonomy, purpose in life, and personal growth, were not strongly correlated to previous measures of well-being. The results partially supported her claim that key aspects of well-being were not presently represented in the empirical arena. Ryff suggests that too much emphasis has been given to

short-term affective well-being, and not enough attention paid to the ongoing life challenges of sense of purpose, having satisfying relationships with others, and achieving self actualisation – all of which she considers central to psychological well-being. There is some growing interest in the use of Ryff's scales (see Heidrich 1993 and Heidrich 1998).

Ryff and Keyes (1995) tested the scales on a nationally representative sample and compared the scores with 3 prominent indicators from prior research, that is, happiness, life satisfaction and depression. There were moderate to strong associations between self-acceptance and environmental mastery with the single and multiple item scales of happiness, life satisfaction and depression. However, the remaining 4 scales showed mixed or weak relationships with the prior indicators. The authors suggested that continued use of the usual indicators results in neglecting key aspects of well-being, and concluded that there is more to well-being than feeling happy and satisfied in life. Subsequently, a national Canadian study has been conducted with a modified version of Ryff's scale, reducing the number of items from 120 to 18, being 3 items for each of the six dimensions of well-being (Clarke et al. 2000). The reduction in the number of items should make the scales more user friendly.

Ryff's scale appears to offer some promise as it has a strong theoretical base and takes a very holistic approach to well-being. From the literature reviewed, it seems that well-being is mostly perceived and measured as being either physical or psychological. While separate scales of physical and psychological well-being have their place, occupational therapy practice would want to consider well-being for older persons from a more holistic perspective, not divided and reduced to physical and psychological states. Ryff and Singer (1996) proposed that the more richly detailed life histories of individuals would provide a greater explanation of well-being than summary measures of socio-demographic factors. Qualitative

forms of inquiry are more likely to reveal a more holistic approach to the construct of well-being, one that is potentially more consistent with the philosophy of the profession and which may inform more holistic practice. Qualitative research may also be used to gain the perspective of the older person.

The missing older person's perspective

In returning to one of the original questions underpinning this chapter, that is, does conceptualisation of the concept of well-being in the literature include the perspective of the older person, it can be seen that thus far, the perspective of the older person is conspicuously absent from the literature reviewed. Only a small number of qualitative studies of well-being in older people were found that attempted to incorporate and/or focus on the perspective of the older person.

Ludwig (1997) reports on how routine facilitated well-being for a sample of seven women over the age of 70 in the United States. The study aimed to gain information about the conditions and processes that enhance occupational meaning. Ludwig proposes that, if occupational therapists can better understand how a client makes meaning of his or her life through engagement in occupations, then they can treat the client more effectively. This grounded theory study has enabled the development of a theoretical model to describe the primary conditions and processes through which routines may be used to maximise well-being. Enhanced understandings of well-being such as that proposed by Ludwig, thus have the potential to provide the basis for subsequent occupational therapy practice. Routines were linked with nine adaptive outcomes for the participants: meet obligations; maintain activity level; maintain health; anticipate or look forward to things; maintain control; balance work, rest and play; accomplish and achieve; feel good about self; and provide continuity. The outcomes constituted well-being for the study participants. This study was limited to women,

because of documented differences in time use by different gender groups, highlighting the need for a study of well-being that includes both genders. However, the results of this study offer useful information to occupational therapists and others about the use of routine by older women; and help to confirm some assumptions that underlie occupational therapy philosophy, and hence practice, about the relationship between engagement in occupations and positive health outcomes. Unfortunately Ludwig, while providing valuable information around the area of well-being, did not precisely define the use of the concept of well-being in her study.

Clark et al (1996) interviewed 29 residents of an apartment complex for well, older adults with low incomes, to document their perceived life domains of importance and associated strategies of adaptation. The data from the interviews was analysed by the interviewers who developed typologies of life domains and major classes of adaptive strategies. The investigators then further developed the typologies. One of the ten life domains was psychological well-being and happiness, which concerned living a satisfying and happy life. The adaptive strategies identified were '1. keeping active by engaging in worthwhile activities; 2. using formal professional services to remain happy or well; 3. maintaining a proper, positive state of mind; 4. treating other persons properly' (p. 107). The authors suggest that the adaptive strategies "constitute a collection of helpful hints" (p. 105) available to both older people and occupational therapists who are working with older people. This study adds valuable information about possible strategies that older people could use to enhance their well-being. Further research is needed to determine if the strategies generated from studying older people in a low-income apartment complex in downtown Los Angeles are useful to older people in other parts of the world, and specifically Australia.

Another American study of women only over the age of 85 and living in the community asked them to identify what growing older was like and what it meant to them (Lysack & Seipke

2002). The women judged their own well-being in relative terms making comparisons with other women they knew. Well-being was more closely linked to their functional ability rather than their medical condition, as it was important for the women to be able to complete the activities that made up their traditional role as a woman. For the women it was possible to have good health despite having a chronic condition. If they were not able to complete their usual activities then they used a strategy the authors called "communicative compensation". This involved either talking about the past when they were able to complete activities or having a justification for their inability to complete tasks.

In another occupational therapy study, Hasselkus (1997) explored the well-being of day care clients with dementia, from the staff's perspective. Hasselkus interviewed day care staff and asked them to describe especially satisfying and dissatisfying experiences of care. The narratives were analysed phenomenologically to gain an understanding of occupation as it was lived by the staff members in these experiences of day care. The staff members described a process of connecting with the individual client, enabling the client to engage in some occupation, which then led to the client appearing to experience well-being. Observable indicators of well-being, as described by the participants, were smiles and laughter, signs of affection and friendliness, attentiveness and more settled behaviour. This study further illuminates the place of occupation in promoting the health and well-being of clients with dementia, when their ability to participate in occupation is diminishing. Studies like this need to be conducted with the participation of older people, to find out how well-being is achieved and maintained from the point of view of the people themselves.

In a Slovenian study, Piskur, Kinebanian and Josephsson (2002) conducted focus groups with people aged 25 to 65 years of age and asked questions about engagement in occupations and well-being. For their participants occupation was used as an organizer of a preferred temporal

rhythm, as an opportunity to experience mastery and control, as a facilitator of social connectedness and as a way to connect and contribute to family and society. Older people were not represented in the sample group and the authors posed the question, is well-being experienced differently by different groups of people?

There are two Australian qualitative studies of women's ideas around aging and well-being, one focusing on rural women (de la Rue & Coulson 2003). For the rural women their relationship with the land was enmeshed with thoughts of well-being. Living on the land was a way of life and gave their life meaning. Well-being was also related to their self-perception of their health, being fully occupied and busy and having a positive mental approach to life. The other study from metropolitan Melbourne involved women who had participated in writing workshops (Feldman 1999). Again health was of central importance and the key determinant of the ability to remain independent and autonomous. Dependence on others was not desirable as it threatened one's self-respect and dignity. Both of these studies are with women so there is a need for the addition of the Australian male perspective.

Within the nursing literature, one example was found of a qualitative study utilising grounded theory, which resulted in the author proposing an Ecological Well-being Model (Ruffing-Rahal 1998). The three core themes that arose from her interviews with older women were activity, affirmation and synthesis. Well-being was characterised by engagement in meaningful activities, perceptions of a positive continuity over the life course, and the reconciliation of negative experiences into an overall personal framework of meaning. A conceptual model of well-being was depicted by Ruffing-Rahal; however, in my opinion, while offering much potential, the model needs further development, particularly in helping the practitioner move from the model to its application in practice. One measure of the success or usefulness of a conceptual model is whether other researchers continue to test the

model in further studies. At this stage, it does not appear that Ruffing-Rahal's model is being applied or researched by other authors.

An older Canadian study offers some insights into well-being (Thorne, Griffin & Adlersberg 1986). The well seniors were asked about health and well-being and the findings revealed that health and well-being were experienced at 3 levels. The first level was concerned with comfort and abilities, which was in contrast to experiencing chronic illness, physical discomfort and limitation of mobility. The physical aspects of health were only important if they impinged on the older person's ability to experience health and well-being at other levels. The second level was related to connectedness and competence where older people gained meaning in their life through relationships with others and engaging in activities that enabled them to demonstrate the skills and abilities acquired over a lifetime. The participants were interested in protecting their independence and self control, however independence was viewed more as interdependence rather than as aloneness or control over others. The third and highest level was a sense of meaning that enabled the older people to still feel healthy despite some physical discomfort, disability or decremental loss of lifestyle. The older people could adapt as long as their life had a sense of meaning. This phenomenological study has supplied some insights into the experience of well-being, but we still need to know more about the process of how well-being is achieved.

An interesting Scandinavian study selected participants from a larger study of nonogenarians. Participants were selected according to their scores on measures of well-being with 6 from the group who scored highly and 6 from the group who scored low. The findings revealed the following categories: outlook on life; social and emotional ties; engagement with the outside world; and physical capability. Those scoring high on the measures of well-being tended to have a more positive attitude to life in old age, had adjusted well to being old and mostly

continued to live in a way they found satisfactory. In contrast those who scored low on well-being measures tended to be negative about being old either because they had become trapped in the past or were disappointed with their current life. For this group the present had failed to offer much happiness and they had little to look forward to in the future. The values of pride in independence and not being a burden on others were strongly held. Again we gain insights about what well-being is like or not like, but the process of achieving well-being remains a gap in knowledge.

One other qualitative study into the related area of the experience of quality of life in old age by some older people in Sweden offers some insights (Nilsson, Ekman & Sarvimaki 1998). The results gave a varied picture of experiences of a good life that contrasts with the negative stereotypical images of old age. The qualities that contributed to a positive experience were: strong mental energy, family connectedness, a sufficient number of meaningful activities, and a sense that life had been worthwhile and that they had a meaningful future. The conditions have some resonance with occupational therapy philosophy, as well as the scales devised by Ryff referred to earlier in the chapter. This study was about quality of life and not well-being per se, but serves to illustrate the benefits of a qualitative approach.

This review of qualitative studies of well-being with respect to the older person has revealed some important contributions to the literature incorporating aspects of older persons' perspectives on well-being (summarised in table 3). However, the review has only found a small number of studies about the well-being of older people with few examples of Australian studies and men are not well represented. More qualitative work needs to be done in this area as qualitative forms of inquiry will give older people a presence, and promote acceptance of the views of older participants as legitimate. Qualitative studies are not the only research

approach to be used in studying well-being, but the approach adds another dimension to our understandings, a dimension which to date is largely absent.

Author	Focus	Sample	Design	Findings
(Clark et al. 1996)	How older people manage the challenges of life	20 women, 9 men	Descriptive qualitative	10 life domains and associated strategies
(de la Rue & Coulson 2003)	Meaning of health and well-being for older rural women	5 older women	Life history	Living on the land and being connected to the land emotionally
(Feldman 1999)	What is integral to health and quality of life	40 older women in writing workshops	Memory work, storying	The power of the stereotype; health is of central importance; and living lone lives
(Hasselkus 1997)	Experience of occupation in day care centres for people with dementia	42 day care staff	Phenomenology	Well-being was achieved through *engagement in* occupation
(Ludwig 1997)	How routine is used to influence well-being	7 women	Grounded theory	Routine was linked to 9 adaptive strategies
(Lysack & Seipke 2002)	The meaning of aging and well-being for women	23 women over 85 years old	Grounded theory	Health and well-being judged in comparison to others, against a backdrop of traditional feminine activities, well-being linked to functional ability
(Nilsson, Ekman & Sarvimaki 1998)	Meaning of lived experience related to quality of life	30 people aged 82-92	Hermeneutic phenomenology	Successful aging related to good health, relationships, keeping busy, strong faith, past and present integrated, hope for the future.
(Piskur, Kinebanian & Josephsson 2002)	Slovenian's experiences of daily occupations and relation to well-being	24 people aged 22-65 years old	4 Focus groups	Occupation enabled organization of time; master and control; social connectedness; and ways to contribute to family and society
(Ruffing-Rahal 1998)	What well-being is for older women	No description of sample size or characteristics	Narratives, content analysis of field notes	4 themes of individuation
(Thorne, Griffin & Adlersberg 1986)	What constitutes health and well-being	15 older people	Descriptive qualitative	Well-being experience as comfort and abilities; connectedness and competence; and sense of meaning

Table 3: Summary of Well-being literature

What is known about well-being and older people?

A few recent Australian studies are worthy of consideration. Using data from the Victorian Quality of life panel survey and the International social science surveys, Headey (1999) found that older people were neither more or less satisfied with their lives than their younger counterparts, however older people did report fewer positive moods and emotions and less anxiety and depression. It appears that life for older people was 'on a more even keel' without significant highs and lows. Headey noted that Australians generally report high levels of life satisfaction and positive affect and low levels of anxiety and depression.

Bar-Turr, Levy-Shiff and Burns (1998) studied mental engagements as a moderator of losses for older men, where mental engagements are activities and interests which involve the person cognitively and occupy the mind, and emotional engagements are relationships with significant others. They measured well-being in terms of life satisfaction and morale, and found that both mental engagement with the present and emotional engagement with significant others contributed significantly to well-being. Present mental engagement appeared to mediate the negative impact of losses. Three categories of losses had a significant impact on well-being: loss of work, loss of health and financial loss.

Ranzijn and Luszcz (1999) investigated the relationship between acceptance and well-being based on Erikson's theory of the life goal in older adulthood, this being to achieve integrity versus despair. They found a significant relationship between acceptance and well-being and suggested that acceptance may be one of the ways in which older people adapt to some of the changes associated with aging. It appears that it is better for older people to accept the inevitable rather than let it pull them into despair.

More recently, Kendig, Browning and Young (2000)using data from the Health Status of Older People study with a sample of 1,000 people aged 65 and over, found that positive and negative mood were significantly correlated with major illness, pain and measures of activity. Positive affect was predicted by social support, gender and marital status. It appears that positive affect is only affected indirectly by illness when illness affects the person's capacity to engage in activities and everyday life.

Mookherjee (1997) studied older rural Americans with data from 10 years of General Social surveys and found that marital status, education and financial status were significant variables influencing perceptions of well-being. People with higher well-being were also more satisfied with their neighbours, hobbies, family relations, friendships, health and financial situation.

Conclusion

From this review of the literature, three key points have emerged. First, the definition of well-being is often assumed, or is used interchangeably with other concepts such as life satisfaction. Second, quantitative scales of subjective or psychological well-being are frequently used to measure well-being, even though there is little agreement amongst researchers about the concept of well-being itself. The third finding is that the older person's subjective perspective is lacking in all but a few studies. Use of qualitative studies that incorporate the perspective of the older person, to generate theories about well-being for older people could lead to the development of better ways for occupational therapists to practice that will enhance the well-being of the older clients that they work with. It could also lead to the development of new research tools that more accurately reflect what is important to older people.

Therefore in this study I will use a qualitative research design to answer the research question "What are older people's understandings and perceptions of well-being?" In the previous chapter I built a rationale for why this study needs to be conducted, and in this chapter I reviewed the relevant literature to establish what is already known about well-being, particularly with respect to the occupational therapy and related literature. In chapter three I will move on to discuss the particular qualitative research approach chosen to answer my research question, namely grounded theory.

Chapter 3: Tenets of grounded theory

Introduction

In this chapter the particular approach used in the study, grounded theory, will be explicated. Grounded theory will be described, along with a description of the theoretical orientation of symbolic interactionism, and how that informs the study. Description of the elements of grounded theory is provided including constant comparative method, memoing, theoretical sampling, core category, and theoretical saturation and sample size. A brief critique of grounded theory is offered together with a discussion of the choice of traditional Glaserian grounded theory for this study. The use of grounded theory in occupational therapy research is reviewed before the chapter concludes with a rationale for choosing grounded theory for this study.

Research paradigm

A qualitative research design has been chosen for this study. Qualitative research designs enable the researcher to capture the individual's point of view and secure a rich description of the individual's experiences within the context of everyday life (Denzin & Lincoln 1989). The focus is on the individual as a whole (Roberts & Taylor 1998), which is congruent with the holistic philosophy of occupational therapy. Qualitative research is based on the assumption that a central goal of enquiry is to understand the interpretations and meaning that persons negotiate in their natural settings (Carlson & Clark 1991). In the words of one of the best known occupational therapy theorists, Gary Kielhofner (1982)

> There is a special harmony between the concerns of occupational therapy and the paradigm and methods of qualitative research. Both focus on the realities of everyday life. Both appreciate the deep richness of mundane affairs. And both attempt to gear their techniques to the realities of the people involved. (p. 162)

It is assumed that knowledge is subjective and needs to be experienced to be understood. Therefore the researcher needs to be in close contact with people, situations and phenomena

under study. Ontologically the position is that of relativism, which acknowledges that there are multiple constructions of reality, dependent on the people who hold them. Reality is dynamic and constantly being negotiated (Minichiello et al. 1996). This is in contrast to studies in the quantitative paradigm where the position is that the social world can be reduced, objectified and measured. As the research question is concerned with trying to understand how older people make sense of the world to construct their perceptions and understandings of well-being, a qualitative paradigm is appropriate for this study.

Position of the researcher

When taking a qualitative approach to research it is important to consider the position of the researcher. Within the qualitative paradigm the researcher is not able to take the position of a distant objective observer removed from the action. The researcher attempts to discover and understand what the world is like for the participants and how it is constructed and experienced (Blumer 1969/1986). Bowers (1988) describes this ability as being '..able to maintain one foot in the world of the subjects and one foot outside the world, viewing actions from the perspective of the subjects while standing back and asking questions about what the subjects take for granted' (p. 43). Participants allow the researcher the privilege of entering their social world whilst the researcher attempts to interpret what they see and to attempt to capture the richness of everyday life.

The type of data that is collected and the way the analysis is conducted will be influenced by the position of the researcher. The questions asked in interviews and the follow up probing questions will be influenced by the background of the researcher. The analysis is interplay between myself as the researcher and the data as it is interpreted by me as the researcher. I have already described in the introduction to this thesis how I came to do this research study and what I bring to the study as a researcher to give the reader an understanding of my background and how this might influence the study. Researchers inevitably bring their prior

theoretical stance or research experience to the research endeavour (Bailey & Jackson 2003). Therefore, my background as an occupational therapist and an occupational scientist influences how I view and interpret data. This does not mean that I am able to make or force the data to conform to any preconceived ideas about what I might find, but acknowledges the relative subjectivity of the qualitative paradigm. The use of reflexivity and a detailed explication of the data analysis in the next chapter will lay out for the reader how I have kept the theoretical orientation of the chosen approach to this study, yet managed to tread that fine line between interpretation and 'forcing'.

Having considered the position of the researcher within a qualitative research study, I turn now to describe the particular type of enquiry for this study, namely grounded theory.

Grounded theory

Grounded theory is an analytic inductive technique based in the interpretive tradition that is used to examine social situations and the social construction of reality. Roberts and Taylor (1998) offer a simple definition of grounded theory as an approach that 'starts from the ground and works up in an inductive fashion, to make sense of what people say about their experiences, and then to convert those statements into theoretical propositions' (p. 102). For example, grounded theory has been used to study and produce theories about the process of death and dying in hospitals (Glaser & Strauss 1965), how women with postpartum depression regain control over their lives (Beck 1993), and the quest for equanimity by people with bipolar depression (Hutchinson 1993b). The aim of grounded theory is to generate theory that is "grounded" empirically, that is grounded in the data collected.

The approach was developed by two sociologists, Barney Glaser and Anselm Strauss in the 1960's and was first articulated in a text published in 1967 (Glaser & Strauss 1967). Strauss

was from the University of Chicago and strongly influenced by interactionists and pragmatists such as G.H. Mead, Herbert Blumer and John Dewey. On the other hand, Glaser was from Columbia University and was influenced by Paul Lazarsfeld and a quantitative research background. Together Glaser and Strauss developed grounded theory and conducted a landmark study of death and dying (Glaser & Strauss 1965).

Grounded theory aims to develop mid-range theory and is particularly useful in areas where little is known about the phenomenon of interest, or where there are few adequate existing theories to explain or predict a group's behaviour. Mid-range theory, as opposed to grand theories, which are complex and explain a broad area within a discipline, considers limited concepts and aspects of the real world. Substantive and formal theories are both considered to be examples of mid-range theory (Glaser & Strauss 1967). Substantive theory is theory that is developed for one particular area of enquiry, for example, the process of adaptation to disability following stroke, whereas formal theory is developed for a formal or conceptual area of enquiry. Using the same example, formal theory might describe the process of adaptation to any disability. Thus, formal theory emerges from a study of the phenomenon examined under several different types of situations (Glaser & Strauss 1967). The findings from this study, a mid-range theory, will contribute to the substantive area of well-being for older people. No claim is made to the development of formal theory, which is beyond the bounds of this study.

Assumptions

Having established that grounded theory aims to develop mid-range theory, and that it is timely and relevant for occupational therapy, it is important to examine the assumptions underpinning grounded theory. A number of assumptions underlie grounded theory, namely:

- Inquiry is directed as discovery of social and social psychological processes;

- Data collection and analysis are conducted simultaneously;
- the data collected further directs the process and outcome, it is not determined by preconceived theoretical frameworks;
- analysis aims at discovering and developing theory rather than verifying pre-existing theory;
- 'grounded theory methodology not only aims to study processes, but assumes that making theoretical sense of social life is itself a process' (Eaves 2001,p. 676); and
- systematic application of grounded theory analytical techniques leads progressively to more abstract conceptual levels (Charmaz 1994; Glaser & Strauss 1967).

Theoretical pillars

Grounded theory is informed by symbolic interactionism . Many sociologists, philosophers and psychologists have influenced the development of symbolic interactionism, most notably George Herbert Mead and Herbert Blumer. Bowers (1988) has defined symbolic interactionism as 'a social-psychological theory of social action' (p. 36). Symbolic interactionism focuses on the individual as a socially constructed being, and on the processes of social interaction by which individuals make sense of the world. The self is defined through the social roles adopted, the expectations associated with those roles, and the way those roles are viewed by society. The main components of symbolic interactionism are the self, the world and social action.

Denzin (1989) suggests that there are 3 basic assumptions of symbolic interactionism:

1. Each person's reality is a product of his or her social world. Interacting individuals produce their own reality, yet shared reality is created through social interaction;
2. Humans engage in self reflection or dialogue with themselves, and are capable of influencing their own behaviour and that of others; and

3. Humans interact with one another and make sense of the world through interaction.

Interaction is symbolic as it involves symbols, words, meanings and language. The researcher from the symbolic interactionist perspective is interested in discovering the realities of the research participants, the nature of objects in their worlds and how they define and experience their world. Drawing on the tenets of symbolic interactionism, grounded theory assumes that people order and make sense of their world, when it may well appear that it is disordered. Reality is therefore a social construct. In grounded theory the researcher looks for processes that are going on in social situations, and studies these in order to arrive at a theory that explains the action in the social context under study (Stern 1980). Therefore, grounded theory is particularly useful in areas where little is known about the phenomenon of interest or where there are few adequate existing theories to explain an individual's or group's behaviour. The focus is on everyday life situations where processes, relationships, meanings and adaptations require explication as it is assumed that people sharing a common circumstance will also share some common meaning related to that circumstance. The researcher attempts to discover the processes that people use to make sense of their situation. The resulting theory must be "grounded" in the data, that is, it arises from the data, in contrast to traditional or experimental research, where empirical work is designed to test a hypothesis derived from a theory or model. In other words, it is inductive rather than deductive in approach.

Data collection

Grounded theory questions focus on process, and so are often "how?" questions. For example, how do occupational therapists go about their work? How do occupational therapists think about and understand their work? How do occupational therapists define and use evidence? Grounded theory questions may also be "what" questions, such as in this study,

where the research question is 'what are older people's perceptions and understandings of well-being?'

A range of methods and techniques are used to collect data in grounded theory. Often these will involve in-depth interviews or participant observation, or a combination of both. The interview questions usually move from the general to the particular to elicit information about behaviour, as well as strategies, contexts, temporality and consequences of actions. For example, in Farber's (2000) study of mothering with a disability she began with the "grand tour" question, "what is the experience of being a mother with a disability"? Further questions, included "what was it like for you as a parent in the beginning and what is it like now?" as well as, "what do you think is most important for anyone to know about parenting?"

If using participant observation the researcher will focus on the social actors or participants involved, observing who is doing what, who is relating to whom and recording these details in field-notes for analysis. The researcher makes notes about both verbal and nonverbal behaviour, together with notes about how space is used, and the temporality of events. For example, in a nursing study of therapeutic touch (Heidt 1990) the researcher observed treatment sessions involving therapeutic touch, and noted all verbal and nonverbal expressions as well as all other body movements of the nurse and the patient.

Constant comparative analysis

Data analysis begins by analysing a transcript or field notes line-by-line and assigning "in vivo" codes. An in vivo code is a word or a short phrase that describes what is happening, often quite close to the original words of the participant. It can range from the simple and concrete to the complex and abstract. For example, the line of transcript "*I think just to, to*

enjoy your life within your capacity. And everyone has limitations on their capacity haven't they, and limitations on their interest too" (from the participant named Joan) might be coded, 'enjoy life within your capacity'.

Put simply, coding is the process of sorting, labelling and organizing the data (Charmaz 1994). In open coding initial categories of information are formed about the phenomenon being studied by segmenting information (Creswell 1998). The codes assigned in open coding often use the words of the participant and range from the simple and concrete to the complex and abstract. Table 3 gives some examples of pieces of text from this study and the assigned codes used in the open coding process.

Text	Code
I have a cat which is very important to me, who I love dearly, I think everyone has to have something in their house to love (Joan)	Everyone has to have something to love
I see this friend "S" every Wednesday, I see another friend on Tuesday, we go to the art gallery and have lunch in town (Bev)	Routine
I had to give that up (linedancing). Hopefully the swimming will take the place of that (Bev)	Replacing activities as can't do anymore
We do all our own gardening. I do all my own housework. (Elspeth)	Pride in being independent

Table 4 Examples of initial open coding

Codes are then clustered with similar codes into categories. As further data are collected, it too is coded and categorised. For example, the codes 'importance of family', 'importance of friends', and 'belonging to a club' were combined into the category 'being connected'.

Following initial open coding data in a grounded theory study are analysed using a process of constant comparative analysis (Glaser & Strauss 1967). Constant comparative analysis involves coding a unit of data and comparing it with all the other units of data coded in that category. It is a systematic tool for developing and refining the theoretical properties of a category, and if applied rigorously will assist the researcher to move from a simple description of the participants' categories to a theoretical level (Seale 1999).

Theoretical sampling

As early data are analysed and emergent themes arise theoretical sampling is employed (Glaser 1992; Glaser & Strauss 1967). The categories in the emerging theory determine where or from whom the next data is to be collected. Informants are sought whom are thought to be able to contribute further data relating to the important emerging theoretical constructs so that the constructs can be examined and elaborated further. Glaser and Strauss (1967) suggest that 'the basic question in theoretical sampling is: What groups or subgroups does one turn to next in data collection? And for what theoretical purpose?' (p. 47). Those questions guide the researcher as to which cases to study, which people to interview or which settings to observe in order to find things that might challenge and/or extend the emerging theory (Seale 1999). For example, in a study of how women managed post-partum depression, Beck (1993) chose to interview a woman who was pregnant for the third time and had suffered post-partum depression after each of her first two pregnancies to see if things were different from some first time mothers who refused to take the gamble on having post-partum depression again. Different questions may be asked of different participants as the theory evolves.

Memoing

During a grounded theory analytic process memos are written. Memoing is a way of preserving emerging ideas and hypotheses about the data as analysis is conducted. As ideas strike the researcher they are recorded in the form of a memo. If ideas are not recorded at the time they may well be forgotten and lost. The ideas arise as a result of analysing the data, and are thus "grounded" in the data. Bowers (1988) states 'Memoing is a crucial process for the grounded theory researcher...' (p. 51), and suggests that memoing serves several purposes. Firstly, to record the development of the theory including decisions about theoretical sampling, changes of focus in interview questions and tentative hypotheses. Secondly, to

record categories and ideas which seem to be unrelated to the emerging theory at that time for possible re-integration into the analysis at a later point. And thirdly, memos are used to record methodological decisions and problems. Bowers suggests that combined theoretical and methodological memos record the possible impact of methodological issues on the emerging theory. Memos are used to raise the data to a level of conceptualisation (Grbich 1999) and to locate the emerging theory within existing relevant theoretical frameworks (Glaser 1978). Memos themselves are also sorted and further memos written as the theory is developed (Grbich 1999). Examples of some memos written early in the analysis process are included below:

8th October
Routine

> Each of the people interviewed so far, when asked to describe how they spend their time give a description of the routine. They usually start with what time they get up and dressed for the day and also include the time they usually go to bed at night. There is variety in the amount of routine that is described. Some have routine in the day, others it is more commitments on different days of the week, or month. Connects to Ferol Ludwig's study of how routine facilitates well-being for older women. Leads to the question about how much variety in an individuals' routine leads to well-being? Can a highly routinized person, that is one who follows exactly the same routine every day, experience well-being? Can a person who doesn't appear to have any routine in their life experience well-being?

> Memo 28th July, 2001
>
> Importance of family and friends. What is it about family and friends? Is it connectedness? Continuity? Go back to the quote from Bev, something to do with friends - a sense of shared history.

Core category

Grounded theorists search for the social processes present in human interactions (Hutchinson 1993a). The aim is to identify a core category. A core category arises from the data, linking the various pieces of data together, and explains much of the variation between data (Hutchinson 1993a). Discovery of a core category is a requirement for a quality grounded theory study (Hutchinson 1993a). The core category is somewhat like a central theme and becomes the basis for the generation of theory. For example, Jonsson et al. (1999) in examining how people with poliomyelitis sequelae managed their occupations in everyday

life, identified the core category of 'keeping the balance for the present and the future'. The authors suggested that the strategies identified by the participants would be helpful to occupational therapists in promoting adaptive behaviour in clients with polio sequelae. Glaser (Glaser 1978) offers some guidelines for determining a core category:

- A core category is linked to as many other categories as possible;
- The core category occurs frequently in the data, thus a pattern emerges of the core category and its properties;
- Saturation of the category takes longer than any other category;
- The links between the categories are quickly revealed; and
- The core category has explanatory power for the total analysis.

All studies will have a core category, but not all studies will reveal a basic social process. The basic social process is similar to a core category, except it has two stages or phases that account for process or change over time (Glaser 1978). For example, in a nursing study of post-partum depression (Beck 1993), the basic social problem was loss of control, and the basic social process was identified as teetering on the edge, which referred to the women's perception of walking a fine line between sanity and insanity. Four stages were experienced as participants struggled with the problem of loss of control, namely encountering terror; dying of self; struggling to survive; and regaining control. In this study the core category to emerge was 'perceived control', which enabled participants to use the basic social process of 'trading off'.

Theoretical saturation and sample size

It is not possible to predict the sample size prior to commencing a grounded theory study. Data are collected until no new codes or categories emerge, thus achieving what is termed saturation. By achieving saturation the researcher ensures that the theory accurately reflects

the situation and the result is a rich "thick" description. As the researcher sees similarities in the data again and again the researcher becomes confident that a category is saturated. Glaser and Strauss (1967) state that it is easy to detect an inadequate theoretical sample as the associated theory is 'usually thin and not well integrated, and has too many unexplained exceptions' (p. 63). Thus the emphasis is on achieving a sample size that generates enough data to achieve theoretical saturation, rather than a concern with how large or how small the sample is.

The concept of theoretical saturation is an interesting one as one wonders if it is possible to reach a point where no new information is revealed. However, Seale (1999) suggests that knowing when to stop sampling is guided by the pragmatics of ceasing inquiry when it seems unlikely that further investigation will be fruitful. The researcher needs to balance stopping data collection too early and ending up with a theory that is not well developed, with the potential for spending too much time in data collection and analysis without completing the research study.

Critiques and trends of grounded theory

Grounded theory continues to develop and evolve. It is important to note that there are different inflections to grounded theory. These largely derive from developments of the original Glaser and Strauss concept of grounded theory. In this study I have chosen to use what is known as the traditional Glaser and Strauss approach (Glaser & Strauss 1967), and later traditional Glaserian position (Glaser 1992). In later years Glaser and Strauss differed on the developments in the approach to grounded theory, to the point where Strauss developed a version of grounded theory with Corbin (Strauss & Corbin 1990). Glaser considers that the approach developed by Strauss and Corbin is no longer grounded theory (Glaser 1992),

however others disagree and view it as a development of grounded theory. Other variations have been described by Stern (1980), Charmaz (1994), and Eaves (2001) for example.

Annells (1996) provides a detailed examination of the differences between grounded theory by Glaser and that by Strauss and Corbin comparing the philosophical perspectives, the intended product and the procedural steps. Whilst the traditional Glaserian approach is underpinned by symbolic interactionism, Strauss and Corbin's approach reflects Strauss' theory of continual permutations of action. Milliken and Schrieber have questioned whether you can actually "do" grounded theory without symbolic interactionism, and concluded that whilst you can use some of the techniques such as constant comparative method, 'grounded theory is more than a sum of its techniques" (p. 187). Moreover they argue that symbolic interactionism pervades at every technical level and that any adequate grounded theory cannot be divorced from it.

The hallmark of grounded theory analysis, constant comparative method is used in both the Glaserian and Strauss and Corbin approaches; however Strauss and Corbin identified the need to have a more elaborated approach to analysing data. They developed what might be viewed as a more formulaic "recipe book: approach, or as Stern states 'from it original concept of emergence to a densely codified strictured operation' (p. 220). Glaser (1992) also argued that Strauss and Corbin's approach was not grounded theory, but the development of a new approach as it involved forcing the data into conceptual categories rather than emergences of the categories from the data.

It is important to be aware of the nuances in the approach and to take a considered and argued position with respect to the inflection used. Whilst the option of having a structured approach such as that offered by Strauss and Corbin is attractive to the novice grounded theorist, I

wanted my study to be firmly situated within a theoretical orientation. Consequently I chose to follow the traditional Glaserian approach with its focus on process, stemming from a theoretical orientation in symbolic interactionism.

Postmodernists criticise grounded theory for its affinity with positivism (Grbich 1999) as the first step of analysis, coding, de-contextualises the data and forces the researcher to adopt a "narrow" view of the data. According to Seale (1999), postmodernists 'equate grounded theorizing with an attempt to impose a single, exclusive interpretation of data' (p. 103), rather than acknowledge that there may be multiple realities. However, such a critique could equally be levelled at other qualitative interpretive methodologies. The debate is as much about philosophy as it is about grounded theory.

Gribch (1999)argues that in the health area researchers have used grounded theory to generate theory 'that is little more than an affirmation of their own biases' (p. 180). However I would argue that this criticism is as much about "sloppy method" or "method slurring" as about grounded theory. Good grounded theory is not about imposing pre-existing theories: it's about generating theory that is grounded in the data. To avoid "method slurring" researchers are advised to make explicit which version of grounded theory they are using and to describe - and justify - any deviation away from the chosen approach (Cutcliffe 2000). Stanley and Wise (1990) argue that it is not possible to generate theory that is entirely grounded in the data as all researchers come to the research study with experiences, ideas, values – all of which influence the analysis, and thus the theory generated. Obviously researchers are not 'clean slates', but in grounded theory analysis they must use processes to ensure that the theory really does emerge from the data and is not forced. Conversely, Glaser (1992) suggests that it is the researcher's professional and personal experience together with an in-depth knowledge of the data that gives them the sensitivity to generate categories. Keeping

detailed audit trails and making the analysis process transparent at the writing up stage strengthens the position of the grounded theory researcher.

Upon searching and reading the literature I reached the conclusion that many research studies cite the use of constant comparative analysis while not necessarily doing grounded theory. It seems at times that the technique is being used as an analytical tool rather than following a ground theory approach with a theoretical orientation in symbolic interactionism. This is probably further evidence of "method slurring" which needs to be discouraged as it detracts from the quality of qualitative research.

High quality qualitative research is time intensive and particularly so with grounded theory studies if saturation is to be achieved. Grounded theory may not be the approach of choice for research projects that need to be completed in short time frame for fear of not achieving a point in data collection approaching theoretical saturation. The resulting theory would suffer as it would be incomplete and lacking in density, and would therefore not be a useful addition to occupational therapy knowledge.

Application of grounded theory in occupational therapy research

Grounded theory has been used by sociologists since the early 1960's and appears to have been used extensively by nursing researchers (Annells 1996; Beck 1993; Hutchinson 1993b; Irurita 1992; Stern 1980; Wilson & Hutchinson 1996). Occupational therapy, at its current stage of development as a profession, would benefit from generating theories grounded in the reality of practice. An examination of theories used by the occupational therapy profession suggests that many have been "borrowed" from other disciplines such as psychology, (for example, Maslow's theory of self actualisation (Maslow 1954), or are theories that are logically derived rather than based on empirical studies, for example, Kielhofner's Model of

Human Occupation (Kielhofner 1985). It is timely that occupational therapy theorists and researchers develop occupational therapy specific knowledge. Grounded theory offers a systematic, well recognised approach to study the richness and diversity of human experience to generate theory related to the use of occupations to enhance health and well-being. Hasselkus writing in 1995 urged occupational therapy researchers to extend their knowledge about, and use of, qualitative research approaches beyond ethnography, and suggested that grounded theory was worthy of investigation (Hasselkus 1995). This particularly applies in relation to well-being which is such a central concept within occupational therapy writing and theory.

Use of grounded theory within occupational therapy research

Having considered what grounded theory is, and discussed some critiques of it, I turn now to discuss the contribution of grounded theory studies to occupational therapy in the past. A search of the occupational therapy literature using AMED and CINAHL databases revealed a small number of published grounded theory studies (refer to table 4). The studies were considered to be examples of grounded theory if the authors stated that they were using grounded theory, cited key references to do with grounded theory and then used some or all of the elements of grounded theory described earlier in this paper. In this section a selection of published grounded theory studies in the occupational therapy literature will be used to illustrate the contribution of grounded theory to occupational therapy practice, education and occupational science.

Author	Domain	Focus of enquiry	Sample	Data generation methods	Findings	Trustworthiness
(Bye 1998)	practice	Occupational therapists working with people who are terminally ill	10 occupational therapists working with clients who are terminally ill	In-depth interview, participant observation	Core category - affirming life: preparing for death	Detailed method, brief analysis No discussion of limitations or rigour Theory has grab and fit
(Carswell et al. 1992)	practice	Functional performance of clients with Alzheimer's disease	11 professional or family caregivers	Observation of video-tape		Theory building is done through group consensus. Detailed method. States uses grounded theory, but doesn't fit conventions
(Chang & Hasselkus 1998)	practice	Satisfactions and dissatisfactions of working with clients after stroke	Random selection of 32 therapists	37 narratives from mailed questionnaires and telephone interviews	Core category - expectation, satisfaction when clients fulfilled therapists' expectations	Sub-set of data from larger phenomenological study Detailed analysis
(Cohn, Miller & Tickle-Degnen 2000)	practice	Parents' expectations of sensory integration therapy	Random selection of 5 parents from larger study sample	Video-taped semi-structured interviews	3 child focused outcomes and 2 parent focused outcomes	Grounded theory only used for analysis, detailed analysis and theoretical validity of interpretations
(Cusick 2001)	practice	Influences, processes & outcomes for clinicians who do research	Purposive sample, 15 clinicians who do research in acute care hospitals in 1 city	In-depth interviews	Core category- becoming a clinician-researcher, described process	Details method and analysis, core category and process has fit and grab, discusses trustworthiness.
(Drake & Irurita 1997)	education	Experience of fieldwork supervisors dealing with students with difficulties	Purposeful sample, 17 fieldwork supervisors with experience of phenomenon	Interviews	Core category - ambiguity, process of clarifying ambiguity in 3 phases	Detailed method and analysis, theory has fit and grab, discusses trustworthiness

(Dubouloz et al. 1999)	practice	Practice and perceptions of evidence-based practice	Theoretical sampling, 8 occupational therapists	Semi-structured, in-depth interviews	Evidence based practice is a process of looking for understanding, involves research, is a potential threat	Detailed method, theory has fit and grab, acknowledges homogeneity of sample
(Farber 2000)	practice	Women with disabilities engaged in occupation of mothering	Snowball sampling, 8 mothers	Interviews	2 themes - maternal self description, perception of interpersonal environment	Detailed method and analysis, used member checks, no core category
(Francis-Connolly 1998)	occupational science	Mothering across the life course	Purposive & snowball sampling, 17 mothers aged 32-83 years	In-depth interviews, focus groups	2 themes - mothering as a lifetime occupation, influence of perfect mother image	Detailed method and analysis, no core category, no discussion of rigour
(Francis-Connolly 2000)	occupational science	Mothering at 2 life stages	Convenience & snowball, 20 mothers of a pre-school aged child, 20 of young adults	In-depth semi-structured interviews, questionnaires	2 themes- immersion in motherhood, mothering as an enfolded occupation	Modified version of grounded theory, details method and analysis, acknowledges limitation of homogenous sample
(Jonsson, Moller & Grimby 1999)	practice	Adaptation of everyday occupations for persons with poliomyelitis sequelae	Theoretical sampling, 22 participants	Interviews on 1-3 occasions	18 concepts describing adaptive strategies	Brief method and analysis, triangulation of data, no core category, typology of strategies, no discussion of limitations.
(Ludwig 1997)	occupational science	How women used routine to influence well-being	Theoretical sampling, 7 women > 70 years of age	Observation, in-depth interviews, autobiography	Theoretical model of process through which routine was used to maximise well-being	Detailed method, achieved saturation, theory has fit and grab, discusses rigour

(Pierce 2000)	occupational science	How mothers manage the space and objects for development of infants	Stratified sample, 18 mother-infant dyads	Monthly videotape of infants at play, monthly interviews	Maternal work of managing play objects in the home, & of organising and maintaining the home space to support development	Highly detailed method and analysis, theoretical suppositions well supported, discusses rigour
(Primeau 1998)	occupational science	Exploration of parents' play with pre-school aged children	10 families (mother, father, first born pre-school aged child	Participant observation, in-depth interview	Identified process of occupational scaffolding	Detailed method, triangulation of data, no mention of transferability or limitations
(Stephenson & Wiles 2000)	practice	Patients' & therapists' views of home delivered and hospital based therapy	15 participants, 6 therapists	Semi-structured in-depth interviews, discussion groups for therapists	5 themes - convenience, therapeutic environment, social contact, control, grateful recipient?.	Details method, brief analysis section, no discussion of limitations or rigour, no core category
(Sweeney, Webley & Treacher 2001)	practice	Processes underlying supervision in occupational therapy	30 female occupational therapy supervisors	Semi-structured interview	Supervisors adopted an egalitarian approach and used covert strategies	Details method, highly detailed analysis section, discusses transferability, theory has fit and grab
(Tamm & Skar 2000)	practice	How children with restricted mobility play in different situations	10 children aged 6-12 years, unable to move without aid of wheelchair or walking device	Formal and informal interviews, observations	Core category – How I play, 3 types of play – with friends (interactive & onlooker), play alone, and play with adults, model of characteristics and consequences.	Detailed method and analysis core category, acknowledges limitations of sampling and difficulties interviewing children
(Tamm 1999)	practice	Occupational therapists view of family caregivers in rehabilitation in the home setting	18 community based occupational therapists	Open-ended interviews	Core category – existential insecurity and six categories broadly relatives as help or hindrance	Detailed method, theory has fit and grab, core category, used member checks

Table 5 Summary of occupational therapy studies using a grounded theory approach

Occupational therapy practice

As can be seen in table 4, examples in the literature were found relating to practice in diverse areas such as palliative care, people with poliomyelitis sequelae and older women. The findings from these studies have contributed to occupational therapy practice in various ways. A theoretical framework has been developed that assists occupational therapists working in palliative care to reframe their work so that they are able to make a meaningful and unique contribution to client's lives and deaths (Bye 1998). From Jonsson et al.'s (1999)study strategies have been identified that help clients to adjust to the occupational impact of disability resulting from poliomyelitis sequelae that could be useful for other occupational therapy clients. If researchers were to build on this work and study the process of adaptation to the occupational impact of a variety of diseases and disabilities using grounded theory it may be possible to build a formal theory about the process of occupational adaptation. That would be a most significant addition to occupational therapy knowledge.

Grounded theory has also enabled researchers to identify ways of improving information and treatment options for clients. For example, the findings from Ludwig's (1997) study of how older women used routine to influence their well-being highlighted the importance of helping older adults to continue to thread past themes of meaning into present contexts and occupations, particularly those that engendered feelings of achievement and accomplishment. Ludwig recommended that occupational therapists explore the use of routine with older clients to increase the likelihood of home programs being adhered to, and including others in the routine to increase the likelihood of a client doing certain occupations.

Another area where grounded theory has been used is in researching issues of importance to the development of the profession. Cusick (2001) has studied the influences, processes and outcomes for occupational therapy clinicians who do research, and described the process of becoming a clinician-researcher. The findings are useful for occupational therapists considering doing research in their clinical position, and for occupational therapy managers who want to increase the research productivity of the area they manage.

Occupational therapy education

Only one grounded theory study of occupational therapy education was identified. Drake and Irurita (1997) used grounded theory to explore the experience of a group of Australian occupational therapy fieldwork supervisors dealing with students at risk of failing a fieldwork placement. The core category identified was ambiguity or uncertainty about the student's performance and the basic social process was clarifying ambiguity. Identifying the basic social process enabled the authors to suggest a number of strategies for supervisors to pick up warning signals early, to enable the clarification process to occur and thereby, hopefully avoiding failure for the student and a sense of failure for the supervisor.

Occupational science

In the domain of occupational science, several grounded theory studies have been made of the occupation of mothering or parenting thus contributing to the occupational science literature. Two studies have explored the nature of parent's play with children and how it was orchestrated within their daily occupations (Pierce 2000; Primeau 1998). The findings resulted in the naming and framing of a new term in the lexicon of occupational terms, occupational scaffolding (Primeau 1998), and in adding to the knowledge base about how mothers manage space and play objects to facilitate their child's development.

Studies have also been conducted on the tasks and activities involved in mothering (a common occupation for women) (Francis-Connolly 1998, 2000), the use of adaptive strategies of time use among mothers with children with attention deficit hyperactivity disorder including the concept of enfolded occupations (Segal 2000), and the parenting process for mothers with disabilities (Farber 2000). All these studies reveal the potential of grounded theory to contribute to the development of knowledge in occupational science, which in turn could inform occupational therapy practice.

Selection of grounded theory for my research

Grounded theory was chosen for this study because of its usefulness in an area where little is known about the phenomenon of interest Grbich (1999), that is older people's perceptions and understandings of well-being. Carpenter (1995) suggests that if a researcher is considering using grounded theory that they ask the following questions:

- Has enough attention been paid to this particular phenomenon in terms of the individual's point of view?
- Has the published literature offered an in-depth coverage of the concepts relevant to the phenomenon of interest?
- Is there a need for a deeper understanding of particular concepts related to the phenomenon of interest?
- Has the phenomenon been previously investigated?

From the review of the relevant literature reported in chapter 2 it was evident that the view of older people on what well-being is has not been studied, and that current representations of well-being in the literature are lacking in empirical support. After critically reviewing the literature presented in the previous chapter it also became evident that occupational therapists

and those with an interest in the field of gerontology do not have a clear, widely accepted view of what well-being is for older people. This appears incongruous given that well-being is a central concept to the occupational therapy profession. Also the older person's view about well-being appears to be absent in both the occupational therapy and the gerontological literature. This study aims to address the gap in the literature and to generate a theory about well-being from the older people themselves. Therefore, the choice of grounded theory for this study is appropriate, and will be used to answer the study question "What are older people's perceptions and understandings of well-being?"

The lack of congruence in the literature about a definition of well-being suggests that it is a complex concept. Using grounded theory, with its origins in symbolic interactionism, to study older peoples' perspectives of well-being, will address issues of social process, shared views and strategies to facilitate the interpretation of the interactive nature of the complexity of well-being. Some of the complexities lie in the personality of individuals, their living situation, and the society in which they live. Grounded theory provides the approach to explore the inter-relatedness of all these conditions.

Chapter summary

In this chapter I have discussed the choice of a qualitative research design as being appropriate for the research question, and also an approach that fits well with the philosophy of occupational therapy. I then discussed grounded theory beginning with the theoretical orientation that informs grounded theory, namely symbolic interactionism. An understanding of the theoretical orientation is important as it informs the whole approach to data gathering and analysis. I described the elements of grounded theory including the approach to data collection and data analysis, constant comparative method, the use of theoretical sampling and memoing. Where appropriate I have drawn on examples from my study to illuminate the text.

A critique of grounded theory was presented along with a discussion of developments within grounded theory. I have justified the choice of a traditional Glaserian approach for my study. I have also presented a review of occupational therapy research studies that have employed grounded theory. The review has highlighted the contribution of grounded theory thus far, and the potential contribution that grounded theory studies could make in the future. Indeed, I have argued that it is timely for occupational therapy researchers to be using grounded theory to develop occupational therapy theory to guide practice that is grounded in the world of people's lives. A rationale for the choice of grounded theory for this study has been presented. In the next chapter I detail the steps used in this study to explore older people's perceptions and understandings of well-being using grounded theory.

Chapter 4: Method

Introduction

Having outlined the approach used in this study, namely grounded theory in the previous chapter, this chapter will describe the specific methods I used to conduct the study. I begin by describing the selection criteria for participants in the study and providing a rationale for each of the criteria. Then the sampling approach is described before a justification of the choice of semi-structured interviews as the data collection strategy is presented. I turn then to a description of the recruitment procedure with details about the sample. Following the description of the participants I consider the ethical issues that needed to be taken into consideration in the conducting of the study. A detailed description of the approach to analysis follows. Included with the details of the analysis is a description of the methods I used to manage the data generated in this study. The chapter concludes with a description of the efforts made to ensure rigour and the trustworthiness of the study findings.

Selection criteria for participants in this study

To address the research question it was decided to interview men and women over the age of 75 who live in the community in metropolitan Adelaide. A rationale for each of the selection criteria is offered below.

Gender

When considering gerontological research, women as a gender group tend to be studied more than men, in contrast to research in general. This is because women generally live longer than men. Whilst being a woman myself it was tempting to study only women I decided that research including perspectives of older men was sparse and so this study would include both men and women.

Age

A review of gerontological literature was conducted to assist in deciding what age was considered to be "old". It became apparent that there was little agreement in the literature as to what age was considered to be "old". Upon reviewing the studies I divided them into 3 groups; the young old, the old and the old-old. The results of the review are summarised in the table below.

Age group	Reference:
Young old 55 years +	(Friedman 1997) (Hill et al. 1998) (Kahana et al. 1995; Webster 1997)
Old 60 or 65 years +	(Bisconti & Bergeman 1999) (Chamberlain & Zika 1988) (Heidrich 1998) (Korten et al. 1998) (Krause & Thompson 1998) (LaLiberte Rudman, Cook & Polatajko 1997) (Liddle et al. 1996) (Meddin 1998) (Miller & Lago 1990) (Mookherjee 1998) (Morris 1997) (Ong & Jordan 1997) (Ruffing-Rahal 1998) (Searle et al. 1998) (Silveira & Ebrahim 1998)
Old old 75 years +	(Coleman, Ivani-Challian & Robinson 1998) (Fox & Gooding 1998)

Table 6 Summary of literature review of sample age

Whilst this table is only a snapshot of gerontological literature it is quite evident that there is wide variety of ages used when referring to older adults. In an aging society it is difficult to accept that 55 years of age, or even 60 or 65 years is considered to be old. Even though the studies with samples beginning at age 60 or 65 contain much older people in the sample, the mean age when reported, is often still not very much higher, reflecting that the majority of those in the sample were of a younger age. It is evident that the old-old age group is understudied. Additionally, Hilleras, Jorm, Herlitz and Winblad (1999) suggest that research on the very old has mostly concentrated on deficits in cognition and abilities rather than well-being. According to Pearson Scott & Butler (1997) the old-old age group is presently the

largest growing segment of the population and possibly the most disadvantaged with respect to education, income, and health. It could also be argued that the old-old age group is a relatively recent phenomenon resulting in the necessity to study this group as not much is known. For these reasons I have chosen to study older persons 75 years and older.

Community dwelling

As has been described in the introduction to this thesis Australia's population is aging and there are growing numbers of older people. By far the majority of older people live independently in the community with less than 10% of older people over the age of 65 living in a high care facility[1] (Australian Bureau of Statistics 1999b). Because of the growing numbers of older people living in the community I thought it important to situate my study in that context. I therefore needed to define the concept "community". A search of the relevant literature was conducted to ascertain a definition of "community dwelling" for participants of this study. A number of studies refer to the subjects or participants, as "living in the community" yet do not define the term in any more detail. One study (Ruffing-Rahal 1998) with a random sample of older women used the selection criteria of living independently, in non-institutional circumstances. La Liberte Rudman, Cook & Polatajko's (1997) descriptive qualitative study used maximum variation sampling of older people living in the community, with the only clarification of community dwelling being those who were not receiving intensive support services. Even in a systematic review of effectiveness of occupational therapy for community dwelling elderly people the authors didn't define community dwelling beyond the phrase "living independently" (Steultjens et al. 2004).

[1] A high care facility is the term used by the Australian government to define a nursing home facility, that is, residents require and are provided with a high level of nursing care to meet their daily needs. Similarly, in a low care facility residents receive a lower level of nursing and personal care.

It appears that knowledge of the terms community dwelling or living in the community is often assumed and it is also assumed that all researchers and readers will have the same understanding of the terms. If researchers are unclear about how they operationalise their selection criteria it makes it difficult for readers to make useful comparisons between studies. The definition given by Ruffing-Rahal (1998) appears most useful as it nominates a non-institutionalised sample. Therefore in my study community dwelling will refer to any older person not living in a high or low care facility. That person may be living by themselves or with family and/or friends, with varying levels of support from private and government agencies.

Metropolitan

This study draws its sample from older people living in a metropolitan area. Part of the decision to restrict the sample to the metropolitan area was made for convenience and manageability for myself as the researcher. However, the decision was not only made on the grounds of being convenient for myself. Inequalities in the health of those living in urban parts of Australia and those living in rural areas are well documented, with those in rural and remote areas of Australia being disadvantaged both in terms of health and access to health services (Strong et al. 2002). As health and well-being appear to be inextricably linked it is reasonable to assume that well-being may be different for people in rural and remote areas. This gives a strong argument to study older people from metropolitan areas separately from those from rural and remote areas. There is no doubt that on completion of this study there will be a need to either study older people from rural and remote areas, or explore the application of the theory with that sample.

Selection of participants

Having decided to include both male and female participants who were over the age of 75 years, living in the community in metropolitan Adelaide, I then needed to decide how to select

the participants for the study. I therefore reviewed the literature to see which sampling strategies had been used with older people. As most of the studies in the literature were quantitative studies, the recruitment procedures used have been various forms of sampling to ensure generalisability. These included use of electoral roles (Korten et al. 1998; Liddle et al. 1996), phone numbers (Morris 1997), and population registers (Peters & Liefbroer 1997) or large population studies. Registers of general practitioners were also used (Silveira & Ebrahim 1998) as well as recruitment from notices in senior citizen centres and community organizations (Chamberlain & Zika 1992; Takahashi, Tamura & Tokoro 1997), and advertising in newsletters (Webster 1997). Most of these types of sampling aimed to obtain a random sample representative of the population of concern. Generalisability of findings is not a key concern for a grounded theory study, where the in-depth richness of the qualitative data are valued. If the study is conducted to a point of theoretical saturation it is likely that other people within the target population will find some resonance with the findings.

The study aimed to include older people living independently in the community. Sampling selection strategies were needed that were congruent with grounded theory and that would uncover information rich cases, rather than seeking to generate findings that could be generalised. Therefore the sampling approach chosen was purposeful. 'The logic and power of purposeful sampling lies in selecting *information-rich cases* for study in depth. Information rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research, thus the term *purposeful* sampling' (Patton 1990) p.169. Thus the sample is selected according to the informant's knowledge of the topic (Morse 1991). Participants were needed who were knowledgeable about the topic, and prepared to spend time in communicating that knowledge to the researcher. These participants are considered to be good informants (Morse 1991) or "information rich".

Patton (1990) suggests a range of specific types of sampling within the broad framework of purposeful. The specific types used in this study were opportunistic and snowball sampling. In the initial stages of the study opportunistic and snowball sampling were used concurrently. Opportunistic sampling was used to obtain the first participant and then snowball sampling provided the next three participants. As snowball sampling faltered I would return to opportunistic sampling. The two approaches are described in more detail below.

Opportunistic sampling

Opportunistic sampling takes advantage of opportunities available to the researcher during the course of the study (Patton 1990). This consisted of people who were either acquainted with the researcher or who the researcher became aware of during the study, who were thought to be information rich. Ludwig (1997) used opportunistic sampling in her grounded theory study of older women and routine with the first participant in that study being Ludwig's neighbour, who had also participated in a previous research study and shared her views on successful ageing with classes of occupational therapy students. The second participant was someone Ludwig had met by way of introduction from the water aerobics instructor at the local gym. Both of these women were chosen for their ability to provide rich descriptions of the phenomenon under study. For my study I initially approached older people that I knew, read about in the newspaper (for example, in an article about growing old), or were recommended to me by my family members, friends and professional colleagues.

Snowball sampling

Just as a snowball gets bigger and bigger as it rolls down the hill gathering more snow, snowball sampling involves starting with a small number of participants, which could even be just one well situated person, and the sample grows by referral (Patton 1990). Snowball sampling can also be called nominated or network sampling (Morse 1991). The first informant is invited to nominate another prospective informant and in this way more

information rich participants will be able to be identified, and the sample size grows, and includes participants who are seen by the members of the sample being studied to exemplify the phenomenon under study. The richness of the data are ensured, as those within the group being studied know who is most knowledgeable about the topic. Hutchinson (1993b) used snowball sampling successfully in her study of people with bipolar disorders. In my study I planned from the beginning to start with opportunistic sampling and move to snowball sampling by asking participants to suggest someone I should talk to. However, once the study began the snowball sampling happened without me initiating anything. The first participant had already asked her neighbour if he wanted to be involved before I conducted her interview, and the neighbour also spoke to friends about the study who contacted me and volunteered. This enabled me to access people that I otherwise would not have had contact with. Thus, I had in play both opportunistic and snowball sampling.

Theoretical sampling

As the early data were analysed and emergent themes arose theoretical sampling was employed (Glaser 1992; Glaser & Strauss 1967). Theoretical sampling included using the literature and further interviewing to explore emergent categories and their properties, and to clarify relationships between categories in the emerging theory. Different questions may be asked of different participants as the theory evolves. For example, after interviewing the first male participant who spoke about the lack of male companionship I coded that section of text 'gender imbalance'. I began to wonder if there were other examples of how the predominance of females in the older age group affected well-being. In my next interviews I used the probing question, "Other people have told me about their experience in social groups with women far outnumbering men, how has that been for you?" thus using theoretical sampling. This probe was designed to flesh out the dimensions of the property 'gender imbalance'.

In grounded theory theoretical sampling also includes drawing on published literature. For example, as the categories were emerging to a more abstract level I had the sub-categories 'feeling needed and wanted' and 'being connected'. It seemed to me that they could be brought together into one category but I could not think of a conceptual label that encompassed the data from both sub-categories. In reading about resilience I came across the concept 'being engaged'. As that concept highlighted the importance of being connected to other people and to society in meaningful ways I thought that it had a good fit for the category name.

Data collection was driven by the emerging theory. Informants were purposively sought who could provide data that would "flesh out" the emerging constructs. Glaser and Strauss (1967) suggest that 'the basic question in theoretical sampling is: What groups or subgroups does one turn to next in data collection? And for what theoretical purpose?' (p. 47). Those questions helped to guide me in selecting which people to interview in order to find things that might challenge the limitations of the emerging theory. For example, as the analysis progressed I needed to expand the category 'being in control'. To do this I decided to look for "negative cases". I needed to find situations where I thought the older person might not be in control, such as, living with a chronic health problem, or about to enter residential accommodation. Therefore recruitment continued using opportunistic sampling until all categories appeared to be saturated, that is, no new data were emerging. "Theoretical sampling on any category ceases when it is saturated, elaborated and integrated into the emerging theory" (Glaser 1978) (p. 36). Having considered the selection criteria and sampling strategy I move now to discuss the choice of data collection approach.

Data collection strategy

In grounded theory studies data are often collected by in-depth interview. In this study in-depth interviews were used with older people who met the selection criteria. According to Minichiello et al (1996) 'in-depth interviewing is a conversation with a purpose – a conversation between the researcher and the informant focussing on the informant's perception of self, life and experience, and expressed in his or her own words' (p. 87). The face to face verbal exchange is an opportunity to find out about things that can not be observed, such as thoughts, feelings, intentions, things from the past and plans for the future. The use of in-depth interviewing in qualitative studies assumes that the perspective of the participants is meaningful, knowable and that it is possible for participants to make it explicit through language (Patton 1990). If we believe that social reality exists as meaningful interaction between individuals then it can only be known through understanding others' points of view, interpretations and meanings. If meaningful human interaction depends on language, then the words people use and the interpretations they make are of cental interest to researchers. In-depth interviews are an appropriate way to gain access to the individual's words and interpretations. Gillham (2000) suggests that interviews are appropriate if small numbers of participants are involved, the people are accessible, most of the questions require an extended approach, and the research aims are related to gaining insight and understanding. My study meets all of these criteria. Interviews alone have been used in a number of grounded theory studies (Beck 1993; Blenner 1990; Hutchinson 1993b; Jacelon 2003; Martin 1998) and are an accepted data gathering approach.

Choosing semi-structured interviews

Most research method texts present a continuum of the forms of interviewing which range from structured interviews at one end to unstructured interviews at the other (Fontana & Frey 1998; Minichiello et al. 1996). Semi-structured interviews lie somewhere between the two ends of the continuum. With semi-structured interviews researchers utilise a question guide

developed around the topics of interest to the researcher. The questions do not have fixed wording or a fixed order allowing the researcher flexibility to respond to the participant in a conversational style. The participant is able to express their view of reality (Minichiello et al. 1996). I decided to use a semi-structured approach to the in-depth interviews in my study as I thought while the conversational style would facilitate the participant to discuss the phenomenon of well-being, the question guide would give a framework for the conversation. I also spent quite some time thinking about framing the questions so that they were consistent with the theoretical orientation of symbolic interactionism and were phrased in an open-ended way that would encourage an extended response.

Interviews used a funnelling technique beginning with broad open-ended general questions, moving to more specific questions about strategies and processes (Hutchinson & Wilson 1994). The questions used in the early interviews were modelled on grounded theory studies conducted by Hutchinson (1993b) and Bowers (1988) and were as follows:

- In order to understand you a bit better, tell me about how you spend your days?
- As you know, I am interested in finding out about the perceptions and understanding of well-being of older people, so if I said to you, "what does well-being mean to you?", what would you say"?
- Tell me, how do you achieve well-being?
- What difficulties do you encounter in achieving/ maintaining well-being?
- What advice would you give to a person who is not experiencing well-being?
- What would you like to tell health care professionals about well-being for older people?
- What would you like to tell your family and friends about well-being?

- What would you like to tell politicians and governments that would improve the lives of older people?
- Is there anything else you would like to comment on about well-being?

In addition, basic demographic data were collected about age, gender, living situation and suburb to enable description of the sample. A number of different types of probing questions were used throughout interviews. Examples of the types and format of probing questions is offered below (Gillham 2000):

Clarifying- I don't quite understand that, can you explain it to me?

Showing understanding – How did you feel about that?

Justifying – What makes you say that?

Relevance – You've lost me, how do those two things connect?

Asking for an example – What do you mean by ...? Can you give me an example?

Extending the narrative – Tell me more about that.

Accuracy – Now, let me see if I've got things in the right order?

Whilst interviewing is an appropriate choice to gather data for this study it is not without its disadvantages. Face-to-face in-depth interviews have been criticised on the basis of how much time and therefore money they take to conduct (DePoy & Gitlin 1998). On balance, I think that the richness of the information gained in an interview in the participants' own home was well worth the time invested, although they did generate a lot of data and were time intensive on my part.

Interviews are also criticized for the tendency of the participant to tell the researcher what they think they want to hear, rather than their own opinion. Building rapport before, or in the early stages of the interview, and demonstrating a genuine interest in the participant's perspective can help overcome that tendency. It may not be possible to overcome it entirely

as participants have the power to choose what they say and how much they might reveal on a topic, however, quantitative researchers also face a similar issue with the tendency for people to complete psychometric scales in a more positive manner than what might be expected.

In interviews the participant's account of events may not always be chronologically correct or exactly as things happened. The philosophy behind in-depth interviewing acknowledges there may be a lack of historical accuracy. What is important is the participant's perceptions of events. Their perspective may bear little resemblance to the 'truth', but it is their perspective. This is what you are interested in as the researcher as it is what the participant considers important enough to tell.

Process of interviewing

Interviews were conducted in the participant's home in a room of their choice. It was important that they were comfortable and at ease to enhance the quality of the interview. Using the home environment also provided me with an opportunity to observe participants within their context. They often showed me objects in the home to illustrate some of the points that they were making, particularly photographs of family members to demonstrate their connections to the social world. Some of the participants expressed concern that they really didn't know if they had anything to say, or whether it would be what I wanted. Despite their concerns, each interview lasted at least an hour, many for an hour and a half. Once transcribed the average number of pages of transcript on A4 paper was 10.

Participants were interviewed once, despite the information sheet implying it may be more than once. I considered it more valuable to theoretically sample further participants rather than return to participants for a second interview. This is in keeping with studies by Beck (1993) and Ludwig (1997).

Transcribing the data

After each interview the tape was transcribed verbatim. The first 8 interviews I transcribed myself and used the transcription process as a way of becoming familiar with the data within the transcripts. Later I decided that it was more efficient to have a professional transcribe the tapes for me, to give me more time to do the analysis and writing. After listening to the tapes of these later interviews the transcripts were read numerous times so that I was quite familiar with them. I reverted to transcribing the last two interviews myself due to financial constraints.

Recruitment

Once potential participants were identified they were sent a letter inviting their participation (see Appendix A) in the study together with an information sheet (see Appendix B). The information sheet included a brief summary of the purpose of the study, the nature of involvement and participant's rights. If the person wished to participate they then rang my workplace to volunteer. I then spoke to them and arranged a time to conduct the interview.

Sample

There were 15 participants in the study. All participants were given the opportunity to choose a pseudonym to be used in the written report. (Refer to table 6, which summarises demographic characteristics of participants).

Name	Age	Gender	Living Situation
Joan	80	female	Alone, unit
Bev	77	female	Alone, retirement village
Bob	88	male	Married, unit
Elspeth	80	female	Married, house
Reg	87	male	Married, house
Ruth	76	female	Alone, retirement village
Martha	77	female	Married, house
Kate	78	female	Alone, unit
Mary	90	female	Alone, unit
Isobel	91	female	Alone, house
Herbert	78	male	Married, house
Radlee	76	female	Married, house
John	84	male	Married, unit
Rosemary	84	female	Alone, independent living unit
Bill	82	male	Alone, independent living unit

Table 7 Demographic characteristics of participants

The first participant in the study was Joan. I met Joan about 12 months before data collection began. When I came to begin data collection I thought immediately of Joan as I believed she would have something to say in her articulate way. So I wrote to Joan and as soon as she received my letter describing the study and asking her to volunteer she agreed. Joan lives by herself after the death of her husband eighteen months ago. Before I had the chance to ask Joan about anyone she knew that she thought I should interview, she said to me, you must talk to my neighbour and she had already showed him my letter. The snowball sampling was in operation without me even asking.

So, Joan referred the second participant, Bob. Bob lives with his wife in a two bedroom unit with a small garden in an eastern suburb of Adelaide. As I was interviewing Bob, he told me that he had a friend that he thought I should speak to who was considerably older and thought by Bob to exemplify well-being, thus adding to my snowballing sample.

About the time that I was first looking for participants I read an article in the newspaper that gave the opinions of several older women who had been interviewed by a journalist about marriage. Two of the women were over 75 years of age, and as the article identified the retirement village where they lived I wrote to them asking them to participate in the study. Bev responded to my letter and agreed to be interviewed as the third participant. She lives in a neat retirement village just on the outskirts of the city. This is an example of opportunistic sampling.

At first it was unclear how my fourth and fifth participants, Reg and Elspeth came to hear about the study and telephone me to volunteer. When I eventually met them, I discovered that it was Bob who had suggested that they contact me. Reg and Elspeth live in their own home with a very large garden in the foothills. They were keen to be participants, leaving two voice mail messages on the same day, as they believed they had some insights on the topic.

After completing the first five interviews no new leads for snowball sampling had been revealed so I decided to use more opportunistic sampling and asked around the office at work and amongst my family, and came up with the next three potential participants who all agreed to be interviewed.

I had met Ruth on a couple of occasions. She is the mother of a work colleague and I remembered meeting her and spending some time with her at a recent social event. I also

knew that Ruth had had a difficult time in recent years with the sudden loss of her husband, some health problems including a partial amputation of her foot, relocating to Adelaide from interstate, caring for her own mother and coping with her mother's recent stroke and death. I thought that Ruth would be able to speak from the experience of someone who has had numerous challenges to her well-being as she ages. Ruth lives in a retirement village in an outer north-eastern suburb.

My next participant was my grandmother's cousin. I had only met Martha at one family occasion that I could recall, yet I knew that she had been very involved with the University of South Australia and its antecedent institutions during her career. I thought she might be interested in being involved and knew that she would be able to give an account of what well-being was to her. As a woman who had led a different life to many of her generation I thought she would give a perspective on what life in old age might be for many women in future generations. Martha lives with her husband in their own home in an inner suburb.

Kate was referred to me by one of the clerical staff where I work. Kate is a friend of her family, particularly her mother, and they both thought that Kate would be good for me to speak to, as someone who is active and able to discuss the issues. I was quite pleased that Kate was from a different part of Adelaide, thus a different socio-economic area from all the other participants. Whilst I was not aiming to have a representative sample, I thought that Kate might offer a different perspective. Kate lives in a unit in a suburb just outside the city.

After a break in data collection to allow for thorough analysis of the data collected thus far, I decided that I needed to probe around the code 'financial security' and to do that I needed to speak to people whose only source of income was a government pension, and who were from an area that might be perceived as "working class" rather than middle to upper middle class.

Discussions with colleagues revealed two possible people who both agreed to participate. Both Mary and Isobel lived alone in old seaside suburbs, Mary in her own unit, and Isobel in her home. Mary was always out and about, whereas Isobel did not go out much at all.

After further analysis where I was starting to see saturation of data in some categories and coming closer to finding a core category, I needed to explore the category 'perceived control' further, as it did not appear to have reached saturation and I was beginning to suspect that this was the core category. So I was keen to interview some people who might be in positions that could be considered to be out of their control as negative cases to help me 'flesh out' the properties of the category 'perceived control'. I set about finding people challenged by health problems that might be threatening their independence. Through networking with my occupational therapy clinical colleagues I was given some further contacts. The first of these was a married couple, Herbert and Radlee, who both had significant health problems, particularly Radlee causing a considerable burden of care on Herbert. They lived in their own home with assistance through a Community Aged Care Package. Their family perceived that very soon Radlee's care needs would exceed Herbert's abilities even with the assistance of the carers provided by the package.

The next person was John who lived in a unit with his wife. John was still recovering from a sudden bout of illness about 4 years earlier, which has left him with some residual disability and a chronic health problem. John lived with the knowledge that at any time he could suddenly or slowly get worse and die.

At this stage of the study the analysis was becoming much clearer in terms of the core category and basic social process and how the categories related to each other, but I wanted to interview some more participants to feel confident that I had reached theoretical saturation. I

sought the assistance of a clinical colleague to find more participants who had faced recent health challenges. Potential participants were approached by the clinician and asked for permission to give their name and address to me. I sent them a recruitment letter and information sheet and they had to ring up to volunteer. Participants were reassured that their decision to be involved in the research study was quite independent of their relationship with the agency that provided occupational therapy services in keeping with accepted ethical practices. Thus I came to meet Rosemary who lives alone in a small unit and had been widowed for many years. She is of Sri Lankan background and had lived in London for some time before coming to Australia back in the late 1960's. A few years ago Rosemary had a fall, which resulted in a fractured vertebra, and now her mobility was significantly impaired.

The other participant referred by my clinical colleague was Bill. Having been a widow for a number of years, Bill had recently spent time in hospital for major surgery related to a diagnosis of cancer, so I thought he could speak of the need to maintain perceived control, which was emerging as a core category.

To summarise, the sample consisted of 15 participants ranging in age from 76 to 91. The aim of sampling was to obtain a sample of participants that were 'information rich' rather than representative of the community. However, the participants did come from a variety of living situations, different areas of the city and varied in the degree to which they enjoyed good health and community mobility.

Having discussed how each of the participants came to be a part of the study I turn now to consider the ethical aspects of the study.

Ethical issues

Ethical approval was sought and gained from the Human Research Ethics committee, University Of South Australia in March 2000 and approved in April (see Appendix C). All participants received a copy of the information sheet (refer to Appendix B), which set out the aim of the study, what was involved, and the rights of the participants, prior to signing the consent form (included as Appendix D). Participants knew that they were able to withdraw from the study at any time without prejudice. At the interview, participants were offered an opportunity to select a pseudonym in order to protect anonymity and confidentiality. The risks for participants for engaging in the study were minimal.

All raw data both tapes and transcripts were kept safely during data collection and analysis. On completion of the study the audiotapes were destroyed and the remaining data will be kept in a locked compactus in the Centre for Socially Sustainable Health Research, University Of South Australia for 7 years in keeping with National Health and Medical Research Council guidelines for the conduct of research.

Kvale (1996) discusses the ethics of interviewing and suggests that researchers need to respond to the following ethical issues:

- informed consent;
- confidentiality and anonymity;
- the benefits to the participant of being in the study; and
- the consequences of being in the study.

In this study participants received a letter outlining the purpose of the study, what their involvement would entail and their rights as a research participant. All participants received this before agreeing to do the interview, and then at the time of the interview signed a consent

form. Participants were offered the opportunity to choose a pseudonym that would be used in the reporting of the results, and were assured that findings would not be reported in a way that would identify individuals. There is no direct benefit to the participants of the study, however the benefit of the study is in the form of increasing general knowledge of the human situation. It was not anticipated that there would be any adverse effects experienced by the participants beyond those normally encountered in every day life. Having said that, if participants chose to reveal very personal information then there was the possibility of "opening up old wounds", of revealing circumstances of neglect, or of identifying a mental health problem. I am an experienced occupational therapist with skills in identifying and managing clients in distress as well as knowledge of community referral sources should the need arise. Any need for counselling would be managed by referral to a community agency and not by myself to maintain my position in this situation as the researcher not the therapist. Whilst some participants did experience some sadness and tears as they recounted their experience I did not encounter any situations of concern necessitating referral for counselling.

During my reading and thinking about the in-depth interviews I came across two further ethical issues. The first issue related to me interviewing people who could be perceived to be vulnerable. The second one, closely related to the first, was the ethics of inviting myself into people's lives, and expecting them to divulge personal information without having an ongoing relationship with them and without their getting any direct benefit from participating in the my study.

Russell (1999) has addressed the issue of interviewing vulnerable older people by posing the question 'should we be "mining the minds" of these disempowered people for our own research purposes?' (p. 403), and suggested that it may be more ethical to offer more than a

"hit and run intrusion". In my own case, I was very mindful of the power I had as a researcher. However I would argue that the people in my study were not particularly vulnerable or disempowered. They were all living independently in the community and were free to exert their own free will and autonomy about whether or not to participate in the study. They also had the freedom to choose how much they divulged in their responses to the interview questions.

I would argue that if we continue to see older people as vulnerable it is possible that we are reinforcing negative societal perceptions and expectations (Russell 1999). Researchers need to be mindful of this issue and make sure that their research is conducted in a manner that gives control to the participants and respects their position in society. Perpetuating negative stereotypes, such as older people being unable to look after themselves, seems particularly incongruous in my study of older people and well-being. So, whilst an older person living alone in the community may be perceived as vulnerable, they are not necessarily any more vulnerable than anyone else.

The researcher has the responsibility to be sensitive to the power they may hold as the superior socially distant interviewer and to think about interviewing in a style that attempts to address the power issues. The use of reflexivity also helps the researcher to consider power issues. In my case I felt a strong need to listen to other information and "stories" that were shared with me that did not necessarily contribute to my data about well-being but were important to the older person. As a researcher I was aware of the responsibility to be sensitive to the power that I potentially held as 'the interviewer from the university'. It is not possible to equalise the power relationship between the researcher and those being researched, but the differential may be reduced by close scrutiny of what is being studied, why it is being studied,

and who is to benefit from the research (Suto 2001). Carpenter and Hammell (2001) suggest that the resultant knowledge needs to be placed at the disposal of the researched as well as the researchers. Mindful of this, I produced a summary of the key findings, in accessible language, and made this available to all the participants. One participant received a complete copy of the thesis at her own request.

Russell went on to write that the older people in her studies do seem to derive some benefit from participating. That was certainly my experience. The participants in my study appeared to experience the interview as an enriching experience and were reluctant to end the session. The participants appeared to enjoy telling their story, and to have the opportunity to reflect on their life experience. Feedback from Ruth's daughter highlighted how the interview was a positive growth experience for her and had led to further reflection and insights for Ruth. I thought that this was evidence that the participants could gain some direct benefit from being interviewed.

In summary to this point, the selection criteria, sampling strategy and data collection strategy have been detailed and the ethical issues considered. I turn now to give a detailed description of data analysis.

Analysis

Whilst the analysis of data are presented here in a linear fashion to demonstrate how I moved from the transcripts to a core category and basic social process, it bears emphasis that doing grounded theory is much more of an iterative process. Data collection and analysis occur simultaneously, then the researcher returns to the field, in my case to do more interviews and collect more data for analysis, and employs the use of theoretical sampling of participants and

the literature. The approach to the analysis was based upon a traditional Glaserian approach as outlined in the previous chapter.

Analysis began with open coding. Initial coding of the printed copies of the transcripts was performed manually. Transcripts were printed with line numbers and a large right hand margin for writing in the codes. At this stage the transcripts were read line by line and open codes recorded, often using in vivo codes, that is, using the language of the participants. For example, a section of text from an interview with Rosemary talking about her use of routine in the mornings with the first corresponding coding that I applied follows:

R: Well I wake up, usually early, not today, today I work up late. I usually like to wake up between 4 and 6. Then I go out and have a	Early morning riser
shower, nice hot shower. That helps me with the pain in my back. I feel better after that.	Shower to relieve back pain
Then I have my breakfast. Come out and have two cups of coffee. I make two cups of	
coffee but first I drink a glass of warm water with a teaspoonful of honey and a dessertspoonful of cider vinegar, apple cider vinegar. Then I have one cup of coffee and I	Self maintenance of health
have my morning tablets for blood pressure, high blood pressure and then I read my book	Takes tablets, health maintenance
called 'A course of miracles'. There are 365 lessons but you must only do one lesson a day. You can take as long as you like over	Reads a book, lessons

that one lesson, but only that one. So I read my lesson from the course of miracles, I spend 15 minutes on that because there is a lesson and 2 pages of text. I have my breakfast. After I have had my breakfast	
there is the washing up, which isn't much but it is best to get it out of the way, and then I	Washing up
think now what have I to do today, and I try	Think about what to do today
to make some interesting thing, or if I have nothing something might happen. Something	Try to make something interesting happen
wonderful might happen. But I have to do	Something wonderful might happen
this this, I make a list, because my left brain loves lists. And then I start with, I like	Makes a list
Deepak Chopra's books, especially the Mind body medicine book. And I do 15 to 20 mins	Likes books, alternative medicine
of transcendental meditation, one hour after	Does transcendental meditation
my breakfast. I try to sit as still as possible.	Sits as still as possible
And then I do the work that I have for the	Does the housework
day. If I have to go out that is good. I love	Loves going out
going out. I never used to be in when I was well, and it is very hard to take my mobility	Difficulty adjusting to decreased mobility
going, not being able to do this, not being able to that. Then I write the thing I would like to do	Stops her doing things

Table 8 Sample of text from transcript with open coding

Large numbers of initial codes were generated in this way so that after coding the first three interviews I had over 45 codes. Using constant comparative method I re-examined each of these re-coding some and subsuming others into another code. For example, 'being positive' and 'positive outlook' became one code, 'being positive'.

As further interviews were conducted and transcripts produced I continued with the open coding. These transcripts were either coded using the existing codes or, if new data emerged a new code was created. As the data collection and analysis progressed the codes were compared with each other, and organised into clusters according to fit. These codes were then labelled as categories. For example, 'staying in own home' and 'value independence' became the category 'maintaining independence'. 'Aspects of well-being' was far too undifferentiated to be a code, so I had to re-examine each section of transcript that was initially coded that way and re-code it more appropriately.

Selective coding

Following open coding of the first few interviews I was able to consider selective coding. Selective coding involves a much more conscious search for the core category, and is at a higher or more abstract level of coding. Use of constant comparative analysis continues to compare the emerging categories, and collapse them into more abstract categories (Stern 1980). For example, in my study I grouped the emerging categories of 'financial security', 'feeling safe and secure', and 'being comfortable' under a single category label of 'being comfortable and secure'. Now as further interviews were conducted I still went through an open coding process with each transcript, adding to the codes of the data already collected, and forming new codes if required by the data. Selective coding was also applied, so that analysis was a cyclical process of data collection, analysis and return to the field for more

data. The aim of the selective coding process is to bring the coded data to a higher level of abstraction.

Theoretical coding

The next step in analysis is theoretical coding. Glaser (1978) suggests that theoretical coding is used to reveal the conceptual relationships between categories. To assist with analysis I began to draw diagrams in order to try and reveal some of the relationships between the categories (see figs. 2, 3 and 4). The series of diagrams is included to illustrate the process. Discussing the diagrams with peers along with continued use of constant comparative method enabled me to further refine and clarify the relationships between categories and begin to identify the core category. It also enabled me to see where I needed to do further theoretical sampling.

As the theory began to emerge I could see that some categories appeared to have reached saturation: in other words, no further data were emerging. This seemed to be the case for 'personal resources', 'feeling safe and secure', and 'challenges to equilibrium' but I was still unsure about 'perceived control' and 'up to me'. I had had a hunch for some time that 'perceived control' might be the core category and I was aware that the core category was usually the last to achieve saturation. I therefore set about interviewing further to test my idea out. I sought participants who might be in situations that would challenge their ability to maintain perceived control. These might be people who had health challenges, were at risk of losing their independence or has experienced significant loss.

During the analysis I kept coming across expressions of actions that seemed to me to be examples of trade-off: situations where participants gave up something but replaced it with something else. This was not a code or a category, but participants described taking actions

that I labelled 'trade off'. In my analytical diagramming I superimposed trade-off in the form of a sticky label over two categories, 'being realistic about limitations' and 'maintaining independence'. I began to suspect that trade-off was a basic social process. I was hesitant in declaring it a basic social process as I was expecting to find a core category but I was not necessarily expecting to identify a basic social process. Only a few of the grounded theory studies that I had read had been able to define a basic social process. I turned to the literature, firstly to clarify the definition of a basic social process, and secondly to look for examples. As stated in chapter three Glaser (Glaser 1978) defines a basic social process as similar to a core category, but it has two stages or phases that account for process or change over time.

I had collected a large amount of literature in my database from a variety of fields that used grounded theory so I searched the articles for studies that identified a basic social process. I identified two studies that clearly described a basic social process that fitted with Glaser's definition. Rose, Mallinson and Walton-Moss (2002) studied families' responses to mental illness and found the basic social process of pursuing normalcy. This was achieved in 3 stages of confronting the ambiguity of the illness, seeking control over the illness, and adopting a stance of possibilities and realities. The other study by Wilson and Morse (1991) sought the perspective of husbands whose wife was undergoing chemotherapy for treatment of cancer. The basic social problem was coping with their wife's reaction to chemotherapy and the husbands used the basic social process of 'buffering', which was a process of filtering and reducing the stresses of day to day living to protect their wives. The stages mirrored the stages of undergoing chemotherapy, that is, identifying the threat (diagnosis), engaging in the fight (having chemotherapy), and becoming a veteran (completion of treatment).

After finding these examples of a basic social process in the literature I then went back through each of my transcripts and made notes in a chart that identified how each participant

used trade off, why they used it and the outcome (see table 8). Glaser argues for the use of theoretical coding families to assist the researcher to see relationships among categories. One of these coding families is the 'six C's', that is: causes; contexts; contingencies; consequences; covariance; and conditions. To apply the six C's the researcher asks the following questions:

- Is this category a condition of another category?
- Is this category a cause, context or contingency of another category?
- Does this category co-vary with other categories?
- Is this category a strategy? (Corbin 1986)

The examination of the transcripts in the table is an example of applying the coding family of the 6 C's in considering the context, the cause, the contingency and the conditions.

Name	Task	Why	Outcome	Cost
Isobel	Digging garden Cutting lawns Taken shopping Gave up bible classes Wears continence pads Wears dark clothes	Loss of physical capacity " " Didn't' want to be a bother Loss of physical capacity	Maintains autonomy in own home Maintains control Maintains dignity	Dependence on others Loss of valued occupation Acceptance of diminished capacity Loss of role
John	Wife does gardening Replaced lawn with pavers Sedentary activities Gave up woodwork, joined a travel club	Reduced physical capacity	Keeps garden in satisfactory state	 Loss of valued occupation
Kate	Moved to smaller unit Will get help with window cleaning	So not to be a problem when she dies Reduced physical capacity	Maintains autonomy	Left long standing neighbours For dependence
Martha	Husband does gardening She does cooking	Preferred interest	Harmonious agreement	
Ruth	Shopping is home delivered Moved to retirement village Rests each day	Saves energy from reduced physical capacity To be nearer to family Reduced physical capacity	Maintains control Maintains autonomy Preserves energy for interests	Increased dependence on others Moved from familiar environment Acceptance of loss of capacity

Name	Task	Why	Outcome	Cost
Reg	Gave up committee work Pottering in shed	Unable to hear well Poor eyesight	Maintained control	Loss of valued role Loss of valued occupation
Elspeth	Help with housework	Reduced physical capacity	Maintained independence	Increase in dependence on others
Joan	Gave up volunteer work	To care for husband	Maintain control	Loss of valued role
Bev	Gave up line dancing and took up swimming	Bad back	Maintained control	Acceptance of decreased capacity
Radlee	Carer for personal care Home help shopping	Reduced physical capacity	Maintained independence Maintained control	Acceptance of decreased capacity
Herbert	Gave up some social activities Gardening	To care for wife Reduced physical capacity	Maintain relationship Maintain control	Loss of valued occupation
Rosemary	Carer for housework, shopping Friends shop, carer takes her to beach	Reduced physical capacity	Maintain independence Maintain control	Increase in dependence on others
Bill	Accepted Meals on Wheels, given up cooking	Convalescing after 6 weeks in hospital	Maintain independence	Increase in dependence on others

Table 9 Use of trade-off by participants

Having completed the interview with Bill I felt comfortable that I had achieved saturation for all categories, that is, no new information emerged. Some of the things that were key features of Bill's interview had also emerged as major categories within my findings, so I felt confident that the analysis was appropriate and not forced, and that 'perceived control' was the core category. I was still a little unsure about the basic social process being trade-off so decided to interview some participants who were likely to be having their perceived control challenged so that I could ask probing questions about the decision making process of 'trade off'.

During all of the analysis process I was writing memos of my thoughts on the analysis and recording the analytical decisions. I recorded analytical decisions such as the merging of codes into categories and the relabelling of categories. I also recorded hunches about the core category. Whilst these hunches did not always turn out to be the case, the documenting and recording of my rationale helped me to move further in the analysis process and arrive at the resultant theory. The writing of memos also helped me to clarify where to turn for theoretical sampling. I would determine the part of the theory that needed developing and then think about whom I needed to interview, or what interview questions I needed to ask, or the area of literature that I needed to read. At this point I changed 'trade off' to 'trading off' as the basic social process is a 'gerund'. 'Gerunds suggest movement and change, or process over time' (Fagerhaugh 1986) p. 135) therefore need to be an action verb ending in "ing".

In keeping with the grounded theory design the literature is theoretically sampled during analysis. I was anxious not to begin sampling the literature too early in analysis, as I wanted to make sure that the theory was grounded in the data and not overly influenced by pre-existing ideas. It was not until I felt close to forming the major categories and exploring the relationships between them in the search for the core category that I turned to the literature to

see what had already been published in relation to the emergent categories. Thus the literature is incorporated as data at this stage. I also turned to the literature to look for other examples of 'trading off' to see if this basic social process was used by other groups. In this case I found some articles written by occupational therapists about individuals with disabilities and how they adapted. This helped me to confirm the phases of the basic social process.

Theoretical saturation

Data were collected until no new data were emerging, thus achieving what is termed saturation. By achieving saturation the researcher ensures that the theory accurately reflects the situation and the result is a rich "thick" description. As similar instances were seen again and again I became confident that each category was saturated. Knowing when to stop is difficult and in the end becomes a pragmatic decision of ceasing data collection when it seems unlikely that further investigation will be fruitful (Seale 1999). When I came to the fifteenth interview I began to feel quite sure that I was not hearing anything that would dissuade me away from the core category and basic social process. In fact this interview made me feel quite confident that I had reached saturation for all the categories.

Data management

Having considered the data analysis process in step-by-step detail it is important to document how I managed the data for the study. Two approaches were used to manage data during the study, one for managing the large amounts of literature and one for managing the data from the interviews. On commencing the study I established a database for the literature I would be using with the Endnote 5 software (later upgraded to version 6 and 7). I diligently entered the details of all literature encountered and established a retrieval system. The Endnote database not only facilitates accurate citation and reference list formatting in documents, but

also has a search feature. The search feature was used during analysis in the theoretical sampling phase, where a key word or concept was from the analysis could be used to search for related literature, for example,

Effective management of large amounts of textual data generated by the study was a constant challenge. Once data gathering began, I had to make a decision about how I was going to manage not only the data collected, but also the analysis, including the recording of an audit trail. I investigated the use of computer software, but decided that the benefits of using a commercially available means were outweighed by the disadvantages of cost, and the learning time required for mastering the program. I had also read cautionary tales warning of the risk of over-emphasising codes and categories and thereby generating variable analyses removed from the situational context. Such an approach would be more aligned with a positivist theoretical orientation and therefore not appropriate for my grounded theory study. Richards and Richards (1998) noted that it is important not to let the software determine the form and content of the interpretive activity. As my preferred learning style is very visual and "hands on", I probably made the right decision to tackle analysis manually even if there were frequent occasions on which I regretted this decision.

All transcripts were kept as word files. After the early interviews were open coded I literally copied and pasted the relevant sections into other word documents labelled with the codes. This was repeated for each interview. Each section of transcript was identified by the name of the participant and the line numbers of the original transcript. This enabled me to return to the transcript if required to reconsider the context of the statement. The pages of codes were then printed out so that I could consider each one and compare them with all the other codes in the constant comparative method process. This enabled me to see similarities and differences between codes and cluster them together as part of data reduction.

Later in the analysis when further interviews were conducted, I would cut a copy of the transcript into pieces and place the new statements from the transcript against the previous codes. At this stage too I drew diagrams or "mud maps" of the codes and the relationships between them (see figs. 2 - 4). (A "mud map" is an Australian expression for a rough drawn diagram that is not to scale). Another form of "mud map" was kept on the wall of my work office and stimulated conversation about the analysis with my colleagues and students. The conversations assisted me in clarifying the codes or category and the relationships between them. Numerous diagrams were drawn as data were repeatedly compared, with a number of codes being collapsed into categories and re-named. The diagrams also enabled me to explore the relationships between categories in the search for the core category. These diagrams too formed part of the audit trail: a strategy for ensuring credibility and trustworthiness.

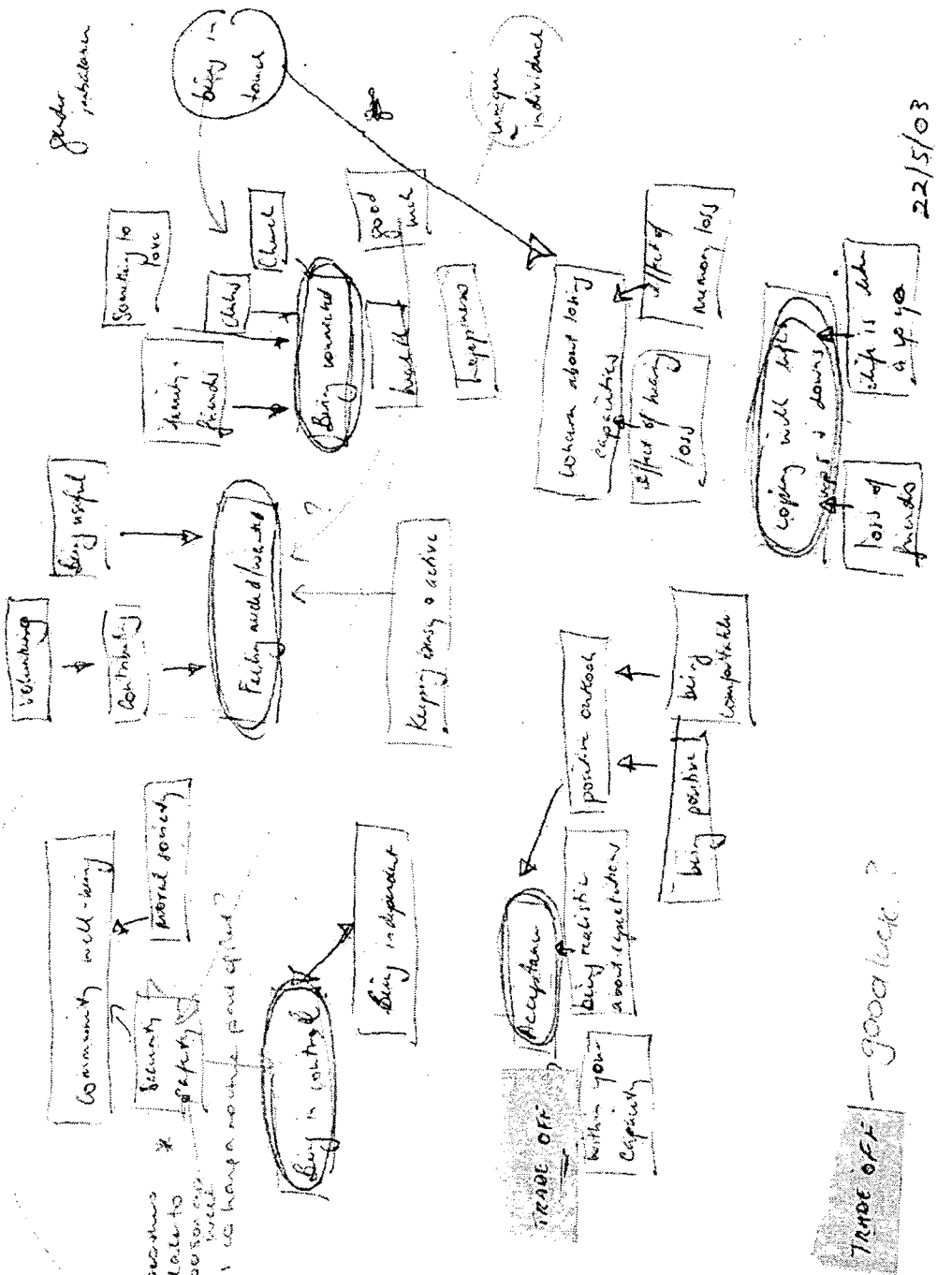


Figure 2. 'Mud map' of analysis

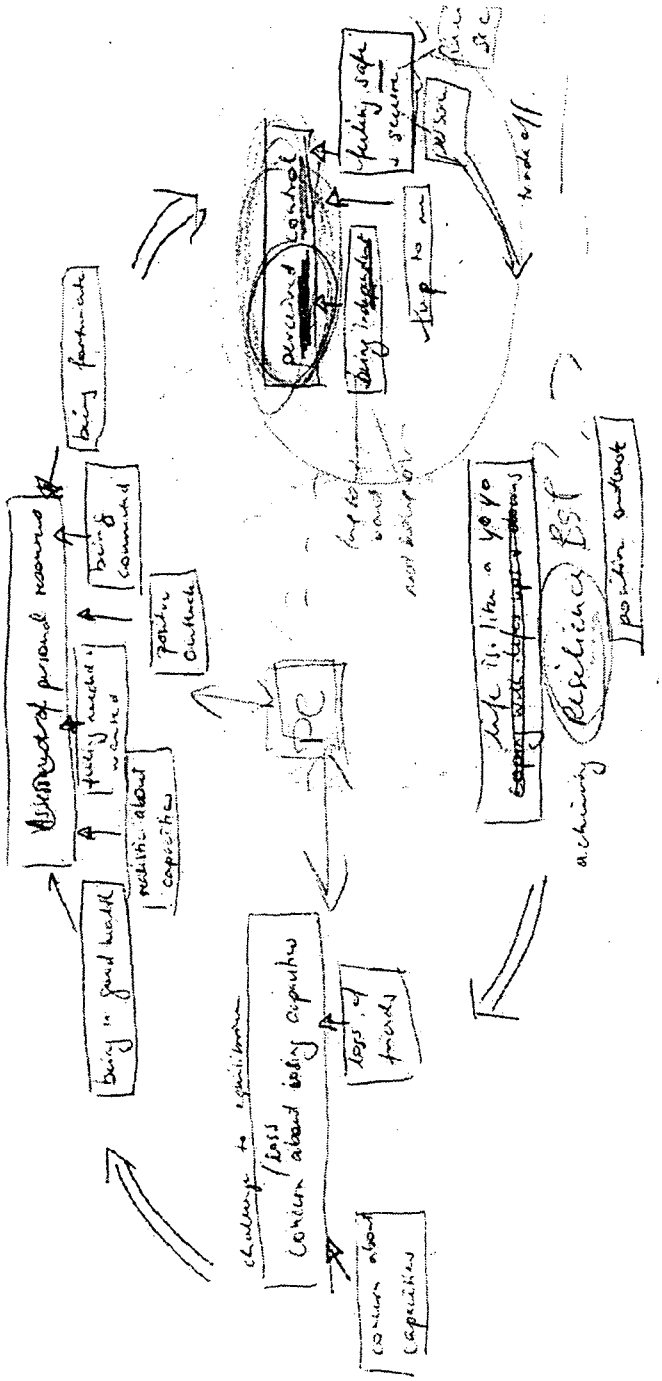


Figure 3. Next iteration of analysis mud map

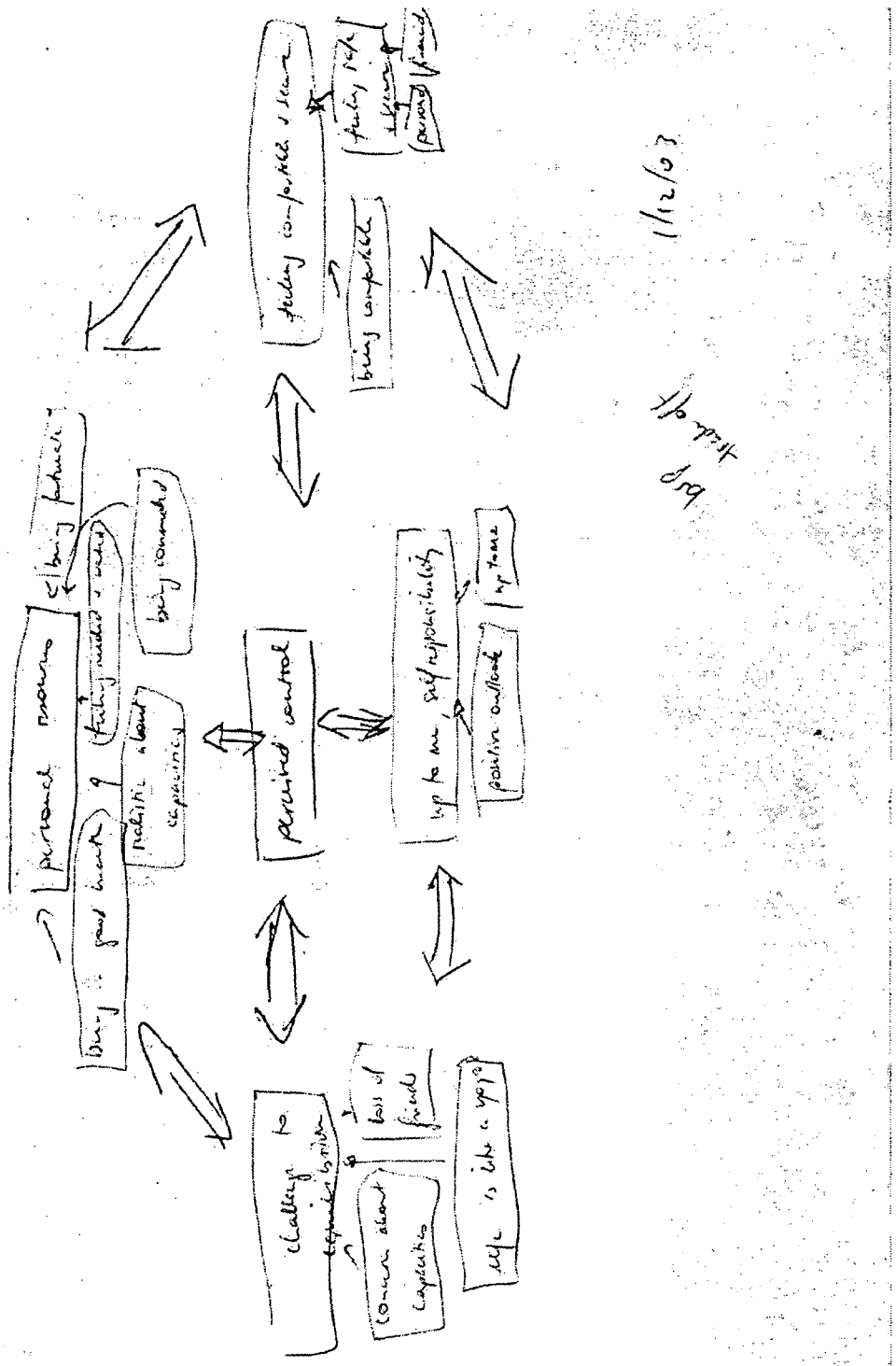


Figure 4. Further analysis

Strategies used to ensure rigour

In the chapter thus far I have provided a detailed description of all the steps in the data collection process. It is important now to consider the strategies I used to ensure that the study was conducted in a rigorous manner. As part of rigour procedures such as peer coding and code/ re-code were used. Sections of some early transcripts were coded separately by my supervisor and myself and comparisons made. Differences in coding were discussed. This peer coding process enables a check that the researcher is not imposing her ideas on the data rather than allowing the analysis to arise from the data. Sections of a transcript were also coded then re-coded one week later. Consistency of use of codes used in analysis was checked.

The specific strategies used to address rigour in this study were informed by Krefting's (1991) suggestions, which follow Guba's (1981) model of trustworthiness. The model is based on four aspects of trustworthiness that are relevant to both quantitative and qualitative research: (a) truth value, (b) applicability, (c) consistency, and (d) neutrality. Krefting (1991) suggest that the four aspects of trustworthiness become four aspects of rigour: credibility, transferability, dependability and confirmability. Each of these aspects will now be expanded upon and specifically discussed in relation to this study.

Credibility

Credibility assures the reader that the research is a 'credible' account of the lives of the people involved, that is, the findings would be recognisable by the participants and others in a similar situation. The research needs to represent the multiple realities present as adequately as possible. Strategies used to ensure credibility include prolonged engagement in the field to make sure the researcher has a good understanding of the substantive area, and using numerous interviews to check various perspectives. In my case, the interviews for data

gathering took place over a period of three years. The assumption is that prolonged engagement is much better in ensuring that the data will reflect the social situation, and that the resultant analysis will be "thick" and credible. For my study, prolonged engagement was with the field of study rather than with each participant. I also used reflexivity to examine the influence of my own background, perceptions and interests on the research process. Notes were kept in memos to record my personal thoughts, feelings, ideas and hypotheses. These thoughts were kept in an effort to become more aware of my own preconceived assumptions. Peer examination (as described above) was also used to enhance credibility. This involved discussions with my principal supervisor as well as several colleagues with experience in qualitative research about the analysis and analytical decisions. Probing questions during these discussions helped me define categories and pursue lines of analysis that were not evident to me beforehand.

Transferability

Generalisability of results is not relevant to qualitative research, however according to (Guba 1981) transferability is. The purpose of qualitative research is to provide a rich description of a particular phenomenon in a particular research situation. Lincoln and Guba (1985) argue that it is not the researcher's responsibility to apply this criterion. As long as the researcher presents sufficient descriptive data to allow comparison by the reader with their own context, then the problem of transferability has been met. Therefore in this study I have given a thorough description of sampling, data gathering and data analysis in order for the reader to make their own decision about how transferable the findings might be.

Dependability

Whilst quantitative researchers assume that there is one reality and that it can be studied and measured, qualitative researchers are looking for varying perspectives that represent multiple

realities. Therefore dependability is interpreted as trackable variability, that is, the variability can be ascribed to identified sources. Qualitative research is concerned with the range of experience rather than the "average" experience, so atypical situations are important to include in the findings. Dense description of methods provides information so that other researchers could try and replicate the study, or make a decision about how unique the research situation was.

In this chapter I have provided a dense description of the methods and I kept an audit trail which records the decision trail used in analysis. An audit trail is the documenting of 'the path of thinking and action processes so that others can clearly follow the logic and manner in which knowledge was the developed' (DePoy & Gitlin 1998)(p. 230). Examination of the audit trail would reveal how the core category was developed from the categories, and how the categories were developed form the initial codes. It enables a researcher to track the analysis process, and justify decisions. The use of peer examination was another strategy employed to ensure dependability.

Confirmability

A major technique for establishing confirmability is an audit trail. Reflexivity is also used so that the researcher is aware of the influence they are having on the data. Reflexivity is defined by Depoy and Gitlin (1998) as 'the process of self examination' (p. 230), and by Mason (2002) as 'thinking critically about what you are doing and why, confronting and often challenging your own assumptions, and recognizing the extent to which your thoughts, actions and decisions shape how you research and what you see.' (p. 5). The researcher examines his or her own perspective and determines how this has influenced what is learned in the study and how it is learned. Further, Finlay (2003) suggests that reflexivity is the process of "examining how the researcher and the intersubjective elements impact on and

transform research" (p. 4). The purpose of reflexivity is not to establish neutrality but to use reflexivity to achieve a far more intense insight.

I grappled for quite some time trying to understand this notion of reflexivity, and found reading Frank's (1997) discussion of the use of reflexivity in an ethnographic study insightful but was unclear how to apply it to my study. I had been examining my own perspective but it hadn't brought me to any deeper insights. That was until I conducted one of the last couple of interviews with Radlee and Herbert together. I knew this couple had significant health issues and that Herbert had been caring for Radlee for a number of years and was getting exhausted. Their family perceived the situation as tenuous and had discussed the need for the couple to move to more supportive accommodation. I went to their home anticipating that both participants were probably not experiencing well-being and in fact may well be depressed or in despair about their situation. I couldn't have been more wrong. This led me to the insight that it is the participant's perception of their situation and if they perceive that they are in control, not an external judgement by family or health professionals.

Chapter summary

In this chapter I have described the study method in detail. I began by describing the selection criteria for the study sample and offered a rationale for choosing over 75 year old participants living in the community in metropolitan Adelaide. Details of the opportunistic, snowball and theoretical sampling followed together with a discussion of the data gathering approach and consideration of the advantages and disadvantages of in-depth interviewing. A detailed description of how each of the participants was recruited was given so the reader would be able to form a picture of the sample group. I discussed the ethical issues, with a particular focus on the power differential between the researcher and the researched and how I have attempted to address issues of power.

A detailed step-by-step description of data analysis followed together with illustrations of the conceptual maps that assisted me to move from coded data to a core category and basic social process. To conclude the chapter I have described the procedures used to ensure rigour following the model suggested by Krefting (1991), and included a definition of reflexivity, and how its use enabled me to gain deeper insights. I turn now to present the findings over the next three chapters, bearing in mind the resultant theory has categories that are all inter-related rather than able to be presented in a linear fashion.

Chapter 5: Articulating the theory: an overview and the core category

The purpose of this study was to explore older people's perceptions and understandings of well-being. To achieve this I have used a grounded theory approach the rationale for which I have described in chapter 3. In chapter 4 I outlined the specific data collection approach of semi-structured in-depth interviews and described the data collection and analysis processes in detail, as well as the steps taken to ensure a rigorous study. In this chapter I will begin to present and discuss the findings. Doing so in a way that is logical and has a minimum of repetition is quite a challenge as all the major categories to emerge not surprisingly relate both to each other and to the core category, reflecting the inter-relatedness and complexity of the phenomenon, well-being. Whilst one might imagine that it is simple to move from a description of the analysis to explication of the theory, it is not such a straightforward process. The analysis and theory generation continues even in writing, as in having to articulate the relationships between various parts of the theory the process of writing helps to produce further clarity and insights. At times I had a sense of trying to peg down a very large tarpaulin in gale force winds, and no sooner had I pegged one corner and moved to peg another, and the first corner was already being lifted by the wind.

It was difficult to decide how best to present the theory so that it was clear for the reader. Do I start with describing the basic social problem, then the major categories and conclude with the core category and basic social process, or the other way around? In the end I decided to begin by giving an overview of the theory to emerge to give the reader an overall appreciation of how the core category, 'perceived control', is related to the other categories, and the categories to each other. The overview includes an introductory description of the basic social process identified, which I have called 'trading off', used by participants to achieve

'perceived control', the core category. Following the overview I will proceed to describe the core category and related basic social problem in more detail. The remaining categories are discussed in detail in the chapters following this one, finishing with an extensive discussion of the basic social process that underpins the theory. This seems to be the most logical way to present the thesis as all the data connects to and in some way "leads" to the basic social process, 'trading off'. In my description of the theory I will use the following conventions: category names will be denoted by inverted commas, for example, 'personal resources'; and direct quotes from participants will be in italics within quotation marks and include a reference to the line numbers of the transcript.

Overview of the theory to emerge

A diagrammatic representation of the relationships between the core category 'perceived control', the other categories and how the basic social process 'trading off' is used is supplied in the pocket at the rear of this thesis for the reader to refer to. In the text to follow the various elements of the diagram will be described briefly before progressing to more in-depth descriptions later in this chapter and in the following two chapters. Analysis of the data revealed the categories 'personal resources', 'it is up to me', and 'feeling comfortable and secure', which provide a basis for older people to face the 'challenges to equilibrium' and for them to use the basic social process 'trading off' to achieve 'perceived control' and thus well-being.

A 'challenge to equilibrium' such as ill health or loss of a friend, threatens the older person's ability to perceive that they are in control. This prompts the older person to review their 'personal resources'. The category 'personal resources' consists of the properties 'being in good health and good fortune', and 'being engaged and active'. Personal resources help older people to perceive that they are in control and contribute to 'feeling comfortable and secure'.

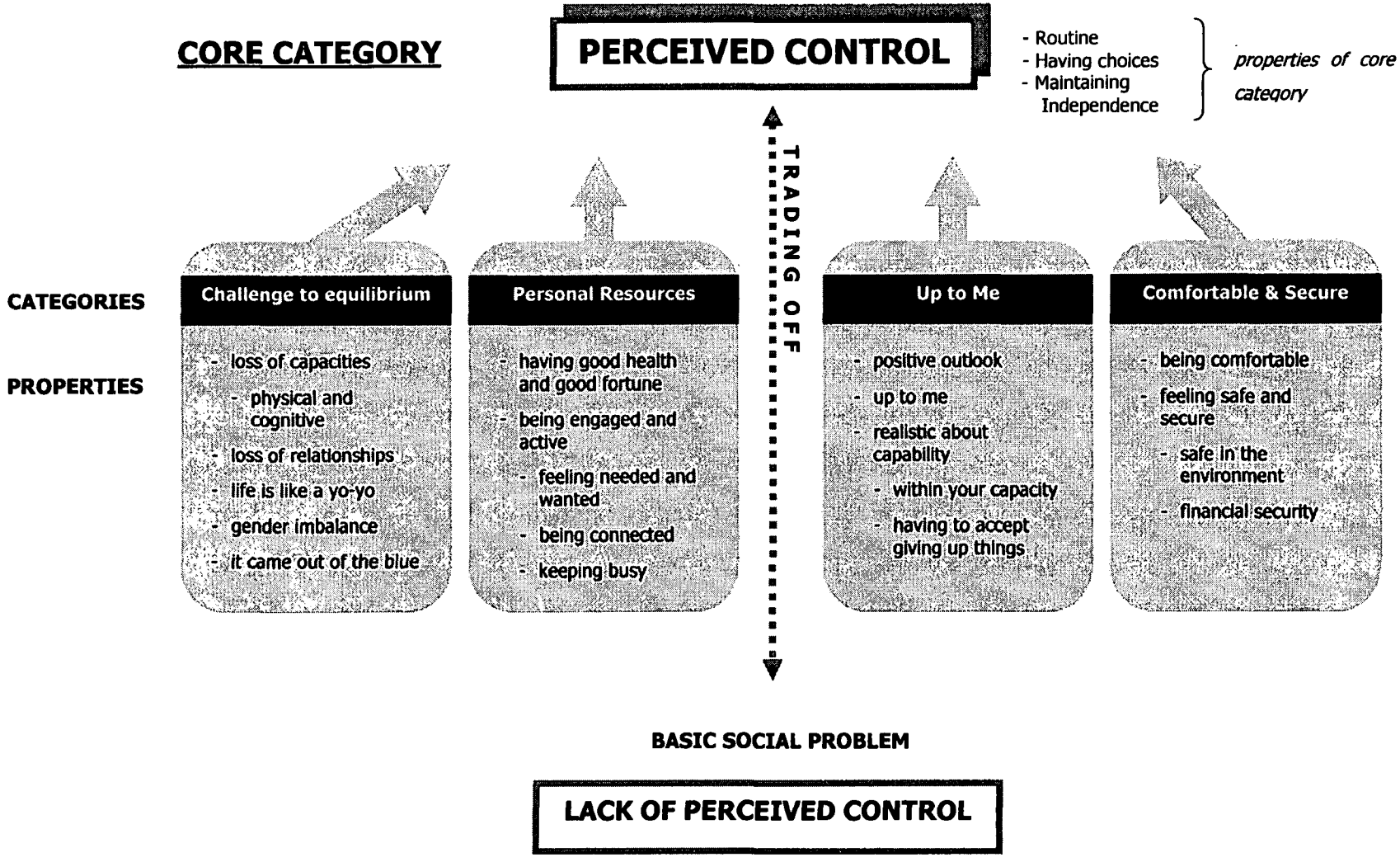


Figure 5. Diagram of relationships between categories, the core category and the basic social process

Personal resources can be used to buffer the challenges to equilibrium. For many participants being in good health was basic to well-being. Whilst chronic conditions might exist and were managed or lived with, ill health was the greatest threat to well-being.

'Being engaged and active' is a very large property of the category 'personal resources' and encompasses a range of ways that older people were connected with others socially and kept them busy and active. Belonging to clubs and contact with family members as well as friends and neighbours are all part of being connected. This enabled people to feel that they were not alone in the world.

It is important for older people to have a 'feeling of being needed and wanted' and to be of use. Volunteering in a formal sense or doing for others informally both contribute to a sense of being needed and wanted. Older people value making a contribution to society in some way and all older people in the study needed to feel needed and wanted and of use. Therefore they also liked to 'keep busy', and to engage in occupations that were stimulating and provided some challenge. There was a sense on the part of the participants that you have to keep the mind and body stimulated and challenged so that you don't risk further loss of capacities.

Some of the participants drew on faith or spiritual beliefs as a resource to buffer the effects of losses. Participants had affiliations and beliefs with particular religious organizations as well as spiritual practices such as meditation. Drawing on a connection to a higher being or spiritual practices such as meditation helped people to feel centred and thus contributed to a sense of well-being.

A person's attitude makes a significant contribution to the older person perceiving that they are in control. To experience well-being older people identified the need to have a positive outlook and an attitude of 'it is up to me'. There is recognition and acceptance that it may not be possible to change the normal ageing process, or life events such as ill health or the death of a friend, but what it is possible to control is the reaction to those adverse events. If one is able to take as positive a view as possible about events it helps. There is a sense that brooding or worrying about things only makes them worse.

Taking a positive outlook in life is part of demonstrating self- responsibility. Participants seemed to support the old adage – you only get out of life what you put in. This translates into feeling that it is 'up to me' to take responsibility for my actions and emotions. Participants saw it as their responsibility to maintain their health by doing such things as eating well and getting exercise.

To take responsibility for oneself also involves the need to be realistic about one's capacities. As capacities are reduced by the effects of "normal" ageing or by ill health the participants had to accept the loss and adjust to the new "self". If they didn't accept the reduced capacity or weren't realistic about their limitations then they felt miserable and depressed. New ways of doing things had to be found that fitted within their limitations. Sometimes they could find suitable, meaningful alternatives or they might need to accept they could no longer perform that occupation. This might involve finding someone else to do housework or providing assistance with shopping for example.

To perceive that they are in control older people need to feel 'comfortable and secure'. Being comfortable includes the basic human comforts of being treated with respect and with dignity. Older people want to be viewed as unique individuals, not stereotypically reduced to the old

grey haired person who is diminished both physically and mentally. Older people also wanted to be comfortable in the wider community setting but reflected on what is perceived as the widening gap between 'the haves and the have nots' which makes them feel uncomfortable and insecure. Personal resources help bolster or protect the person against the effects of a challenge to equilibrium.

To feel comfortable and secure older people need to feel both personally and financially secure. Personal security involves feeling safe in one's own home and in the wider community. There was a general perception that going out at night is not safe and would be putting oneself at some risk of coming to harm. Older people tend to remain home at night to stay safe. In fact, the perception of older people going out at night being unsafe may be much stronger than the "real" risk. Financial security doesn't necessarily mean abundant riches, but enough money to meet one's needs, or to support the choices that the older person makes in their lives. People who were superannuates or had their own source of income couldn't see how people who only had the pension to live on could experience well-being. The people whose sole source of income was the old age pension lived within their resources and still felt financially secure. It did however limit the choices they were able to make, particularly with regard to accommodation options. Well-being was impinged upon when the financial resources limited the choices available, however as long as people perceived that they had enough money to meet their needs they experienced well-being.

With increasing age it is likely that older people will be faced with challenges or changes to the status quo, or as I have called the category relating to these challenges and changes 'challenge to equilibrium'. The challenges can be in the form of reduced capacities, which may be part of the normal aging process, such as reduction of vision or hearing. Capacities may be reduced as a result of ill health, most often resulting in loss of physical capacities such

as mobility and endurance. Loss of capacities can also result from insidious disease processes such as Alzheimer's disease leading to memory problems. For some participants there was not only actual loss, but also worry and fear of potential loss of capacities as part of the ageing process. Worrying about loss of capacities that may not ever eventuate detracts from a sense of well-being.

'Challenges to equilibrium' also occurred as the result of 'loss of relationships'. As one ages there is a gradual reduction in the number of friends. Friendships are discontinued as a result of death of the friend or a gradual drifting apart, perhaps due to re-location of the friend to a retirement village or nursing home, or to a location closer to family members. Drifting apart can also result from the friend having a reduced capacity to maintain the friendship in the customary manner and so the friendship doesn't meet the needs of a person and it isn't pursued.

One of the most difficult things about 'challenges to equilibrium' is the unpredictability of all the events and the suddenness of some – they come 'out of the blue', and make it seem that 'life is like a yo-yo'. Some of the effects of ageing are slow and insidious, such as a reduction in visual acuity or hearing, but even if it is a gradual and subtle change, the older people in the study talked of not knowing if it would happen to them or the next person. Also some of the participants had the experience of being in good health and then suddenly being diagnosed with a serious illness. The death of a friend could also happen without warning. The lack of warning meant they couldn't prepare mentally and they were faced with changes to their capacity or the loss of a relationship concurrently with a reduction in the capacity to deal with losses.

The theory described thus far covers the four major categories which all contribute to the core category perceived control. The core category itself has the following properties: 'routine'; 'having choices'; and 'maintaining independence'. 'Routine' was one strategy that participants used to maintain 'perceived control'. For some people there was quite a strict routine of daily activities whilst others were more flexible, but combined this flexibility with a routine based on weekly or monthly activities. Some participants did things in a certain order during the day to make sure that they were done, for example taking medication, and to reduce anxiety. Other activities marked the week, such as lunch with a friend on Tuesdays, shopping on Thursdays and so on, or marked the time of month, such as a monthly club meeting. These routines provided structure to life and some predictability in an unpredictable world, which helped people to perceive that they were in control.

To perceive that they were in control, the older people in this study identified the need to have choices in life, or at least perceive that there was a choice and that one could exercise that choice. Having choices was closely linked to maintaining independence. Living independently and being autonomous were highly valued by the participants, but it didn't only involve living without having to rely on people for assistance. Whilst living completely independently was by far preferred, if receiving assistance meant being able to stay in your own home then it was worthwhile. Participants in that situation maintained independence by being autonomous in decision-making.

The basic social process of 'trading off' was used to achieve 'perceived control' when the participants had 'personal resources', 'felt comfortable and secure' and took the attitude that 'it's up to me' as a basis for examining the situation, were 'being realistic about capacities', and were exploring the choices available. Participants used 'trading off' to replace occupations they could no longer engage in and to maintain independence. Participants came

to realise and accept the 'limits of their capacities', examine the choices available and because they perceive that it is up to them, take control by 'trading off'. Examples of 'trading off' include taking up a new leisure activity to replace one that is no longer achievable, or getting someone else in to do the cleaning or gardening so that energy could be conserved for other things. For example, Radlee had a personal carer come several days a week to help her shower and dress so that the care burden on her husband was reduced, and that enabled both of them to maintain their independence in their own home. Use of trading off enabled participants to perceive that they were in control, and thus experience well-being.

Having given an overview of the theory I move now to a more detailed account of each category. Extensive use is made of participants' direct quotes to demonstrate that the findings are grounded in the lives of the participants. The remainder of this chapter explores in depth the core category and basic social problem.

Core category: Maintaining perceived control

In this section I will begin with a description of the dimensions and properties of the core category 'perceived control'. As pictured in the theory diagram in the pull out card, perceived control has the properties of 'routine', 'having choices', and 'maintaining independence'. All of these properties need to be present for the person to perceive that they are in control and thus experience well-being.

Routine

The first property of perceived control that I will discuss is 'routine'. All of the participants used routine in some way to help them maintain perceived control; however there was considerable variation in the flexibility of the use of routine. There was a temporal rhythm to the descriptions of the occupations they engaged in of either their daily routine, "*Well, I get*

up about ....", or their weekly routine, "*I see this friend S. every Wednesday, I see another friend on Tuesday, we go to the art gallery, and have lunch in town."* (Bev, 98-100). I had some concern that the first question used in the interviews, "Tell me about how you spend your day?", prompted participants to respond from a temporal perspective. However, upon consideration of the literature it appears that what I report is in keeping with the literature and that the older people imposed a structure to organise their lives in place of the socially imposed temporal structure of a working day or week (Jackson 1996; Ludwig 1997).

For some of the participants there appeared to be considerable rigidity about the use of routine. For Ruth, routine was vitally important to her well-being as it helped her control her chronic health problems. Ruth had diabetes and had had several toes amputated in the past as a result of gangrene. She therefore followed a regime of foot care to prevent any further problems. She also had a lung condition that requires her to use a nebuliser morning and night. Ruth had a particular routine that she followed to make sure that she completed these health maintenance tasks, as she was fearful of forgetting, and of the consequences of not preventing further health problems. Ruth said that using the routine helped to reduce her anxiety, "*It gives me a sense of security and certainty about what I have and haven't done*" (Ruth, 373-374).

Rosemary also had some set routines that she followed each day. She would rise early in the morning and eat her breakfast. Over breakfast she would read a lesson from a book, which has a lesson for the 365 days of the year and involves contemplating the meaning of the lesson. She also spent 20 minutes every morning practicing transcendental meditation. The time spent meditating prepares her for the day and makes her "more settled in herself". Rosemary spent time each day making lists of things she wanted to achieve. This might include a list of the shopping she needed and whom she might be able to ask to purchase

things for her. Making lists helped Rosemary to have a higher perception of being in control when she was not able to perform so many occupations in the community.

The use of a more set routine helped both Ruth and Rosemary to reduce their anxiety levels and feel in control. It appears then that routine is an adaptive strategy that provides a level of security to help older people perceive that they are in control. Similarly, Ludwig's (1997) grounded theory study of well-being for older women in the US found that routine was an important part of well-being for those women. Routine provided nine adaptive outcomes, namely it enabled the women to: meet obligations; maintain activity levels; maintain health; anticipate and look forward to things; maintain control; balance work, rest and play; accomplish and achieve; feel good about self; and provide continuity.

In this study routine appeared as a code, a property of perceived control, however it did not assume the same central importance as in Ludwig's study. Interestingly, Ludwig's participants used routine to maintain control as in this study, but here 'perceived control' was the primary concern, or core category, and participants used routine as a strategy to help them achieve that. In contrast, within Ludwig's study maintaining control was one of 9 adaptive strategies facilitated by the use of routine.

Another aspect of the temporal rhythm of the daily lives of participants was the use of temporal pacing to help them carry out daily occupations and participate in social interaction. For example, with increasing loss of physical capacities it takes longer to prepare for a social engagement such as going out to lunch and there is also much more planning involved as potential barriers to participation need to be anticipated. If more time is spent on preparing for occupations then the whole round of daily activities is affected. Pacing is a well-documented technique that occupational therapists use in therapy, particularly with clients

who have cardiac problems (Turner, Foster & Johnson 1996). Pacing involves time management in order to maximize the amount of activity that a person can do. The client learns to set priorities and plan so that they engage in periods of activity and then periods of rest. Complex tasks are planned for when they are at their best and not at the end of the day when they are tired. Energy is conserved wherever possible so that energy reserves are not depleted to the extent that they impinge upon further engagement in occupation.

It is unlikely that older people will be educated about energy conservation and work simplification unless they have a specific diagnosis such as chronic cardiac disease or if the older person identifies the need and specifically asks for help. It appears that older people accept the temporal slowing as part of the usual ageing process and make some of their own common sense adjustments. Quality of life could be improved however by the provision of information and teaching of techniques so that older people set their own plans and priorities, which will assist them to perceive that they are in control. Information about pacing could be made more widely available to older people through the popular media and information brochures in local pharmacies and doctor's surgeries. Armed with the information older people could then make their own choices about which strategies fit them and so which strategies they employ in their lives.

Having choices

Another property of perceived control is 'having choices'. To be in control or feel as though one is in control older people need to have choices and perceive that they are able to use the choices available. As Joan identified, "*when you think of it really a life is made up of choosing. So choice is very very important to me. Choice is freedom. And that is terribly important.*" (491-493, 504-506), and "*I think it is important in every aspect of their life to have choice and for the choice to be there, within reason, you can make sweeping statements,*

but I think choice is one of the most important things" (Joan, 465- 469). Joan particularly voiced her opinion about the right to have the choice of euthanasia. She had watched her daughter die of cancer and her husband deteriorate slowly with Parkinson's disease, and firmly believed in the right to choose to die to relieve suffering. Joan articulated her views on choosing euthanasia but that wasn't the only thing in which she thought you should have choice, believing that it was important to have choices in all aspects of life, and the perception that those choices could be utilised if necessary. Joan's beliefs were echoed by the participants in a English study of dignity in old age (Woolhead et al. 2004) who saw dignity in old age as a basic human right evidenced by the freedom to choose one's destiny. That included choice about the timing of one's final departure in terms of euthanasia. Dignity was also linked to notions of autonomy in terms of being independent to make one's own decisions and being in control.

Another way that participants exercised choice to maintain control was to limit the amount of bad news they took in. Reading newspapers and watching television news bombarded them with violent and depressing events in the world, which were upsetting. They were unable to control the world events, but what they did have control over was the amount of information to which they were exposed. Choice was exercised about what was viewed or read and how much.

The participants thought you should have choice over where you lived and most were fearful of being in the situation of not being able to choose, or being forced into moving into a nursing home. Loss of choice is perceived as loss of freedom and independence. Having choices seems to empower people to take control. Having no choice or a very limited choice makes people feel powerless and out of control with little flexibility to fit the choices with the individual's desires and values.

In terms of occupational therapy practice this suggests that when working with older people occupational therapists could assist the older person to identify and explore the choices available to them in a particular situation. The older person may be overwhelmed by the situation and be finding it difficult to firstly, identify the choices available and secondly, explore the available choices and appraise them in order to make a decision about trading off. For example, an older person may not be aware that there are services available in the community to assist them to live independently in their own home. Faced with reducing capacities the person may believe that the only option is to sell their house and move to a nursing home. If they are assisted with information about the range of options and the range of services available they may be able to perceive that they are in control and use 'trading off' to maintain their autonomy and independence. With assistance from the occupational therapist to identify the choices available the older person is then in a better position to make an appraisal of their situation and make their autonomous decision about action. The ability to make that decision with autonomy is important to perceive that you are in control. Another part of autonomy and perceived control for older people is 'maintaining independence', which is the second property of the core category that I will discuss in depth.

Maintaining independence

Participants were keen to maintain their current living situation as long as possible. Being in your own space, be it your own house, unit or retirement village unit, was an important indicator of '*being independent*'. People told me with pride that they did all their own gardening, or all their own housework. As Ruth said "*My aim is to keep myself independent as long as I possibly can.*" (37-38) Ruth had had the experience of admitting her mother to a nursing home and visiting her regularly up until a year or two earlier, so for Ruth "*one of the things I think about well-being is, don't end up in a nursing home.*" (882-882) Ruth was not

alone in her opinion. Radlee and Herbert were experiencing some pressure from their family to move to supported accommodation, "*They are very keen for us to go into a home, but that doesn't mean they want to push us*" (467-469). However, the couple could not see that moving into a hostel would be any different from having the care provided in their current home. The only difference they could see was not having the garden to worry about, but they did have a gardener come and take care of it for them. The thought of moving seemed to cause more concern as Radlee said "*We have enough books to sink the Queen Mary*" (487-488). They were very keen to stay in their own home as it meant so much to be surrounded by their treasured possessions. Everything that decorated the room we sat in for the interview had meaning for them, and many of the pictures and objects had been collected on overseas trips or had been given to them so each held valued memories. To have to move into supported accommodation would involve many difficult decisions about what to take and what to sell or give away and that would cause more distress when the intention would have been for them to feel more supported.

For Bill, being able to drive his car was independence. "*Oh yeah, thank God, if they took away my licence they might as well cut me legs off. I think if I lose my licence and lose my car, I think that would be the end of my world in other words.*" (95-99). Bill was the only one to express these sentiments, but it is well documented in the gerontological literature that loss of the ability to drive does lead to a loss of community mobility and thus independence and can lead to depression (Eisenhandler 1990; Fonda, Wallace & Herzog 2001; Rovner & Casten 2002). Bill also spoke of his need to be independent of his family and not to cause them any worry or to be a burden, "*Once again I'm very independent, very, very independent and I don't worry them at all. I think it is nice to be independent. Sometimes they say it is silly to be independent but I don't know, I think it is nice to be independent. I don't know if I am wrong or if I'm right I wouldn't argue on that one, but that's my way of seeing it. Being*

independent you have to have pride in yourself to do so and I feel a certain amount of pride in myself that I can still do things thank God, what I want to do." (460-471).

On the other hand, when I met Rosemary she talked of wanting to leave her home and move into a hostel. I initially thought that she was going to be a negative case for the category 'being independent'. Her desire to move was motivated by a need to have more social contact and not to have the worry of being out of control with respect to the garden and household chores that she could no longer do. As we talked more I also discovered that she didn't want to be a burden on her few family members, "*No you see I have no close relatives here and I don't want to put pressure on anybody. You see I have my sister-in-law and she nursed my brother who had a stroke and she was only 38. And I can see the fear in her eyes. Each time she phones me she says "have you put your name down for a home?" I can hear that*" (605-611). So I discovered that Rosemary still wanted to be independent and that it was independence on her terms. The key point is that it is the older person who defines what independence means to them. For Rosemary that meant wanting not to be a burden on her few family members. The participants in the study of dignity in old age identified that some people were so stubborn about maintaining their independence in old age beyond their capacity to do so that they actually suffered a loss of dignity (Woolhead et al. 2004). Rosemary was determined to maintain her autonomy and dignity by taking control and deciding to move to more supported accommodation so as not to 'be a burden'.

Participants perceived that they had more control over their lives by maintaining their independence in their own living space, even if that meant with outside assistance. Radlee and Herbert were able to articulate this very clearly and give examples. Radlee was quite disabled by Parkinson's disease and experienced episodes of 'freezing', when her entire body goes rigid and she simply cannot move. Movement generally is difficult for her because of the

rigidity and paucity of movement that are symptoms of Parkinson's. On occasions when she had been hospitalised the nursing staff would tell her that she wasn't the only one in the hospital, suggesting that she was too demanding of their time. At home she had her carers and her husband to fetch and carry for her. Despite her disability she was very much in control of the household. In hospital she didn't receive the sort of assistance that she needed to help her feel in control. The other example they gave was pain control. When she had been in hospital in considerable pain the nurses were unable to give her any more pain relief medication as they didn't have any doctor's orders and had to wait for the medication to be prescribed before they could administer it. This obviously caused stress and discomfort for Radlee. At home her husband could have been able to administer pain relief right away (he is a registered medical practitioner). The point is that at home you decide when and how often you take your medication (within reason), compared to not having control over these things in a nursing care situation.

All current federal and state government documents about older people advocate for the right to independence. As can be seen from the findings in this study independence is a very important value for older Australians. Older people do not want to be a burden on their family or on the community. They want to have choice and a sense of autonomy in being able to exercise those choices. To this end a range in the available accommodation options would help older people to maintain their independence together with a range of services that are responsive to the needs of older people, for example, cleaning of house gutters, other home maintenance tasks, gardening, pet walking and so on. Services that are responsive to the needs of older people will ensure that older people can stay at their chosen place of residence for as long as possible and perceive that they are in control. Not only is it necessary to have a range of accommodation options and services but older people need to have information about the choices available to them.

Other examples of the importance of independence for older people can be found in the literature. The participants of Jackson's (1996) study of a meaningful existence in old age also demonstrated a tenacious spirit of independence. Their desire for autonomy and independence was so strong that they would wish for a peaceful death rather than risk becoming dependent and a burden on others. Similarly, Fry and Prem (2000) and Woolhead et al (2004) reported older people expressing strong convictions about the right to control their quality of life and their right to be self-determining and autonomous. The Australian notion of independence, that is being physically self sufficient to care for oneself and to pay for one's own way financially, is firmly embedded in the older people in my study and in Jackson's. Independence and autonomy are seen in Australia as signs of social worth and of personal achievement and success.

It does appear however, that the notion of independence needs to be re-defined to include the cognitive choosing of options as a sign of exercising one's independence and autonomy, not just physical actions. Independence does not have to be associated with separateness or aloneness, of living by oneself without assistance, but rather independence of thought and decision-making. In an Australian study of occupational therapists' understandings of the concept independence in relation to older people, therapists did indeed have a broad understanding of independence along with ideas of independence being synonymous with being able to do things for oneself (Russell et al. 2002). However, it appeared that the rhetoric did not match the practice as the occupational therapists grappled with ethical situations of wanting to honour the older person's right to self-determination, but also needing to maintain a professional duty of care. If the occupational therapist's assessment of the older person's capacities did not match with what the older person needed to do then the therapists would invoke what the authors called 'the safety clause', in that their professional judgement

erring on the side of safety would override the persons wishes in their 'best interests'. There is no easy answer to these practice dilemmas. Russell et al suggest that a necessary first step is to further differentiate self-reliance from self-determination conceptually as well as in pragmatic terms. In the context of this study, independence clearly relates more to self-determination and the right to autonomy than to being self-reliant. Being able to do things for oneself does enable an older person to perceive they are in control, but they can still be in control if they have choices and can make their own decisions despite physical incapacity.

Thus far I have described the properties of the core category 'perceived control'. The description included how the use of routine enabled participants to perceive that they were in control. I have also explored the importance of having choices and the participants' desire and drive for independence and autonomy. I move now to describe what it is like to have the perception of being in control and some of the other strategies that participants used to achieve that goal.

Perceived control

If older people feel safe, comfortable and secure in their environment, are able to participate in activities that make them feel connected, needed and wanted, then they are able to take a positive outlook on life and be self-determining. This enables older people to perceive that they are in control, and to be able to use the basic social process of 'trading-off', should there be a challenge to the equilibrium by some kind of loss, be it a reduction in capacities or a loss of a relationship.

The psychological literature uses the terms primary and secondary control (Schulz, Wrosch & Heckhausen 2003). Schulz, Wrosch and Heckhausen argue that the construct control is the central theme characterizing human development from birth to old age, as the ability to exert

control over the environment is a fundamental building block of adaptive development in humans. Primary control is when individuals actively pursue developmental goals by using personal or external resources. The personal resources that are called upon may be things such as effort, abilities, skill and time; whereas external resources include assistive devices or using others help. Because primary control is directed outward, it enables individuals to explore and shape their environment to fit their particular needs. Therefore primary control is preferred and has greater adaptive value to the individual.

Secondary control involves a degree of flexibility, as the individual has to disengage with respect to the now unattainable goal and select other meaningful goals according to the limits imposed by the challenges of aging. So secondary control requires a change in the individual's expectations, which is at the core of being able to employ 'trading off'. Lapierre, Bouffard, Dube, Labelle and Bastin (2001) investigated the role of tenacity (holding onto goals) and flexibility (changing the goal) on psychological well-being. The results showed that flexibility was a very useful strategy for maintaining well-being when faced with obstacles to goal attainment. It suggests that flexibility might be more useful to older people than tenacity when faced with uncontrollable events and irreversible losses. The participants in my study appeared to be using flexibility in their use of a basic social process – trading off.

Schulz, Wrosch and Heckhausen (2003) further divide primary and secondary control into four types of control. Selective primary control refers to the focused investment of resources such as effort, time, and abilities and skills required for pursuing a chosen goal. Selective secondary control targets internal representations that are motivationally relevant to goal pursuit. Examples of internal representations include the values attached to a goal, the values attached to alternative goals and the perceived self-efficacy of being able to attain a goal. Compensatory primary control is required whenever the physical or cognitive capacities of

the individual are insufficient to attain a chosen goal. Thus compensatory primary control refers to the use of external resources such as assistance from others or assistive devices. Compensatory secondary control serves to buffer the negative effects of failure or losses on the individual's motivation for primary control. Strategies used in compensatory secondary control include disengagement from prior goals and engagement with new alternative goals, strategic social comparison with others, and self-protective causal attributions. The older person can justify to him or herself why the goal was not achievable and feel ok about it. Disengaging from an unattainable goal enables the older person to pursue more realistic goals and to have a more favourable chance of success.

Again flexibility of approach seems to be the key. If the older person continues to direct resources towards a goal that is unattainable because of a reduction in capacities then they are going to experience failure, and may experience negative feelings associated with the lack of success. If they are able to use compensatory approaches, and/or relinquish some goals and replace them with more achievable ones they are more likely to experience success and well-being.

Sharing the strategies that some older people use to maintain perceived control with others may be helpful to other older people. For example, limiting the amount of bad news they take in by watching only one news service a day so they don't become overwhelmed that the world is a bad, unsafe place to live in; making lists; creating something delightful each day. It may be useful to share that there are other ways of being in control. Older people can use secondary control. I will describe how occupational therapists can facilitate older people to consider using secondary control when discussing the use of 'trading off' in chapter 7.

The finding of the importance of perceived control challenges stereotypes about older people as frail, vulnerable individuals who are willing to delegate decision-making. From this study it can be seen that older people want to maintain control, independence and autonomy, and indeed, doing so enables them to experience well-being. It appears that the concept of control has received considerable attention in the psychological literature but far less attention in the occupational therapy literature. While the occupational therapy literature does contain references to perceived control this study points to a far greater importance of perceived control for well-being than has previously been recognised.

Having articulated the properties and dimensions of the core category, 'perceived control', and discussed the core category in relation to the literature, the remainder of this chapter will explore the basic social problem that underpins the theory of well-being.

Basic social problem: having the perception of not being in control

For a core category to exist it is necessary to find a basic social problem that is shared by the participants. In doing a grounded theory study, the researcher aims to identify the social problem that is shared by the social actors in the situation and the way the actors go about resolving this problem. The basic social problem that emerged in my study was the perception of not being in control. Determining the basic social problem was difficult, as not all participants expressed control as an issue. The participants that I interviewed early in the study were chosen or referred to me because they were perceived by myself or their peers to be "exemplars" of well-being, and therefore likely to be information rich. These people did not identify the maintenance of perceived control as a problem, although in the very first interview with Joan, there was some data about having choices and being able to utilise the choices. In fact I used Joan's words as code labels at that point. There was however always present the threat of not being in control. So even for those I thought at first did not share the

basic social problem, it was ever present. As more data were collected I began to suspect that perceived control was potentially the core category, but I couldn't see the basic social problem. It was only through the theoretical sampling of those with health problems and who had experienced loss that the basic social problem became apparent. As I deliberately sought out those facing a challenge to equilibrium I began to see that not being in control was indeed the problem. I was concerned that the problem didn't seem to fit for all participants, but on re-reading the transcripts participants expressed a fear of loss of capacities or relationships, and ways in which they worked to maintain capacities or relationships which was evidence that not being in control was the basic social problem.

Let us consider then, the basic social problem of having the perception that you are not in control. John recounted the experience of not being in control when describing his hospitalisation experience a few years earlier. John has chronic inflammatory demyelinating polyneuropathy, a rare condition that in the acute stage meant he was totally dependent for all his personal care needs.

> *When I first, when I was in hospital there they used to have one of these electric beds, you know you push the button so. And if I wanted to get out to go to the toilet I used to have [them] bring a lift along and lift me out and all that. I couldn't walk, uh, my hands where useless I couldn't use a knife and fork and then I used to use a spoon, you know, and then it would shake like that and drop half of it, you know." (John,131-140) and "It affected both feet, but the main problem was the right arm was hopeless, useless. My right leg was no good, and it's still not back to 100% better. I can't uh do I can't stand on, just balance on my left leg, you know. Uh, but uh I got in there and I got a bit worse after I'd been in about a month, and I thought uh oh going the wrong way (laughs) you know." "When you come to say you know I want to go to the toilet and they have to bring a thing along and skid it underneath you and swivel you out and push you down to the toilet and all this sort of thing you don't feel so sprightly.* (540-555)

Rosemary also felt out of control because of her reduced mobility, "*I never used to be in* [at home] *when I was well, and it is very hard to take my mobility going, not being to do this, not*

being able to that." (42-45). The loss of mobility prevented her from keeping her unit as she would have liked and from doing everyday things, which she found frustrating,

> *The little bit of garden at the back. It's so untidy, it's so, the leaves fall, I can't sweep that up. Both these people [indicating neighbours on both sides] are very garden conscious. I can't clean the windows. I can't, sometimes it is difficult for me to go to the letterbox because when I stand you see there is a tightness in my back, I feel I can't breathe. Even the washing up I've got to sit and do. Even if I want to go out, even post a letter you know it's.., I have to wait until somebody comes to go and post it.* (119-130)

Rosemary expressed the wish to 'go into a home' as "*Things are starting to bug me here*"(114-115). She felt unable to keep the garden up to a standard that the neighbours would be happy with, and unable to do other home maintenance tasks such as washing the windows. Unable to participate in normal everyday activities of maintaining the home and garden threatens an older person's autonomy and independence. The result is a feeling of loss of control.

Another participant who had experienced a perceived loss of control was Bill who had had a recent extended period of illness requiring hospitalisation and surgery and then complications from the surgery. "*I thought I was having a heart attack. And they got me to the hospital and after a few examinations they found I had a cancer, stomach cancer, and they operated on me, and I had pleurisy and it went to the right lung after the operation.*" (Bill, 127-132) He spent 5 weeks in hospital and as he said, "*You can imagine, I was well knocked around*" (132-133), "*and you know these days they don't keep you in the hospital more than 5 minutes if they can help you, so to be there for 5 weeks I wasn't in a very fit position to come around and do things like I used to*" (134-139). Even some 3 months later Bill said he was "*still not 100%*" (140).

It seems then that loss of perceived control can be either in response to loss of control over the body due to ill health or loss of control over the environment due to reduced capacity. Of

course this is not a simple dichotomy as ill health can result in loss of capacities, which may make the person ineffectual in their environment.

Chapter summary

I began this first chapter of the findings with an overview of the theory of well-being derived in my study. Following the overview I detailed the properties and dimensions of the core category, 'maintaining perceived control'. To conclude the chapter I have described the basic social problem, having the perception of not being in control, which is shared by all participants, either by experience or anticipation of an unknown future. If participants had not experienced not being in control they shared the fear of not being in control. In the next chapter I will continue with detailed descriptions of the other categories of the theory, culminating with the third chapter of findings including a description of the basic social process, 'trading off'.

Chapter 6: Articulating the theory: the categories

In the previous chapter I presented an overview of the grounded theory generated in this study of older people's perceptions and understandings of well-being. I also presented the core category, 'perceived control', which was the participants' response to the basic social problem, that of perceiving not to be in control. In this chapter I move on to present the categories that relate to the core category. I begin with the category, 'challenge to equilibrium' as this category forms the first phase of the basic social process of trading off, in that the 'challenge to equilibrium' is the cause of the mismatch between the older person's capacities and what they want to be able to do. I then go on to describe the categories 'personal resources' and 'it is up to me' and 'feeling comfortable and secure'.

Challenge to equilibrium

The category 'challenges to equilibrium' has the properties 'loss of capacities', 'loss of relationships', 'life is like a yo-yo', 'gender imbalance', and 'it came out of the blue', as can be seen by referring to figure 5 and the pullout. All of these properties presented a challenge to the status quo and altered or threatened the accustomed way of life for older people. The challenge to equilibrium precipitated the first phase of the basic social process, 'trading off'. I will discuss each of the properties of the category in more detail.

Loss of capacities

One of the things that caused worry, and thus was detrimental to well-being was the loss of capacities as one aged. There was particular concern about loss of sensory capacities such as

vision and hearing, and loss of mental capacities such as memory. Loss of hearing or vision caused participants to restrict their engagement, and in some instances prevented engagement, in valued occupations. Loss of visual acuity associated with the aging process made usual hobbies difficult to perform. Radlee wasn't ablte to do tapestry anymore because of poor eyesight. She could still knit, but it didn't give her quite the same pleasure as doing tapestry because she enjoyed all the different shades of colour that you can achieve with the tapestry stitches and threads. According to Brennan and Cardinali (2000) vision impairment is the second most prevalent disability among adults aged over 65 years. The onset of vision impairment in late life can have a significant impact on social interaction and on what people do as they are used to being a 'normal' sighted person. Visual loss is noted to be associated with a decline in participation in activities requiring a high degree of visual acuity such as crafts (particularly sewing and knitting), cooking and gardening, and a concomitant increase in watching television and listening to the radio (Brennan & Cardinali 2000).

Reg spoke about his loss of hearing and the impact on enjoyment, "*these days I don't go out to meals with people at a restaurant, I'm not saying I don't go out at all, I do, but I feel that I'm at a disadvantage in talking to people because of the background noise.*" (535-539) He also spoke about not being able to contribute to the management committee of the club he attended, an activity he very much would have liked to do, because his hearing loss would have affected his ability to follow the conversation around committee table. This put him on the "*receiving end*" (574), and he felt uninformed, and passive, "*The net result is some degree of isolation and therefore contraction of the area, contraction of the environment in which I live.*" (577-579)

Studies of the relationship between hearing loss and well-being suggest that it can indeed have a detrimental effect on well-being (Scherer & Frisina 1998). Even if the degree of hearing loss is marginal the person will experience a problem in attempting to converse in an environment with a noisy background. Kampfe and Smith (1998) suggest that the prevalence of hearing impairment in people over the age of 75 ranges from 50 to 74%, making hearing loss a significant problem for older people. Hearing loss not only affects the ability of a person to comprehend speech, but also the ability to detect environmental signs or warnings. This can put the person at risk, for example, of being run over if they don't hear a car approaching, and prevents them from putting preventive and/or protective measures in place. Lack of warning signs can lead to a sense of disorientation and vulnerability, and together with problems of poor or inaccurate speech comprehension it creates ongoing stress and apprehension. As seen in Reg's comments above, the person feels isolated, there is frequent miscommunication, and as a result contact with family and friends is decreased, which adds further to the sense of isolation (Kampfe & Smith 1998). It is difficult for an older person to perceive that they are in control if, first they can't hear information that is given to them; or second, the information is misheard and misinterpreted leading to misunderstandings; and third, the person with hearing loss misses the environmental cues. The effects of hearing loss are further exacerbated if the older person also has some visual loss, as they are unable to use that sense to compensate (Kampfe & Smith 1998). Coping with hearing loss requires the older person to expend more energy in concentration, leaving less energy for other interests. This becomes an even bigger issue if his or her energy supplies are already depleted by other health problems.

Occupational therapists working with clients with hearing loss can educate clients about energy conservation so that clients can prioritise and conserve energy where ever possible. If the older person puts into practise the principles of energy conservation then they are more

likely to have energy for the things they have to do and are important in their life. This may also involve 'trading off' some activities that take a lot of energy but potentially could be performed by someone else, for example, heavy cleaning, to preserve energy for the activities that give meaning to the person's life.

It is also important for occupational therapists to consider the effects of sensory loss on the social aspects of life and not just the physical. There is good evidence that loss of hearing and/ or vision can cause a constriction in the person's daily round of occupations and particularly in social occupations. Without a full complement of senses the older person finds it difficult to maintain social situations and is unlikely to initiate new ones. Any compensatory strategies that occupational therapists may be able to offer could help to arrest the decline in participation in social occupations and reduce the risk of social isolation.

The older people in this study worried about losing their cognitive abilities and having dementia. Ruth expressed her concerns related to her mental capacities, particularly memory. She reported the frustration of putting things down and forgetting where she had put them. I kept thinking that this was "normal forgetting", and that Ruth was being too hard on herself, but she equated it with memory loss as a result of aging and a sure sign that she was going to suffer a dementing illness. In Corner and Bond's (2004) study of older people's perceptions of dementia the participants did just as Ruth, and saw any perceived problems with memory as evidence of the first signs of the onset of dementia. They feared being demented, particularly if they had a relative with Alzheimer's dementia because of the perceived loss of independence, control, identity and dignity.

Ruth used many daily routines in an effort to help her memory particularly for taking her oral medication, using her nebulizer, and for foot care. Having had a toe amputated as a result of

peripheral vascular disease and diabetes, Ruth maintained control of her life by utilising routines so that she didn't have to rely on memory to preserve her health. Ruth expressed pity "*for anyone whose brain has gone mushy on them.*" Ruth's use of routine helped to reduce her anxiety about memory loss and it's link in her mind with evidence of the onset of dementia.

Loss of physical capacities was the reality for some participants. Whilst the older people were often able to compensate for the loss of joint range of motion or loss of strength or mobility, the associated fatigue was often the hardest to manage and the most frustrating, as John describes,

> *Well as I say I get uh I can get very tired, and uh, with this thing, it's a stupid thing. You think oh, I can do that you know it will take me about 10 minutes to do that and you start doing it and you can't finish it you know. It's uh like a, uh it would be12 months ago we put another bookcase in the room there and it was a, normally I would have made the bookcase myself. Buy huh we bought one and just assembled it, and D. said, now don't go doing too much. I said oh no half an hour and it will be finished. Well two hours later I still hadn't finished it, you know. It took me about two and half hours and I'd had it I had to go and lie down, and all this sort of thing. This is the problem.* (63-78)

The impact of fatigue on older people has received scant attention in the occupational therapy literature. There is considerable literature on fatigue that results from specific medical conditions such as multiple sclerosis (Stapleton & Mulholland 2004) and chronic pain (Strong et al. 2002) together with information on what occupational therapy has to offer in terms of energy conservation and work simplification. Currently the information is specific to certain medical conditions. I contend that it would not take very much to take this ready information related to energy conservation and work simplification from other areas and with some re-writing to better target older people it could be used to empower older people with some self management strategies.

For Radlee everything is an effort and takes up so much more time in the day. She described the effort of answering the telephone, "*Just the phone I hate to say this, and I* [would] *hate people not to ring us up,...and the children know and the phone keeps ringing and ringing and ringing. Just getting to the phone and then talking to them, that takes time, and that's where the day goes you know.*" (335-341). The loss of Radlee's physical capacities severely hampered her daily occupations and her physical capacities would further be diminished due to the progressive degenerative nature of Parkinson's disease.

Loss of capacities clearly affects the occupations that older people may be able to engage in. Loss of capacities puts one's independence at risk, as you need to rely on other people. Further, people such as family members, might perceive that you are less than independent and needing to seek more supportive accommodation. Loss of capacities also puts at risk your ability to be in control, and conversely the loss of capacities itself was often beyond the control of the participants.

I was interested that participants themselves used the word 'capacities' as it is a term that is used in occupational science literature in the same sense as participants used it. For example, Ruth said "*to have enough physical and mental capacity to be able to do what you find interesting and stimulating*" (290-292). Wilcock (1998a)defined capacity as 'the innate and perhaps undeveloped potential, aptitude, ability, talent, trait or power with which each individual is endowed' (p. 42). She argues that 'capacities are the building blocks of unique occupational natures and personalities' (p. 42), and despite each of us being endowed with the same range of capacities, there is great variation in how they are used and developed. Wilcock in her theory of human nature argued that the biological capacities of bipedalism, hand function, visual system, language, consciousness and creativity are what make us human and have been necessary for the survival of the species. She returns to the notion of capacities

when discussing well-being and contends that people need to exercise their physical, mental and social capacities in order to experience physical, mental and social well-being. The views of the participants in this study support Wilcock's ideas about well-being in that they believed capacities needed to be exercised. The participants also recognised the inter-relatedness of capacities, so that the loss of say physical capacities like Reg's hearing loss impacts on other aspects of life such as the social domain. Ruth talked about having enough mental and physical capacity to enjoy the things you want to do in life. As people age some abilities diminish not only as a consequence of changes in capacity, but also by changes in the availability of opportunities to develop abilities based on the acquisition of skills and knowledge.

Loss of relationships

Another property of 'challenge to equilibrium' is 'loss of relationships'. In addition to the fear of losing or actual 'loss of capacities', participants expressed 'loss of relationships' as affecting well-being. This loss occurred both by a gradual drifting apart of friends over the years, but more often by those friends dying. Martha spoke of still having school friends, friends from the country town where she lived and had her first job, and friends from teacher's college, "*although a couple of those have died in the last 12 months, and I mean that is going to happen now as we get older.*" (614-616) Whilst it may be expected that more friends will die as the years go on, it doesn't make it any easier. As Bev said "*In the last three years I've lost three friends that I went to school with, and they've left big gaps*" (265-267), and also the loss of her closest friend, "*She died 4 or 5 years ago, and that left a big gap, because I used to know all the things her children did and her grand children did. And then there was nothing, and that makes a big gap.*" (270-274). The death of friends challenged one's ability to cope with life's ups and downs.

Others had experienced the loss of a spouse or a valued pet. As discussed later in this chapter on page , contact with family members is important for older people to feel connected and thus experience well-being. Having an animal for a pet and being attached to that pet can be like an emotional bond to a family member (Sable 1995). It therefore follows that loss of a pet would also be seen by the older person as a 'loss of a relationship'. Pets provide the opportunity for an older person to engage in nurturance of others.

Interestingly, the participants who lived alone all mentioned the loss of a spouse and how long they had been on their own, but little more was said. I had expected that the loss of their life partner would have caused so much disruption to their lives that this would have been a stronger feature of the interview. Perhaps it is a demonstration of the strength of the participants and how they had resolved their grief to move on to create a new single life. Or perhaps it was a release from a relationship that was not satisfying or involved a burden of care. For both Bill and Joan, they were relieved to see their loved partner released from the suffering and incapacity of ill health. The death of Bill's wife prompted him to move house to help cope with the grief,

> *Well the house was too big, and I had big lawns and everything else and 4 bedrooms and everything. And I had sad memories, very very sad memories unfortunately with the loss of the wife and um, I thought well the best thing to do was get out and take the weight and burden and bad memories off my shoulders. Which I tried to do and I have done. I mean it's not like I've forgot the wife she still lives in my heart, but it's neither here or there. There we are. Life was still there and I had to go on living. And this is what I moved in here for because I didn't want the worries of a big house and all those things round me shoulders.* (250-264)

Life is like a yo-yo

Another property of 'challenge to equilibrium' is 'life is like a yo-yo'. In everybody's life there are times when things go well and times when life is more challenging. As Joan said, "*life is a bit like a yo-yo. There are times when everything is great and there are times of real loneliness, not so much depression, but loneliness.*"(116-120). A yo-yo seems to be a good

metaphor for the notion of resilience. Resilience is the ability to "bounce back" from adverse events (Jacelon 1997). When things are going well, it is easier to pick one's self up after a loss or health event; just as with skill and practice it is easy to bounce the yo-yo down and back up again into the hand. When things aren't going well, it is more likely that people will find a loss or a bout of illness to cause distress, for them to feel out of control, and it is harder for the person to return to a state of well-being. If the yo-yo user is unskilled or not concentrating, then they will not be able to snap the yo-yo back up into their hand, and the yo-yo will fall to the floor, requiring the user to wind it slowly back up again. If the older person doesn't have the capacities then they won't perceive that they are in control and able to use 'trading off' to achieve well-being.

Gender imbalance

Another of life's ups and downs, and thus a 'challenge to equilibrium' for the male participants particularly was the gender imbalance. As they got older there was less male companionship. In social settings such as club the numbers of women far outweighed the men. At one of the clubs that Bill attended to play indoor bowls there would only be two men present usually, and all the rest women. As Reg said, "*but that is part of the social environment, and the women dominate in numbers. And the women tend to be more capable, you know I hate to say that.*" (190-193). For Bob it was compounded by the only other male member at his club having dementia, which impacted on his ability to participate in activities to the level that Bob desired. Bob took it upon himself to offer some male companionship to this man but did not find the relationship particularly beneficial in terms of his own needs for some male company. From the female perspective, Mary commented that she much preferred the company of men to that of women as women tended to be bitchy, which she didn't enjoy.

Bill lived in a small block of independent living units owned by a major aged care provider in South Australia, and he was the only man living amongst women. He commented on the impact on him:

> *Um, it's ok, I keep myself in the village to meself, it's a little bit clicky. I shouldn't be saying that but it is. Once again I have to be careful, I shouldn't be saying this, I'm not trying to be sexist in any way, but I'm the only guy here, and I have to be very careful which way I look and which way I smell, and what I might say. I'm very easy I found by experience, I can be taken in the wrong direction so I just keep myself to myself.*(506-516)

Bill wasn't able to relax and just be himself, but instead had to be very careful about his actions or what he said in order that no-one took offence. That puts Bill in a difficult situation given that that is where he lives too. Having to be continually mindful made him tense and did not give him a sense of perceived control and thus well-being. Bill had to be ever vigilant to make sure that he didn't offend any of his female neighbours. The gender imbalance made Bill feel that the women had the control in the situation and not him.

When searching the literature using the term gender imbalance, I found studies of the disadvantages experienced by older women in terms of health and finances. No literature was found related to the difficulties experienced by men in not having enough suitable male companionship as they age. It is well documented that women live longer than men with the mean life expectancy for women being 82, compared to 77 for men (Australian Bureau of Statistics 2003), therefore there are more older women than men. Correspondingly, older men are an under-researched group. However, it is well documented that marital status has a marked effect on well-being with married older adults reporting higher levels of well-being (Peters & Liefbroer 1997). Older adults who have never been married, tend to fare better than the divorced or widowed, especially women. It may be that the loss of the relationship has a profound effect on well-being which is not experienced by those who haven't had that marital

relationship. For men who lose their wife, compensating for the loss of the relationship by finding other men for friendship is even more difficult because of the gender imbalance.

Loss of a relationship may mean that the older person has to adopt new roles that were previously performed by the other person. Occupational therapists can support older people as they go through bereavement in helping the person to adopt the occupations the other person used to perform particularly if there is a gap in skills. For example, the spouse may have always managed the financial affairs and the bereaved partner may lack confidence in that area. Whilst bereavement support and counselling is offered by social workers, church workers and others, the occupational therapy focus is on the occupational transition.

It came out of the blue

The final property of 'challenge to equilibrium' is 'it came out of the blue'. Adverse health events are often anticipated as people age and are feared, yet when they occur it may seem that they come suddenly 'out of the blue'. John had experienced a sudden loss of health and nearly all of his capacities, which resulted in him spending 6 months in hospital. He still has some residual loss of capacity three years later yet had made significant progress. During his early hospitalisation he had been unable to get out of bed by himself, needed to be lifted with a hoist to the toilet and could barely lift a spoon to his mouth, often losing the contents on the way. There was no warning to John and his wife prior to his illness, and virtually nothing could have been done to prevent it. He also now lives with the knowledge that the nature of the illness is he could deteriorate further at any time.

Some of the losses described in this category 'challenge to equilibrium' are sudden. There may be a sudden death of a friend or a rapid onset of a bout of ill health. The sudden nature of these events contributes to the sense of 'it came out of the blue'. The older person has little

or no warning, therefore they can't prepare themselves, and they have no control over the situation.

Summary of 'challenge to equilibrium'

In summary, the category 'challenge to equilibrium' encompasses issues related to the loss of capacities and loss of relationships; that is the losses that may be associated with the aging process. The loss may be sudden making life in old age something of a roller coaster ride with ups and downs, necessitating the need to bounce back after each challenge. Fear of loss of capacities exists even in the absence or actual loss. A challenge to equilibrium challenges the older person's ability to perceive that they are in control, and therefore affects well-being. I turn now to the category 'personal resources' which can provide supports to bolster the older person against the 'challenges to equilibrium'.

Personal resources

This very large category is made up of the sub-categories 'having good health and good fortune' and 'being engaged and active' (refer to fig. 5 or pull out card). Each of these sub-categories and their properties is expanded on below.

Having good health and good fortune

Having good health was seen as a great blessing and good fortune, but also basic to well-being. Martha compared herself to the residents of the nursing home she visited each week, "*and when I go up there, I think how lucky I am, because if you haven't got good health...*". (396-399). Isobel also saw herself as fortunate to have had fairly good health, "*I have been lucky in my life, I haven't had much sickness.*" (92-93), while Martha acknowledged her

genetic predisposition to good health, "*I suppose I'm just a bit lucky with my parents and grandparents in terms of health.*" (204-205)

Whilst some participants spoke about being lucky or fortunate to have good health, others took a more active role. Health was more likely to be achieved by eating properly and keeping fit. Having an education was also referred to as an adjunct to good health as you were more likely to know about eating well and looking after your body. A good education also means knowledge about how to access resources and seek information, as knowledge is required to influence and manage your own health.

I was interested that participants held the dual ideas that health was due to good fortune or being of strong genetic material, and thus out of your control, at the same time as recognising that there were thing they could do to maintain and/or improve their health. They mentioned strategies like eating well and getting exercise as ways they actively sought to maintain their own health at the same time as believing a certain amount of luck or good fortune was involved. Occupational therapists working in the community can contribute to enabling older people to be active in influencing their own health. Health promotion activities could be held in collaboration with other allied health team members to give information to equip older people to better look after their own health and make healthy decisions. Examples of a few possible health promotion activities are cooking for one, walking groups and exercise groups. These examples require active involvement in the occupation, not simply information giving, thus increasing the chances of influencing behaviour change. Information in itself may be useful but the underlying philosophy of occupational therapy suggests that actual participation in the occupation will increase the chances of influencing a person's health.

One thing that participants did not mention during the interviews was falls, yet it is well documented that a fall can lead to severe consequences such as a fractured neck of femur, which can lead to a rapid decline in health. At the very least falls may cause older people to be fearful and reduce mobility with a resultant restriction in occupational engagement (Delbaere et al. 2004). In time by doing less the older person loses strength and mobility and hence is able to do less, beginning a negative spiral. Restriction in engagement in occupations is also a strong predictor of falls together with a fear of falling, particularly for females (Delbaere et al. 2004). Occupational therapists play an important role in falls prevention and in maintaining participation in occupations. Some excellent falls prevention programs are being run in the community in conjunction with physiotherapists and aim to identify hazards in the home as well as build up capacities such as balance. Local councils also have home programs that are part-funded by the government to help identify hazards in the home and install equipment such as rails and non-slip surfaces to increase safety.

Given the importance of good health, it follows that any intervention by occupational therapists and others that aims to improve the health of older people will also promote well-being. Older people need widespread access to information and support to assist them to maintain and improve their own health. This would also help them to maintain perceived control.

As mentioned in relation to health, participants expressed thoughts of being lucky or 'having good fortune'. Not in the sense of being lucky with winning lotteries, but they felt fortunate to be in good health, or to have had little trouble with sickness. They also felt fortunate to have good family, either in terms of loving relationships and/or practical support. I was interested in this, as it seemed to say to me that good conditions were attributed to luck rather than to any role that the older person played. It made me think that they were being fatalistic,

that they believed that events were externally imposed rather than having control, yet that didn't fit with other parts of the theory in 'it's up to me', and the core category 'maintaining perceived control'. The ideas of good fortune or good luck relate to the psychological construct of an external locus of control. People with an external locus of control believe that the environment largely controls them and can attribute success to luck, whereas someone with an internal locus of control believes that they can control to a large extent what happens to them (Bonder 1997). It would seem logical that in order to maintain perceived control participants would need to have a belief that they could be effective over their health and the environment. Yet even the most self-determining participants spoke about luck. In the psychological literature it suggests that individuals have either an external or internal locus of control, but the findings from this study seem to suggest that both perspectives can operate within the one individual. The suggestion that individuals can hold both an internal and external locus of control is tentative and needs further exploration in future studies.

Feeling fortunate or lucky was arrived at after making comparisons of their own position in relation to their peers. John expressed the thought "*If you think you're badly off have a look around, you can usually find someone worse can't you?*" (579-581). That makes it easier to see that in comparison to that person, you are fortunate. John even considered that he was fortunate to have been a prisoner of war in World War II in Japan. Whilst at the time he experienced hardship, after the war he became aware of other prisoners of war who experienced much worse conditions at the hands of the Japanese. In comparison, he was fortunate. He also considered himself lucky that he couldn't concentrate very well when he was in hospital at the worst part of his illness, as it helped to protect him from thinking about how bad things were. John was always able to see the positive side of a situation. So whilst feeling fortunate seems to fit more with a fatalistic approach to life than a self-determining one, some participants saw it as an explanation for why they hadn't experienced an ill health

event, or relatively little ill health. Perhaps the clue is to make the distinction between the things you can and cannot change, so you can be more self-determining about the situations that you can influence and more accepting about those that can't be changed.

Being engaged and active

The other sub-category within 'personal resources' is 'being engaged and active, which has the properties 'feeling needed and wanted', 'being connected', and 'keeping busy'. 'Being engaged and active' is a resource that can support older people to use 'trading off' to achieve perceived control. The properties and dimensions will be presented in that order in the next section.

Feeling needed and wanted

The property 'feeling needed and wanted' is concerned with feelings of worth that arise from doing for others. The dimensions of this property are doing for others in formally recognised ways such as volunteering, and doing for others in informal arrangements.

Some participants described spending time doing a range of different types of volunteer work, for example, as Elspeth said "*it's not very much but it's something, we go once a month and roll up the newsletter.*" (83-85). She also used to offer her services to the local Council, "*I used to help little old ladies doing things, and then I found that I was older than them.*" (375-377). Joan had always done some sort of volunteer work in various different roles since coming to Australia early in her married life, "*the last one was at the Magistrates court information, and I worked there for one morning a week for 14 years.*" (38-40). Martha kept in touch with her previous profession as a librarian though volunteer work in the church archives, as well as being a tour guide at the State library.

Bev was very busy with volunteer work for Meals on Wheels, "*I type all the lists for Meals on Wheels, you know, the routes, they've got to be altered all the time.*" (175-176). This commitment also required her to be at home every day between certain times to take phone calls related to the changes for the lists. As Martha said, "*I think you need to feel that there are things you have to do and that people want you to do, probably, it's feeling needed.*" (205-208).

Studies of the relationship between volunteering and well-being suggest that older people who do volunteer work experience greater well-being (Onyx & Warbuton 2003) than those who don't, although there is some suggestion of a spurious relationship due to the impact of ill-health. As older people with ill health are likely to have a lower sense of well-being, they are also less likely to volunteer because of their health problems. Despite this it would appear that volunteering does provide benefits to the older person. There are a number of suggestions put forward in the literature to account for the effect of volunteering. Firstly, volunteering is seen as a replacement of the work role. Volunteering provides an opportunity to regain the social status of being in paid employment, along with providing some time structure to the week, and it gives the opportunity for socialisation. People turn to volunteering to try and recapture those features of work that were satisfying. Secondly, there is activity theory, which suggests that if individuals are more active in the community, they will age better. Thirdly, role theory suggests that older people need to engage in a variety of satisfying roles in old age due to the loss of the worker role, and loss of relationships. There is some suggestion in the literature that older people volunteer for more altruistic reasons than younger people. Older people are generally more committed volunteers, devote more time and tend to stay with organizations longer (Onyx & Warbuton 2003). Older volunteers appear to gain more benefit from volunteering than younger adults for each hour they contribute, and also experience greater benefits from becoming active with a number of different types of

volunteering (Van Willigen 2000). The older people who do volunteer are more likely to come from higher socio-economic groups, be married, in reasonable health and have larger social networks (Onyx & Warbuton 2003; Shmotkin, Blumstein & Modan 2003). The participants in this study did volunteer work to get a sense of feeling needed and wanted, that contributed to them feeling actively engaged in their lives and not a passive recipient. Doing for others seems to be important to having a sense of well-being.

As well as the formal arrangements of volunteering with an agency, which seems to attract a certain type of older person, there were many informal arrangements that involved helping, or doing for others that also enable people to feel connected and of worth. As Elspeth identified, helping others makes her feel good, and she feels satisfied that she has been able to help, "*But to help people, I will help if it is needed, and I still do. Oh, my neighbours, I take their dog for a walk, help with the shopping when they are sick, things like that. I don't mind. When they really need help I would do it but not to be put on*" (413-418), "*And Reg and I feel quite a lot, because we help a lot of people, you know on and off. Not on a regular basis but we are quite happy to do so. And we feel happy in ourselves that we can do it*" (Elspeth, 1160-1163).

Other examples of doing for others included Martha's commitment to visit her sister-in-law at a nursing home every Thursday afternoon. Also Kate had a friend in a nursing home who wasn't able to manage her own affairs, and who had the services of the Public Trustee. However, Kate thought that her friend, disabled by a stroke, was not getting a fair deal. So regularly, Kate took on the role of advocate to help out her friend, "*so occasionally I get stuck into them [government department] you know on her behalf*" (285-286), "*and I'll continue to do that because I am very very fond of her*" (341). Herbert cares for his wife Radlee with the assistance of personal carers. His carer role occupies nearly all of his time, but as he says,

they have been married for 54 years and he does it out of love. If he didn't love her, Radlee would have required a move to nursing home accommodation quite some time ago.

Elspeth spoke about "*givers and takers*" (1164). Givers help to do for others, but usually find just as much if not greater reward for themselves in being able to help others. Doing for others helps to bring a sense of well-being. Takers are those that receive help and support from others without any reciprocity. The takers are perceived as selfish and perhaps greedy. In Elspeth's view the world would be a better place and more people would experience well-being if more people were givers rather than takers, or that there was a better balance between the two.

In Lawton et al's (2002) study of the number and type of personal projects older people described, helping others was one of the most frequently named projects. Other-directed projects included helping others and volunteer work, and were associated with a higher positive affect, lower depression scores and a higher positive valuation of life.

If it is important to feel needed and wanted then occupational therapists need to find ways in which their clients can achieve this. This may involve connecting them with appropriate volunteer work or working out ways in which they can do for others. Volunteering does need to be approached cautiously as there is a need to balance helping others and feeling needed and wanted with feeling overburdened. Sometimes informal arrangements of doing things for others may feel less burdensome than making a commitment to being a volunteer. In encouraging clients to do for others, it is important to make sure that the client still perceives that they are in control.

Being connected

'Being connected' is another property of the category 'being engaged and active'. The dimensions of 'being connected' are all dimensions of social connectedness, that is, 'belonging to clubs', 'family' 'friends and neighbours', and having 'something to love'.

A number of participants belonged to a club. The clubs consisted of a range of organizations such as Legacy, Australian Retired Person's Association, book clubs and Probus. Being a member of a club gave people social contact and enabled them to 'be connected'. Another place where participants went to 'be connected' was church. I had imagined that participants might talk about church as a place for spiritual expression. However, for the majority of church attendees it was the social aspects that were articulated. For Ruth, it was "feeling a part of the place" (152), and a place to meet old friends as well as make new ones. In that sense, attending church and being a church member was very similar to being a member of a club. John and his wife had recently joined a travel club, which was run by a private company. The company ran day trips in a minibus one day per month, collecting members from their front door and bringing them home again at the end of the day. The company also runs weekend tours to nearby country destinations. Older people are able to spend the day with others of similar interests seeing new sights and revisiting old ones. The way the company conducts its business also ensures that the older people feel safe, comfortable and secure, a theme we will return to later in this chapter (see page 132).

All participants spoke about their family. They talked about children and grand-children telling me how many of each gender, where they lived and how much contact they had with the family members. The participants who did not have children of their own spoke about brothers and sisters or cousins. For example, family was extremely important for Martha in a number of ways as she talked about her activities. Being connected to family for her, ranged

from visiting her sister-in-law each and every week in a nursing home, to being involved in her brother's children's lives, to attending an international family reunion in Ireland the previous year,

> *and we had this great family reunion over 3 days. So that was great, and then I went to another part of Ireland where my maternal grandmother's family came from, but a number of us have been there before we sort of knew that, because they sort of kept tabs. And they were also some families don't worry too much, but Mum's family, the cousins growing up used to sort of go ugh, but they really did keep tabs on other another, when I say keep tabs on one another they kept in contact and even their 2nd cousins and their 3rd cousins, they all knew, and they all felt like they belonged and someone said "oh you claim cousins to the 2nd or 3rd degree" and one of my cousins said "Well why not, we like them* (Martha, 787-800).

Interestingly, Martha had never been able to have children but she and her husband were very involved in the lives of their nieces and nephews and took an active role in helping to raise the next generation, "*my brother has retired as a dentist in Lincoln, and his, he has four married children in Adelaide with children, perhaps we're like a, well one of my nieces says, a spare set of grandparents, so we have a lot to do with them, like with child minding, or picking up or going to school functions, and I think that is very good for you when you are older*" (301-307). Christmas time at Martha's house always involves some family members plus anyone else whom they have heard didn't have family with whom to share Christmas.

Other families didn't experience the same closeness. Some families were physically quite some distance away such as Elspeth's, "*We have our son and grandson who live in* [capital city some distance away]" (67), or for some the family members weren't very far away but led busy lives so that contact was infrequent. Bev stated that she only sees her son at family occasions such as weddings and funerals, and her daughter's life was full with work during the week and sailing on weekends, however she did have regular contact with her grandchildren by inviting them to visit and share a home cooked meal.

Family provided a focus for participants to keep the feeling of 'being connected'. To quote Martha, "*I can go for months, well not months, but weeks and not see them, but we can all ring one another up*" (531-533). Ruth greatly valued the fact that her children visited or rang up, "*Interaction with people that really belong, you don't have to work at the relationships, it's comfortable, I think that is important to me*" (533-535). Ruth noted the difference with her neighbour, "*She doesn't have as much interaction with her children as I do, but she has enough for what she needs. She says I'm not going to have them hanging around me, I'm not going to mind their kids, and they're not going to have to mind me*" (386-390). All participants had some connection to family, even if some of the connections were tenuous.

Another way of showing the connectedness to family was having family photographs on display in the house. The living rooms and dining rooms in each house that I was privileged to enter showcased a display of photographs of relatives and the participants themselves taken on both special and ordinary occasions. The display of family photographs reflects the theme of 'being connected', and has previously been noted by Jackson (1996) and Shenk, Kuwahara and Zablotsky (2004).

Technology was used to maintain connectedness with family. Participants and family members may not have had regular face-to-face contact, particularly if family members were geographically distant but used the telephone and/or email to keep in touch. For some of the participants the need to be connected to family members was the driving force for learning about the Internet and how to use a computer. The participants in a number of other studies Jackson's have displayed similar use of technology for the main purpose of being connected (Bradley & Poppen 2003; Jackson 1996; Malcolm et al. 2001; Thompson 1996).

Participants spoke warmly about friends and neighbours. Friends and neighbours provided another way of 'being connected'. Ruth had to make new friends after moving to the state four years earlier, "*the friends I make at church and the friends at the University of the 3rd Age are really important to me*" (398-399), and described how hard it was for her to make new friends as an older woman, "*I'm only just beginning to realise that if you want to make friends when you are older and you're not involved in things with children and organizations like sport, schools and so on you have to make the first move, 9 times out of 10, and I've done that once, and it's a good thing*" (400-405). She also kept in touch with her old friends by writing letters, "*old friends and so on, I think that is mostly why I write, because I write to people that I have known for years and years and feel relaxed and don't have to be formal, and you can natter on about the few things that happen, that aren't really earth shattering and you know that they will natter back*" (540-545).

Friends often had similar interests, as identified by Kate, "*Another one where she and I worked together so we had some similar interests, if I go, well she's probably 7 years older than I am, or thereabouts, confined to her chair and so forth, but if I turned up on a Wednesday about 1, she'd probably be watching the press club in Canberra. So we're on the same wave length and I really enjoy my visits to her, although it saddens me to see her like that*" (254-262). Knowing what her friend was likely to be doing at a certain time was not an indication of the predictability of a humdrum routine, but more to show that they knew each other well enough and had similar interests.

Neighbours were important both socially and in practical ways. Ruth appreciated her "*popper-inners*", "*2 neighbours who pop in all the time, and I'm really grateful for that because you can be like a snail in its shell in this place if you don't have some sort of casual interaction*" (117-120). Joan appreciated her neighbours for their generosity, "*I live not far*

from an Italian couple and they just couldn't be kinder. They just couldn't be kinder. And neighbours are terrific. I've still got quite a lot of friends in this area, because this is where we lived before, no I'm very fortunate" (306-311). Neighbours brought gifts of home grown vegetables and fruit, and offered to do shopping at times of illness. Martha described how she had the keys to the neighbour's house so they could help out when the neighbours went away, "*While she's away we go into the house and put her mail in there*" (1168-1169), and the neighbour reciprocated when Martha and her husband went away. Even if neighbours were not in the habit of popping in regularly there was still a sense of comfort in knowing them and knowing that they would be concerned for your welfare if something went awry.

Other examples of how older people structured their daily occupations to increase the amount of social contact with friends and neighbours to validate that they were socially connected come from the participants in Jackson's study (1996). For example, one woman positioned herself in a chair by the doorway of her unit to maximise the opportunity for social contact with neighbours passing by so that they might stop and share the time of day. Another participant would go and post a letter or get a few things from the shop to get social interaction with shop assistants and cashiers. These are all examples of the need to be connected socially to friends and neighbours and the community to experience well-being. As well as having friends and neighbours, Joan expressed the belief that everyone needed something in his or her home to love. For Joan, it was the treasured pet cat that she loved dearly. Some people might find owning a pet burdensome, but for Joan the benefit of having a warm living object to love far outweighed the cost or commitment involved. For some, a pet is just the same as another family member.

Given that social connectedness is important for well-being, it makes sense that occupational therapists explore various ways of enabling older people to 'be connected'. I offer some

examples here, but it must be remembered that the over-riding principle is to keep the control with the older person so that they identify what or whom they want to be connected with. Occupational therapists could introduce the older person to a club of their choice such as senior citizens, clubs for people with a common interest, or church groups and so on. If the older person has little contact with their grandchildren due to distance it may be worth involving them with the local primary school to listen to reading and to share stories. For some older people family, friendship and neighbour networks may need to be strengthened. The older person may benefit from increasing their skills and confidence in the use of technology such as email to keep in touch with family.

If people do not have any family or neighbours to draw on for support then services such as the Red Cross Telecross can be used. Volunteers at Red Cross make a daily phone call to check on the older person's welfare. The phone call helps the older person to feel connected to the wider community. Another way of doing this might be to use community volunteer visitors. Many local councils have schemes where they match a volunteer with an older person and that volunteer visits on a regular basis just for a social visit. The aim of all of these strategies is to increase the possibility of the person feeling connected to others. Feeling connected will help them to perceive that they are in control and experience well-being.

As mentioned earlier, attending church was part of being connected socially in the community in which one lives. For some it was also part of being connected to a greater community that connected by a faith in a God. For Ruth going to church was part of the expression of a strong faith. Ruth used prayer to call on help for herself and the world. Accepting faith was a significant turning point in Ruth's life as she tells:

> *But going to church is important to me as I've developed a really strong faith over a long long period of arguing and picking and saying don't give me that stuff it doesn't make sense, but finally when I was really in the pits, not very long after I had my toes amputated just long enough after to know it wasn't going to be better in 6 weeks the way I thought, it's going to affect the rest of my life forever, I finally said, OK Lord, I'm not going to argue anymore. And that really did it for me* (153-162).

Not many participants talked about the spiritual aspects of well-being. This was a difficult, very personal aspect to explore and I was reluctant to introduce expressions of spirituality into the interview questions for fear of influencing participants in a particular direction. I had anticipated that people might talk about the importance of believing in God or a higher being to their personal well-being. This was probably based on an errant assumption that it would be more likely for older people to be religious. Also from the literature, Jackson's (1996) study revealed that religion was the most common theme of meaning for her participants. In that study religion helped to organise the weekly and daily activities of some of the participants, gave the participant's symbolically meaningful occupations and a meaning for existence. The prominence of religion in Jackson's findings which was not strongly expressed by the participants in this study may be due to cultural differences between the US and Australia. Faith does however appear to be another resource that some people call on not only in times of trouble, but also in everyday life.

Occupational therapists working with older people could explore the sorts of spiritual practices the older person may wish to engage in, and help to facilitate that to happen. Spirituality is an area that some occupational therapists neglect or avoid as it might be viewed as too sensitive and the therapist may feel that she or he lacks the skills to be effective. I am not advocating that occupational therapists become spiritual leaders, as there are others more qualified in that area. What can be done is to ask clients about the sorts of spiritual practices that they might like to engage in and whether they are able to do so. It may be that they want to attend the local church but have no way of getting there. The occupational therapist's role

in that case is as a facilitator with the aim of enabling the older person to feel connected in a spiritual sense.

Keeping busy

The last dimension within the property 'engaged and active' is 'keeping busy'. 'Keeping busy' is concerned with keeping busy and active, with activities in one's life that are stimulating and challenging, that will "keep the wheels turning". They are all concerned with the maintenance of capacities, both physical and cognitive, but particularly cognitive. Maintenance of capacities is important given the prominence of the fear of, or actual loss of capacities discussed earlier in this chapter.

Participants spent their daily lives keeping busy to stave off boredom. For some there were always a lot of things to be done about the house – both housework and routine home maintenance tasks, as well as gardening. Active pursuits included swimming, travelling and walking. Bev was a good example of someone who likes to keep busy and active. She lived on the outskirts of the city so she would always walk to town rather than catch a bus, a 15-20 minute walk through the parklands. Every morning she would get up early to go swimming. On her return to her unit she would busy herself with volunteer work, and organising recreational activities for the retirement village where she lived.

Radlee reported that others perceived that she had lots of spare time, however she was busy as everything took so much longer than it used to. She says she is never bored, and that being bored was not allowed in her family. She busies herself with cleaning out drawers and cupboards. Herbert, her husband, is kept busy fetching things and caring for Radlee, doing the things that she used to do herself. Participants saw that it was important to keep busy and not to left with nothing to do. Keeping busy and actively engaged in occupations gave

participants the opportunity to maintain physical, social and mental capacities. Maintenance of these capacities is important for maintaining perceived control, and thus well-being.

Whilst participants believed in keeping physically active to keep the body in good condition they also believed in keeping an active mind to help maintain cognitive abilities. They did activities like cross-words and cross quizzes, or played bridge. Ruth attended language classes at the University of the 3rd Age. Any activity that involved thinking was seen as important to keep exercising cognitive abilities, or as Martha said "*keeps the brain whirling*" (144). Participants appeared to subscribe to the maxim 'use it or lose it'. Being able to participate in cognitive challenging activities confirmed that they still had those capacities and were still in control.

Participants also perceived the need to be stimulated and challenged by the activities they engaged in. Elspeth thought it was important to be interested in a variety of things to keep being stimulated and challenged. Martha and her husband travelled a lot which Martha found stimulating in a number of ways, "*I think it* [travel] *stimulates you, stimulates you physically because you are walking around and getting tired, but certainly stimulates you mentally because you are seeing new things*" (870-873.) As well as the physical and mental stimulation she found it socially stimulating, "*So I think it is the people and the places and the experiences. And it means there is a lot of follow up*" (934-928), which gave her new things to do on her return home.

Ruth also spoke about activities that were stimulating and challenging, "*It would mean to me to have enough stimulation so that you didn't feel at a loose end, and didn't know what to do with yourself next, and to have enough physical and mental capacity to be able to do what you find interesting and stimulating*" (288-292), and was gaining enjoyment from her French

classes, "*I really love it because it is challenging and because compared to the rest of the group I do reasonably well, and I think it is important to do reasonably well at something*" (209-212). At times Ruth found it hard to socialise with the other residents of her retirement village because the activities didn't provide enough challenge, "*But I'm bored out of my mind with the Scrabble because the other 3 ladies use the dictionary and sit for 10 minutes looking up words and I doze off in the interim, and I'm hopeless at bowls, so I'm stuck with the Scrabble*" (85-89). She felt left with the option of not socialising and being viewed as someone who wasn't part of the retirement village or participating in an activity that provided very little challenge.

Similarly, the participants in Jackson's (1996) study of a meaningful existence in old age identified the need for challenge in their lives. Whilst they were content doing everyday activities such as keeping the house clean and tidy, there was a need to have some excitement and challenge every now and then. One alternative used by the participants in that study was to relive memories of a challenging activity. The findings from this study, together with the study reported by Jackson lend support to the idea that older people still have a need for risk-taking. People with disabilities or a level of frailty are often deprived of the opportunity to take a risk in an effort to keep the person safe and comfortable. However, it appears that there needs to be a balance between having some challenge in people's lives and none at all which would be boring and lead to stagnation.

The idea of challenge has to do with the balance between the level of difficulty in the occupation and the level of competency in the person. An occupation with the appropriate level of difficulty provides the just-right challenge, resulting in success (Nelson & Jepson-Thomas 2003). If the occupation is too easy for the person's capacities they will succeed, but as there is little challenge they may become bored. If the occupation is beyond the person's

capacities they will not experience success and may become angry and frustrated. Occupational therapists use this notion of the 'just-right' challenge when choosing meaningful occupations to use with clients to achieve therapeutic goals. The challenge is necessary to stimulate adaptation but the client must experience success to achieve a sense of mastery and perceived control.

Keeping busy, and stimulation and challenge all equate with occupational engagement. 'Keeping busy' is also all about 'doing'. Wilcock (1998b) argued that 'people spend their lives almost constantly engaged in purposeful "doing"' (p. 249) and that doing or not doing were powerful determinants of well-being. Findings of this study support Wilcock's notion of 'doing'.

Enabling engagement in occupation is a traditional area for occupational therapy and occupational therapists, particularly with older clients. The occupations used therapeutically need to provide stimulation and challenge but also need to be within the capacities of the person. The skill of the therapist is in finding the right match between the demands of the occupations and the capacity of the person that enables them to continue to engage in 'doing' and living.

In this chapter thus far I have discussed the category 'challenge to equilibrium' which encompassed the losses often associated with ageing with loss of capacities and loss of relationships. I have also discussed the category 'personal resources' which included ways in which the participants kept themselves busy, challenged, stimulated and connected with others in order to perceive that they were in control. I turn now to the third category that will be discussed in this chapter, 'up to me', which is another category that participants used to perceive control.

Up to me

Participants identified that older people need to take the attitude that it is 'up to me', and take responsibility for themselves to maintain control and to be able to exercise 'trading off'. 'Up to me" has 3 properties (see fig. 5 or pull out card): 'up to me, self responsibility'; 'positive outlook'; and 'realistic about capacities'.

Up to me /Self-responsibility

There was a strong theme of participants seeing the need to take responsibility for their own lives, and thus their own well-being. They also expected others to take responsibility for themselves. Kate expressed great disappointment with one of her friends who she perceived had abdicated the responsibility for her own well-being, "*One friend of mine and I'm very fond of her, she makes no attempt to make her own life more enjoyable, and that I find disappointing*" (244-246), and further commented "*I don't think life will ever be agreeable for her because she is so negative.*" (741-742) As Martha said, "*But you can't wait for that to happen, you've got to go out, and I don't mean joining things for the sake of joining things, but you've got to make the contact, so that it's bit of a snowballing effect, and one opportunity leads to another*" (208-212), "*you can't just sit at home and wait for people to come to you, but I think because I've had all these interests people ask you to do things*" (297-300). So participants perceived that they were the ones who had to take responsibility for their life, how it was led and subsequently, their well-being. This was echoed by Elspeth, "*I think it is up to the individual, what they put into life. If the individual is willing to put something into it they feel much more content*" (1156-1159), and Joan "*But then, it is up to me. I must go out and find something to do, find some people to be with, ask people here, go out*" (123-125),

and "*I think that you have got to, to a large extent, make your own happiness, make your own life*" (226-228).

The category name 'up to me', could have been used as the theme of Bill's interview. He said as such a number of times in a number of ways.

> *You got to go on living, it is up to you whether you want to go on or not. I mean some people sit in the corner with a little finger ache, well it is entirely up to you, if you want to be that person, you can be. I mean people start feeling sorry for yourself, once you start feeling sorry for yourself it is the sad side of your life* (274-281).

> *But as I say it is up to the individual, it is up to you. Even now as I'm talking about going out and meeting people, you've got to have that push. And it is only one person who can give you that push, and that's yourself, no-body else. People can tell you this, and tell you that, they can tell you anything, but if you just sit back and let them tell you you'll never get there. It is up to you to say to yourself what you are going to do. And only you can do it, nobody else* (425-436).

Bill firmly believed in taking responsibility for his own life and his well-being, as he sums up "*My personal world is as happy as I want to make it, as happy as I can possibly make it*"(875-876).

Being realistic about capacities and limitations

Participants were well aware of the need to be realistic about their limitations. Isobel who has a pacemaker stated: " *I've had two. The first one I had for 7 years and now the new one for 2 years. It is not as good as the first one, but that might be old age. I go every six months to the get the specialist to check it out. My feet swell up a bit and they tell me to sit up with my feet, but it makes no difference that is how it goes on. I am still here though*" (287-292).

Isobel also spoke about her difficulties with urinary incontinence, "*with the bladder now a lot of people have trouble. I have to wear a pad all the time because of these water tablets but I manage. You can't do anything about it so I have to manage*" (349-352).

As Joan says "*I think just to, to enjoy life within your capacity. And everyone has limitations on their capacity, haven't they, and limitations on their interests too*" (260-263). If older people are realistic about their capacities and limitations they have to learn to live within their capacities. At times there will be activities that they want to do but are unable to as they realise that the activities are beyond the limit of their capacities. Being realistic about one's limitations is important for perceiving that one is in control. If the older person continues to try to do activities that are beyond their capacities they will continue to experience failure and to feel that they are not in control.

The physical capacities of the participants did not always meet the demand of the activities that they wanted to do. Bev's bad back which had resulted in a back operation meant that she could no longer do line dancing, something that she loved. It also prevents her from standing for long periods,

> ..And you stand and you look at something, and ah, my hip would start to ache, I can't stand for any length of time, because of the back operation. And even when we went to the Art Gallery a couple of weeks ago, the prints of the last 200 years, very interesting, but I had to sit in the middle and sort of look around, whereas J. would stare at every picture, you know. Ah I don't know why I can't stand; it's a big draw back (122-130)

For others they were often limited by energy levels. As Ruth said "*I'm really about as busy as my energy level will allow me to be*" (9-10), and was frustrated that she couldn't do the 12-13 hour days she used to work without getting aches and pains. She found it difficult to adjust to the fact that she can't do the things she used to. To be able to do things, Ruth carefully balances exercise and rest, "*I spend hours every afternoon resting or reading or doing crosswords, knitting in the winter time, but physically resting*" (407-409), "*Any kind of physical exertion you know, you have to find a balance between rest and exercise, because without exercise I wouldn't be able to walk at all*" (418-421). John used to do woodwork, "*I used to do a bit of woodwork but which I can't do now you know. I've tried, tried to saw a*

piece of wood, took me about half an hour, it's only about that thick you know [indicating about 2 cm with his hands]" (688-692).

Radlee and Herbert had reached the point where it was too much for him to perform various activities and include her at the same time. For example, when going shopping, it took much longer to prepare to go out, often to the point of Radlee being exhausted just getting ready to go out. Then Herbert would have all the responsibility of securing the house (something they used to share). Once they got to the shops he couldn't manage pushing her in the wheelchair and a shopping trolley. That meant he either had to buy less than was needed and pile the groceries in her lap, or make two trips to buy all the shopping. They found it much easier for Herbert to do the shopping by himself. This is an example of having to relinquish an occupation that they no longer have the physical capacity to perform or where the effort involved outweighs the benefit of performing that occupation.

The assessment of an older person's capacities and provision of adaptive equipment to help compensate for a loss of capacities is where occupational therapists have traditionally been involved with older people. Occupational therapists assess capacities. Occupational therapists' knowledge about adaptive equipment and compensatory strategies can be used to assist the older people so that they are able to continue to participate in occupations that they enjoy. Also if taught the principles of energy conservation and work simplification techniques to conserve energy then older people can exercise choice and feel in control. Reduced energy resources can then be directed into occupations that bring joy to life not just the mundane. Occupational therapists can also help to find suitable alternatives for occupations that need to be relinquished. The skills of the occupational therapist in activity analysis may be utilised to find alternatives that are within the capacity of the older person and also match with the interests and values of the individual.

Having to give up things/ accepting

Participants learnt that some activities had to be replaced. Reg spoke about the things he used to do "*I used to build gadgets, mostly electronic, measuring instruments as a rule, counters and things like that*" (820-822), but "*I don't do it anymore as I can't see well enough*" (823-824). Reg did still however maintain a workshop where he pottered and mended things for his household and the neighbours. Reg had also given up sitting on committees because of his hearing difficulty, "*I have found some yeasts ago that on committees that people stand up or sit and discuss and I found that I was not able to follow the discussion*" (558-560). He would dearly loved to have been on the committee that ran the club he belonged to as he would have liked to know what was happening and have some influence on the management of the club, but his hearing difficulty prevented him from participating fully and so he chose not to. Joan gave up volunteering, "*Because I am not a very unselfish person, for all these reasons I had to give it up, which I regretted very much as it was extremely interesting, but on the other hand I felt that I needed to keep an eye on my husband*" (50-55).

The recognition that capacities weren't what they used to be and being realistic about living within capacities required coming to acceptance.

> *I'm just coming round to acceptance now, I've been here it will be four years next January, and I've been kicking against the bricks for most of that time. I don't want to be here, I don't want to be growing old. I don't want to be going down hill, I don't want this, I don't want that, but I'm gradually beginning to accept that that is a rotten way to look at your life (Ruth, 351-358).*

Being positive

Part of being responsible for your self was taking a positive view of life. The prime example of taking a positive approach to life was John. He was living with a chronic health problem, the nature of which meant that at any time his condition could deteriorate progressively to an imminent death. At the onset of his health problem John had spent quite some time in

hospital highly dependent on nursing staff for every element of his care. As noted previously, when he needed to use the toilet he had to be lifted with a mechanical hoist, and he could barely hold a spoon to feed himself. Fortunately he slowly progressed and eventually he could be discharged home. He lived with uncertainty, yet John was grateful for the improvement he had made, and always took the attitude that tomorrow things could be even better. It was evident that taking a positive attitude was a feature of his life. John had been in the British navy in World War II when he was captured and became a prisoner of war in Japan. He didn't know it at the time but the conditions for prisoners of war in Japan were more humane than those experienced by others, particularly those on the Burma railway in Thailand. As a prisoner of war in Japan he still had lost his freedom, had to do as directed and did not know how long these conditions would last, nor what the outcome might be. Yet John was still able to keep positive and believe that things would get better. He observed that "*we had people there that were physically they were just as good as we were. And we'd say what's wrong with you, and they'd say oh I can't go on, and you'd oh say pull your socks up and oh no, no and you'd say a few other words to them and then they'd say oh no. And about 9 times out of 10 within about three or four days they were dead*" (1004-1012). John now takes the view "*you die if you worry, you die if you don't, so why worry?*" (443-444).

So as Ruth says, "*And if you want to be happy and experience well-being you have to be a)accepting and b) positive*" (358-360). As Reg recognised "*Really well-being is something that is developed in your brain, if you like it is part of your self-consciousness*" (Reg, 499-501). Part of 'being positive' about life and having a positive outlook is having goals for the future. Kate had an extensive list of activities consisting of new interests she would like to try in the future:

> *I'd love to sit down, I've bought a new sewing machine, I haven't even unpacked it, it's been there since March or something, but just fiddling, I'd like to do that. I'd like to learn to crochet, but it might be one of those passing fancies that mightn't last. I'd also like to use the word processor. That's one thing I'd really like to do, but again I haven't had time* (127-135), *and another thing calligraphy, I wouldn't mind learning to do that, a little bit flash in the pan probably again* (Kate, 147-149).

Many of the participants in Jonsson, Borell & Sadlo's (2000) study of adjustment to retirement had plans, like Kate, of activities that they would like to attempt in the future. Interestingly, few of the participants in that study had put into action any of the plans that they had for their free time in retirement. I had a sense that Kate had a list of activities but few action plans, but it was enough for her to have dreams.

Ruth was learning French with the goal of going for a holiday in France where she could demonstrate her language skills. She wanted to stay for an extended period so she could really experience the culture and further develop her vocabulary and fluency. John had the future goals of celebrating his 90th and 100th birthdays, "*Well I think you've got to accept the fact that you get older, you all get older you know, I'm 84 now, and huh one of my daughters the other day, I said don't want too big a show when I'm 90. (laughs) I said I don't want too big a show for my 90th*" (1087-1096), but his daughter told him he will have to wait until he gets to 100.

To have future goals participants had to have a positive outlook that they would still have the capacity to be adaptable and exercise their choices, and that they would still have the capacities to meet new challenges. The participants in Jonsson et al's (2000) study did not have long term goals, but had a goal of maintaining stability as a hope for the future. They viewed advancing age as a 'slippery slope of decline', yet if they were able to maintain the status quo they could continue to engage in current occupations and be independent. If there was a change in capacities, their ability to perceive that they were in control would be under

threat, and well-being would suffer. For occupational therapists it is important to recognise that clients may have goals and need to work towards them, but at the very least they need to work on the goal of maintaining stability.

Feeling comfortable and secure

Along with the categories 'challenge to equilibrium', 'personal resources' and 'up to me' is the category, 'feeling comfortable and secure'. Having an environment where older people feel comfortable and secure enables them to activate their resources to tackle the 'challenges to equilibrium', and use 'trading off' to maintain perceived control. If older people are able to perceive that they are in control they can experience well-being. The properties of 'feeling comfortable and secure' are 'being comfortable' and 'feeling safe and secure' (see fig. 5 or pull out card).

Being comfortable

I will begin with discussing 'being comfortable'. When asked what well-being was for them, participants often spoke about ideas related to comfort. As Joan said, "*Comfort in many ways, comfort mentally and physically. And to be happy within reason, to accept the state that you are in and to be happy within that context*" (106-109). Being comfortable involves living in a house or similar living space where one can feel comfortable, and links to the other properties of this category, in having enough money to live comfortably. Living comfortably also meant being treated with respect, "*Where you live you have to have acceptable human treatment, you don't need to be put down and criticized and nagged at and yelled at and that kind of thing. I think it is extremely bad for you*" (Ruth, 1032-1035). Part of having a community where one can live comfortably was having the knowledge that help was available

if it was needed, and also that quality supported accommodation would be available if required.

Participants spoke about the importance of having a comfortable home to live in. The older women participants in Shenk, Kuwahara & Zablotsky's (2004) study expressed very similar sentiments. A comfortable home was somewhere that was both emotionally comfortable as it was familiar and housed one's treasured belongings, but also physically comfortable where they could go about their daily routines performing tasks with ease. Therefore, it appears that, not surprisingly, having a certain basic level of comfort is important to well-being.

Feeling safe and secure

The other property of feeling 'comfortable and secure' is 'feeling safe and secure'. Participants talked about the need for safety and security from two different dimensions. First they described the need to feel safe in their environment, and second, the need for financial security. Each of these dimensions will be explored more fully in the next section, beginning with personal safety.

Older people have a need to feel safe in their immediate environment and in the wider community. Participants lamented the days of leaving doors to the house and car unlocked, implying that they currently felt less safe in their own home. As Joan said, "*Yes, safety is a big thing I think. When I first came to live in this area of* [suburb name], *you could go out any time of the day, leave the house unlocked and just drift off, but now I lock everything up when it gets dusk, and I wouldn't answer the gate unless I knew who it was at the other end*" (329-337). Joan lived in a unit behind a brick walled garden with an intercom at the front gate so she could monitor visitors and unwanted guests. Joan's comments were echoed by Isobel, "*Night-time I lock the doors back and front, it is a nuisance but you have to. I never had trouble though I don't feel nervous about it. I was raised in the country and we never locked*

doors at home, never. You can't do it now" (315-318). Although there weren't any accounts of people they knew experiencing home invasions or being threatened in their own homes there was generally the perception that if they locked doors then they would be safer.

Community services do exist that can assist older people to increase the safety and security of their own home. The SA Police has a community safety unit, which will visit people in their own home and make suggestions about home safety. Older people can also join organizations like Neighbourhood Watch, which is auspiced by the police but empowers local communities to tackle local safety and crime issues. Home assist programs run by local councils also examine home safety and make recommendations for improvement to safety along with referrals to accredited tradespeople who will perform the work reliably and for reasonable cost. Occupational therapists can link older people with services that will work with them to increase safety and security, or can give out information about services so that the older person can take their own actions. Being empowered with information about services that will increase the feeling of comfort and safety will help the older person to perceive they are in control.

Some of the participants did have personal alarms, which they wore to summon help if it was needed. Whilst often they are used in case of a fall or medical emergency they can also be used to call for help if personal safety is at risk. There is quite a variety of personal alarms available in the market, and they vary greatly in terms of service and price. The Independent Living Centre[2] is a good source of information about personal alarms, and the older person can get unbiased information about the range and make an informed choice without pressure

[2] The Independent Living Centre is a government funded information service, staffed mostly by occupational therapists, to provide advice about equipment to and for people with disabilities. Independent Living Centres operate in all states in Australia.

from a salesperson. Having made the choice they can then purchase the alarm from the supplier. There is also a need to increase general knowledge about resources such as personal alarms and where to get more information so that people can make their own choice.

There was a strong perception that older people were even more at risk after dark than during the day. As Bill commented:

> *But I'm like a lot of people these days, you don't go out at night, well the way things are you wonder what the world around us is going to be next. I mean, an old person like myself, even young people these days are still molested and assaulted. It doesn't give them, I speak to a lot of people, it doesn't give them the security to want to go out these days (69-76).*

Bill was certainly not alone in thinking that it was not safe to go out at night, but again, not one participant related a story of someone they knew being assaulted, harmed or threatened in any way. The perception of risk seems to far outweigh the reality yet the perception is so strong that it makes older people alter their behaviour.

The importance of feeling comfortable and secure is well recognised by the Federal government. In the publication "Home and Residence choices for older people", the former Minister for Family and Community Services, Senator Jocelyn Newman wrote, ' A comfortable and secure home, whether a private dwelling, a retirement village, hostel or nursing home brings peace of mind and helps older people to stay healthy and keep involved with their family and community' (Department of Family and Community Services 1999) (p. 3).

As well as the need to feel comfortable and safe in their own living space and not fearful of an adverse event there was also the need to feel comfortable in the wider community. Some participants expressed concern at the shifts in community attitudes and values. Mary in particular spoke at length about what she saw as a deterioration of moral standards, which made the community a less desirable place to live in. She thought fashions were too revealing

and that women couldn't possibly respect themselves going out like that in public with "*everything hanging out*", and that there is too much violence and sex on television. She harkened for a return to discipline and morals,

> *You take with children, the police can't hit them, the parents can't hit them, no-one is allowed to, school teachers can't. It is all Dunstan's fault. It was him that said if you don't like the law then break it. If a child knows he can't be touched of course he will go and do wrong. The government gives them money to leave home and live on the streets. We had homosexuals sure but they were quiet, we didn't have lesbians and the like going around lavatories, streets, going up to kids who then think it is okay. See no morals. The young ones don't go to church. Mainly old ones go to church now. There has to be a reversal of the old ways. I got a card that said to me old age is nothing but attitude is everything. Family around you is important, it keeps you on the straight and narrow. The laws today are trying to destroy family life. Children out of wedlock, not one but three or four. You need a mum and a dad for children, they need it, not these single mum. (390-405).*

The need for safety can be tackled at the individual level as already mentioned, but also needs to be addressed at the community level. Lawrence and Schigelone (2002) reported the results of a grounded theory study of relationships between older people in a nursing home community, and identified that the older people worked together to deal with the chronic stressors of aging as a community rather than as individuals. They discussed the term communal coping, a term more commonly used in reference to a community's response to a disaster, which involves the community identifying a stressor as "our" issue and therefore "our" responsibility. Communal coping was identified amongst the members of the nursing home community who helped each other out and kept an eye out for each other, or offered empathy. The findings of this study highlight how occupational therapists could work at the community level as well as working with individuals. We need to build trust so that people feel safer in their local community, and look out for each other and help others in times of need. Strategies such as buddy systems or other coordinated actions for mutual benefit could be put in place, which may facilitate communal coping. Other suggestions include using intergenerational activities with older people helping young ones with reading and local

history, and the younger people helping the older ones to learn how to use the Internet. Strategies such as buddy systems or other coordinated actions for mutual benefit could be put in place, which may facilitate communal coping. In this way social capital can be built, and by building social capital the community will be a better place to live in. If the community is a safe and comfortable environment then older people will be better able to maintain perceived control and well-being.

Financial security

The other dimension of 'feeling safe and secure' is 'financial security'. Participants expressed the belief that financial security was basic and fundamental to well-being. They perceived that it would be difficult for older people to experience a sense of well-being if they were constantly worried about having enough money to pay for the basics. As Ruth said "*It must be terrible to be absolutely broke and old*" (1028-1030).

A number of participants relied on their superannuation policies for income or had a source of income besides the old age pension, and made comments about being fortunate that they had enough money to be comfortable and secure. They compared themselves to others whose only source of income was a government old age pension. "*When I go to supermarkets and I see people who come on some of the local buses for elderly people, and I see them pick a tin, and have a look at the price, put it back and look for something cheaper*" (Joan, 351-356), and from Ruth "*But if I were on a pension I probably couldn't afford those little extra things, which are not matters of life and death, but they are matters of social comfort*" (981-984). Having superannuation generally gave people a little more security, " *we have sufficient income to live on, but we have to live reasonably economically. In our case we don't have money worries but it can become a problem at times*" (Reg, 460-464), and his partner Elspeth, "*But we have never wasted money. And um, we've never been big spenders. No, I think that*

there is becoming quite a thing about those who have the pension and those who don't. Now we are on the borderline, sort of thing, we've got enough to keep us going, we're not complaining" (985-990).

There were divided opinions about entitlement of older people to income and whether they should have saved for old age or if the government should assist people. Some reference has already been made above to the widening gap between the have's and the have not's. There was the perception that generally superannuates were disadvantaged as they didn't qualify for the discounts that pensioners were entitled to, as Martha said, "*I mean J's* [husband] *on superannuation and we've got some investments, and we're not rolling in money but we're these famous self-funded retirees, and we don't qualify for anything, um which is a bit annoying at times when you do see some people who just spend everything or give it to their children so they can just get the pension*" (1007-1014). However, Mary thought she had earnt the pension by paying taxes all her working life. This difference of opinion and values obviously was a source of disgruntlement between friends and neighbours, "*You hear people getting crook about just getting the pension, but you take me, from the time I could work I was paying tax, and in business I paid social service tax which was like superannuation today, we have paid for it indirectly. Her up the front* [referring to a neighbour] *she has a go and calls us scum for getting the pension*" (Mary, 228-233).

Interestingly the participants who relied on the old age pension as their sole source of income did not express any financial concerns, "*You have to have money to get along. I have a set standard I have so much in the bank and I don't touch that, anything over that surplus I can use for repairs etc. I try to keep everything up to scratch*" (Isobel, 255-258). Isobel perceived that there was enough money if you managed your money carefully, and did not spend it on frivolous activities. "*I don't know. With my money I am very careful with it and a lot of*

people blow their money, but I am careful with mine. People should be more responsible for their lot I think. I wouldn't drink or smoke, I don't go dancing or to the pictures but a lot have to have that, but that is their business, but it costs money" (Isobel, 396-401).

So its seems that as long as people perceive that they have enough money to cover the essentials and a few dollars more for a few little extras, it seems that they are happy. The perception is with the individual and not as judged by someone externally. If the older person perceives that they have enough money then they are able to maintain perceived control. Financial security becomes particularly important when the older person is working through the phases of the basic social process, 'trading off', as this is when they are examining their choices in order to do the 'trading off'. I will return to this point in the next section.
The 'user pays' system that is popular with current governments perpetuates the division between the haves and the have-nots. As Reg said, "*Our social environment, our community is these days a bit more divided or divisive then when we first come to Australia, and the factors like welfare which are making divisions between the haves and the have nots*" (1023-1028). Interestingly, Reg saw the provision of welfare as damaging to the well-being of the community as he felt it perpetuated a culture of people who came to look for and rely on handouts from the government rather than earning it themselves. This connects to the category of 'up to me'.

Thus participants expressed a need to feel comfortable and secure in their immediate environment with a comfortable, safe and secure living situation. It is also important to have a safe community that supports older people to feel in control. Part of feeling in control is having enough finances to meet one's needs. If the older person perceives they are in control then they are able to use 'trading off', the basic social process to maintain that control and to

avoid a lack of perceived control. Having discussed all the categories in detail I move now to that basic social process.

Chapter summary

In this chapter I have the four categories and their properties. A 'challenge to equilibrium' such as a loss of capacity or a loss of a relationship stimulates the need to use the basic social process 'trading off'. Challenges to equilibrium may be sudden and 'come out of the blue' making 'life like a yo-yo'. The challenges may be real losses or the fear of loss of capacities. Personal resources and an attitude of 'it's up to me' provide support for the older person to be able to perceive that they are in control. Personal resources consist of 'good health and good fortune' and being 'engaged and active'. Keeping busy and keeping the wheels turning by exercising capacities, as well as being connected with others through clubs, family and friendships all provide a buffer for the challenges to equilibrium. Doing for others is also important to perceiving that one is in control and thus able to experience well-being. The remaining category that provides support for a person to perceive that they are in control was 'feeling comfortable and secure'. Suggestions for ways in which the findings can be utilised in occupational therapy practice have been offered throughout.

Together the categories presented here provide a basis on which the older person can appraise their choices and take action in 'trading off'. In chapter 7 I will expand upon the basic social process 'trading off', and ways in which occupational therapists can work with clients to assist them in 'trading off' to achieve well-being will be discussed.

Chapter 7: Articulating the theory: the basic social process

In this third chapter of findings from the study of older people's perceptions and understandings of well-being I will explicate the basic social process 'trading off'. Attention is paid to how occupational therapists may be able to assist the older clients that they work with to use 'trading off' in order to maintain perceived control, and experience well-being.

Basic social process: trading off

To be honest, I was not expecting to reveal a basic social process from my data. I knew that all grounded theory studies should have a core category, but not all studies have a basic social process. Most of the grounded theory studies that I had read in the literature did not report a basic social process. It took quite some time for me to be convinced that I had a basic social process, but this process kept coming up and it didn't fit neatly into any of the categories. Eventually as described in chapter four I could see that it was a basic social process. I was probably over cautious about arriving too early at naming a basic social process and making a mistake.

'Trade off' was the term that I coined early in the analysis to describe a process that participants were using. Later, in keeping with a grounded theory definition of a basic social process as a 'gerund', I changed it to 'trading off'. 'Trading off' involves older people choosing to replace activities that they are no longer able to manage. All participants used 'trading off', however those who faced more challenges to health and their capacities used it much more often. The older people who were fit and well used 'trading off' to make life a bit more comfortable, for example, Elspeth had some help with housework, and Martha had a harmonious agreement with her husband so that he did the gardening and she the cooking. Radlee was an excellent example of someone who used trading off to achieve perceived

control and well-being. She said, " *I live in an aura of well-being*" (437), yet would have been in a situation that the casual examiner would think was teetering on the brink of breaking down. Her mobility was considerably hampered by the Parkinson's disease, but with the availability of her husband and the personal carers she was able to maintain perceived control. One of the unique ways that she used trading off was in the way she socialised. She and her husband used to hold a lot of dinner parties. Now that Herbert did most of the cooking with assistance from a carer this was not realistic and they were both too tired at the end of the day to host a dinner party. So now they invite friends for afternoon tea, which is much simpler in preparation and clean up, and is time limited, yet enables them to be gracious social hosts and to keep connected to family and friends. 'Trading off' dinner parties for afternoon tea parties enables them to 'maintain perceived control', and thus well-being.

Rosemary provides another unique example of trading off. She had a carer come to her for 2 hours on 2 occasions in the week. The two hours on the Monday were used for cleaning Rosemary's unit. The second two hours on Thursday were allocated to taking Rosemary shopping, however Rosemary tried to make sure that she asked all her friends who called to bring different items of shopping that she needed for the week so that when the carer came she could take Rosemary on an outing to the beach rather than to the shops. This was an excellent example of an older person perceiving that they had control over the situation and exercising that control. Rosemary needed to have her shopping in order for her to eat during the week, but she much preferred to have a pleasurable outing to the beach than a mundane shopping trip.

The outcome for all participants who used trading off was to maintain or increase the perception of maintaining control. Older people used trading off to gain assistance with housework and gardening and other domestic tasks to ensure that they were able to maintain

their independence. Maintaining independence enables older people to retain their autonomy and self-determination and perceive that they are in control of their lives. Feeling or perceiving that they are in control leads to feelings of well-being.

Although the use of 'trading off" enables older people to perceive that they are in control and to experience well-being, but it is not without some cost to the older person. Cost involves one of the following: losing previously valued occupations or roles; changing one's values; coming to accept a reduction in physical capacity and accepting that you can't do all the things you used to be able to; and/or accepting an increased level of dependence on other people. Part of the process of 'trading off' is to weigh up the choices available with their associated costs and to decide that the benefit outweighs the cost. Rosemary provides a good example of this with respect to her choice to move to a hostel. In her current environment Rosemary did not perceive that she was in control. She worried about the garden not being kept tidy and not being able to get to the letter box. She also worried about being a burden on her few relatives. In making the decision to move to a hostel as soon as possible she was exercising control and maintaining her independence of thought at the expense of loss of physical independence and autonomy in her own unit. Rosemary perceived that the benefits of being in a hostel with staff to assist her and other people around to talk to outweighed the costs.

'Trading off' is not a word that is used in the occupational therapy literature but one that seemed to encapsulate the process that the older people were using. The concept of 'trading off' does however have some relationship to the occupational therapy concept of adaptation. When I searched the occupational therapy literature on adaptation I came across a case study description of how a woman with cerebral palsy adapted to living independently (McCuaig &

Frank 1991). The woman, Meagan, was reliant on assistive technology including a powered wheelchair and augmentative communication systems. Despite her significant disability and dependence on technology and carers, Meagan was fiercely independent. The case study included accounts of where the woman used 'trading off' to achieve her goals. When Meagan visits some of the homes of members of her family she has to use a manual wheelchair and have someone push her. Whilst Meagan values her independent mobility, it is more important for her to maintain her relationships with her family. Therefore she trades off her independence for a short while in order to have social contact with family members. This demonstrates the dynamic nature of 'trading off'. In this instance Meagan used 'trading off' for a short term gain and it was a temporary state of affairs. 'Trading off' therefore can be used for either temporary or more permanent situations.

So if there are examples of use of 'trading off' in the occupational therapy literature in for example, the form of adaptation, could there be more? I began to look for others, particularly in the form of case studies or stories, and found several in the occupational therapy and nursing literature (Clark 1993; Neary 1997; Price-Lackey & Cashman 1996). Some of the accounts were about the recovery of people following head injury or stroke and the subsequent adaptation to a new disability, as well as older people.

For example, in a grounded theory study of older women with a disability and how they achieved resilience (Neary 1997) I came across descriptions in the findings of what I have called 'trading off'. A category named 'using alternatives' was reported which consisted of using assistive devices; using alternative forms of recreation; and using alternative means of maintaining relationships (such as letter writing and phone calls). All of these strategies are examples of 'trading off'. The strategies became increasingly salient as participants became more disabled particularly if mobility was affected (Neary 1997). Another strategy was the

use of substitutes for personal care and homemaking. The older women began by appraising their limitations and the need for help; and their willingness to cede some independence and accept help before putting into place the alternatives.

There was the story of Jenny, who had had a head injury (Price-Lackey & Cashman 1996). Jenny was unable to return to her previous valued occupation of being a writer and to achieve her goal of publishing a book because of her altered cognitive abilities. She traded off that occupation but explored other creative occupations, such as working in a theatre arts department and working in computer graphics creating new possibilities for adaptation. When she first returned to work after her rehabilitation she traded off full time work for part-time work to help manage her issues with fatigue. The new Jenny after the head injury caused her to re-appraise her situation and make some changes to her goals in order to achieve success.

Similarly, Clark (1993) told the story of Penny an academic colleague, who had a burst aneurysm resulting in a stroke whilst on holiday in Hawaii. After two and half years Penny could walk with a walking frame and was independent in activities of daily living but still had some resultant disability and was assisted in many ways by her mother. Prior to her stroke Penny was well known amongst the students for throwing cookie parties and later after the stroke was assisted by her mother to give the cookie parties for students as she had always done. Penny traded off some of her independence and accepted assistance from her mother so that she could resume work as an academic. Further, Penny took actions to reclaim her life and to discard the life of a disabled person that people shied away from. She 'traded off' the support of her walker for a walking stick by pushing herself to go for walks and develop her capacities so that she was safe. She seems to be using 'trading off' in reverse here, however the common element is that the person is able to take actions from perceiving that they are in control and to increase their perception of control over their life.

It appears then from the findings reported here and from examples in the occupational therapy and nursing literature that 'trading off' is a basic social process that involves several phases. In the first phase there is a realisation that one doesn't have the capacities to perform a certain occupation, or that the energy requirements of that occupation would cause overall energy resources to be depleted. Once the person has assessed their capacities and realised that they are "lacking", or that there is a mis-match between the demands of the occupation and the environment, they then examine the choices available. The examination of the choices and comparison with their current capacities is the second phase of the process. A range of choices is important so that the person finds a choice that is compatible with their values and other personal resources. Too limited a choice makes the person feel "boxed in" or trapped and out of control. Having the choice may be enough to achieve 'perceived control' without even exercising the choice.

Thus the phases in trading off are summarised as follows:

- Recognition of the threat to perceived control – What is the problem?
- Recognition of the need to take some action – survey choices available, realistic about capacities, consider the potential costs
- Decide what action will be taken – What am I prepared to do?

For example, the sudden onset of John's illness, which severely diminished his capacities, led him to experience being out of control. As he recovered and gradually regained his capacities he realised that he had to be realistic about his capacities and work within them. That meant that he could not do larger jobs around the house such as trimming the bushes. One option was for his wife to take over this chore, however John was concerned that she already had taken on a lot extra and it was probably too risky for her to be climbing ladders with hedge trimmers. Another option was for him to attempt the task but that would mean he would spend the next few days in bed unable to do anything, and the cost was not worth the effort. So he chose to use 'trading off' and pay a gardener to perform that chore. The cost of

increased dependence on others is outweighed by the satisfaction of someone else safely completing the chore.

When the person makes a choice and exercises that choice they engage in 'trading off'. They may choose new occupations to replace old ones or they may find other people to complete that occupation for them, for example, house cleaning or shopping. Sometimes 'trading off' may result in behaviour that may be viewed by others as increasingly dependent, but it may actually be management of the constraints and resources of the situation. In all cases choosing no action is an option.

Trading off and links to occupational therapy notions of adaptation

If examples of 'trading off' were found in the occupational therapy literature on adaptation it seemed important to consider that body of literature further. Adaptation is described as a fundamental concept in occupational therapy but the understanding and use of the concept is varied. The concept has existed in the professional literature since the early writings of Meyer in 1922, however when Schultz and Schkade (1997) reviewed the literature on adaptation they concluded that the concept is so pervasive that the need for definition has been overlooked. I was struck by the similarity with my exploration of the concept well-being. Adaptation is used to communicate a number of different meanings, including compensations that are made by a person to adapt to disability both in terms of the external environment and their internal response. Schultz and Schkade summarised their analysis of the literature in 10 themes that underlie the beliefs about adaptation within occupational therapy:

1. There is an innate urge to effect the environment;
2. The adaptive facility and environmental expectations are predictive of the person-environment interaction;

3. There is a need to experience mastery over the environment;
4. The interaction between the person and the environment occurs in the form of occupations;
5. Perception of mastery results from a match between the abilities and the demands of the environment;
6. Demand for adaptation appears when the 'match' is inadequate;
7. Adaptation is a form of change that occurs in: occupational performance component skills; Adaptive responses; and/ or Physical, social, or cultural expectations/demands;
8. Mastery over the environment brings satisfaction;
9. The experience of success resulting from being a successful agent of change fuels the urge to affect the environment; and
10. Maladaptation is an unsuccessful attempt to meet the environmental expectations.

As Law et al state (1997) "Occupational adaptation is both a state of occupational function and a normative process by which competence in occupational function develops." (p. 94)

Much of the other literature within occupational therapy on adaptation builds on the conceptualisation of Schultz and Schkade (1997). So where does 'trading off' fit? Adaptation involves mastery over the environment where there is a match between the person's capacities and their ability to conduct occupations. The process of 'trading off' is begun when the person realises that their capacities are reduced and that they can no longer participate in a particular occupation, or if they do they won't have any energy left for other occupations that are more valued or have greater meaning. Therefore they choose to relinquish that occupation. The older person perceives that they have a choice and choses to exercise that choice, or they are comfortable in the knowledge that they could exercise that choice whenever they wished.

This leads to a sense of control through exercising choice rather than through mastery. The sense of mastery, or perceived control comes from having the capacity to make the choice to use 'trading off', rather than having the capacities to meet the challenge of the occupation itself. Some times the trading off involves mastery of another occupation, for example, Bev gave up line dancing because of her bad back and took up swimming instead.

Shultz and Schkade's (1997) representation of adaptation as an interaction of the capacities of the person with the demands of the environment to achieve mastery, appears to be too simplistic for such a complex concept as occupational adaptation. The finding of a basic social process in this study, 'trading off', contributes to and extends the theoretical conception of occupational adaptation to include options for adaptation other than personal competence and mastery. Competence is thought of as a process in which the opportunities of the environment and the capacities of the person are marshalled together and if the outcome is judged by the person as successful then an awareness of competence results (Matheson & Bohr 1997). The notion of mastery can be extended beyond the idea of the older person being competent enough to act on the environment to include actions by the older person that meet the demands of the environment, potentially using other active agents rather than themselves. These actions need not be seen as dependence on others, but rather maintaining control to achieve well-being.

It is important to emphasise the dynamic nature of 'trading off' as the various elements may change and impact on each other. A key feature of the concept of adaptation is the interaction of current events, circumstances and relationships with the probable life course, that is, the way we expect our life to be (Larson 1996). Circumstances and relationships can cause

deviations from the course and may also cause the person to react and act in ways that reset the course back toward the expected path. Adaptation is a constant process of negotiation.

If 'perceived control' is the core category and 'trading off' is the basic social process that older people use to achieve well-being, then occupational therapists' efforts would be usefully directed to enabling older people to do this. The challenge is for occupational therapists to find ways of working with older people enabling facilitation of perceived control and empowering older people to use 'trading off' in therapy that will enable well-being for older people. Any consideration of strategies that include enabling and empowerment lead within the occupational therapy literature to the concept of client centred practice. In this section I will define client centred practice and discuss the advantages and disadvantages of occupational therapists working in client centred ways within their practice. Particular attention will be paid to how the use of client centred practice by occupational therapists will facilitate the older person to perceive that they are in control.

Use of client centred practice to enable trading off

The Canadian Association of Occupational Therapists (1991) defines client centred practice in the following way:

> Collaboration and partnership approaches used in enabling occupation with clients who may be individuals, groups, agencies, governments, corporations or others; client centred occupational therapists demonstrate respect for clients, value clients in decision making, advocate with and for clients' needs, and otherwise recognize clients' experience and knowledge (p. 180)

Client centred practice arose in response to a number of movements, including consumers becoming more demanding about their involvement in their own health care. People with disabilities were not satisfied with the position of power that the health professional held, with them as the patient. Knowledge and professional skill gave health professionals including occupational therapists power over the patient and created professional distance. People

living with disabilities did not want to be in the powerless patient role as they were the experts in their own disability. These movements led to the people that occupational therapists work with being called clients and the description of a way of practice that attempted to address the power differential between therapist and client. There is still considerable debate in the occupational therapy literature about the appropriateness of the word 'client' as it is closely allied with consumerism, however client stills seems to be the most commonly used descriptor of the recipients of occupational therapy services.

The Canadian Association of Occupational Therapists has been at the forefront of the client centred practice movement and published the first guidelines for client centred practice in 1991. These guidelines consolidated 5 guidelines documents and one outcome measure, published between 1980 and 1993, all based on the premise of client centred practice.

The guiding principles for enabling occupation in client centred practice are summarised below:

- Practice is based on the client's values, meaning and choice as much as possible;
- The therapists listens to client visions;
- Processes are facilitated for clients envisioning what might be possible;
- Clients are supported to succeed, but also to risk and fail;
- Clients own style of coping or bringing about change is respected;
- Clients are guided to identify needs from their own perception;
- Clients are facilitated to choose outcomes that they define as meaningful even if the occupational therapist does not agree;
- Clients are encouraged and actively facilitated to participate in decision making; partnerships in therapy, program planning and policy formation;

- Information is provided that will answer client questions in making choices;
- Services are offered that are not overwhelming in bureaucracy;
- Open, clear communication is fostered; and
- Clients are invited to use their strengths and natural community supports.

Client centred practice is underpinned by the recognition of the autonomy of the individual and their right to self-determination. There is also recognition of the client's strengths and not an emphasis on problems or deficits. It is purported that if clients are free to choose and participate in a relationship with their therapist that is collaborative and enabling, then the outcomes of therapy will be greater. Indeed, client centred practice represents an ethical stance by the occupational therapist based on democratic ideas of empowerment and justice (Law et al. 1997). It is these notions of autonomy and choice that connect to the findings of this study. In this section I have argued that use of client centred practice when working with older people will facilitate perceived control.

Enabling is the basis of client centred practice and is the process "of facilitating, guiding, coaching, educating prompting, listening, reflecting, encouraging or otherwise collaborating with people in therapy" (Canadian Association of Occupational Therapists 1997, p. 180). The emphasis is on participation, collaboration, partnership, and experiential learning. Use of enabling processes will be key to facilitating the older person to have perceived control and be able to use 'trading off'. Using enabling approaches, occupational therapists work *with* people, in contrast to intervention approaches where therapy is *done to or for* people. Through the use of enabling approaches the person is involved as an active agent in learning to help him or herself. Occupational therapists can work in partnership with the older person assisting them to identify their needs, and the choices available, before appraising the choices and taking action. The older person identifies what is important to them.

Use of client centred practice is highly empowering for the client and is highly individualized, but it is not without some disadvantages. Use of client centred practice can lead to the older client perceiving that the therapist is not very skilled. The client may find the client-therapist relationship ambiguous. They may be seeking help from a professional who they perceived to be the expert, yet the therapist is not taking the expert position. The therapy experience may not meet the client's expectations of the interaction between a therapist and themselves.

Another disadvantage is the need for structural changes within the health services to support client centred practice. It is not possible to be truly client centred if that doesn't fit with the mission of the service agency. For example, in the acute hospital setting the focus is on getting clients well enough to be discharged in as short a time as possible, where the clients' goal may be not to return home until they are able to resume normal activities. There is a clash of values. The occupational therapist working in that setting can demonstrate respect for the client and try and tailor individual therapy, however they have to meet the agency's goal of short bed stays. If they delay discharge it will be costing a lot of extra money to the health system. The need to postpone discharge so that the older person is in a better position to be involved in therapy points to the need for 'step down' wards or convalescence as well as an increase in the availability of short term services to support them at home immediately post-discharge. It is important to acknowledge here that there are some excellent examples of programs such as those just described, however they are in short supply. Supportive programs either pre or post-discharge will enable the older person to re-build or increase their capacities, or to adjust to a reduction in capacities so that they are able to perceive they are in control, and to fully engage in the 'trading off' process of their own volition.

Client centred practice has received considerable prominence within occupational therapy in recent years, yet practice is not always truly client centred. As already mentioned in chapter 5 in relation to independence, Russell and colleagues (Russell et al. 2002) found that therapists did try and take a client centred approach and listen to the needs and wants of their clients. However, there were times when the client's needs were overridden by the occupational therapist. Therapists in that study invoked what was called 'the safety clause' out of concern for the safety of the client and for their own professional duty of care. This raises considerable ethical dilemmas for the occupational therapy profession if we are to consider ourselves as client centred practitioners. Ongoing debate is required to help individual practitioners resolve this issue in a satisfactory way.

Chapter summary

In summary, 'trading off' is the basic social process used by older people to maintain perceived control, and thus experience well-being. Trading off is used in response to a 'challenge to equilibrium'. To use 'trading off' older people need to 'feel comfortable and secure', have the 'personal resources', and hold an attitude of 'it's up to me'. Suggestions have been made at various points throughout the last 3 chapters for how occupational therapists could apply the findings from this study in their practice with older people. Enabling older people to perceive that they are in control and to use 'trading off' will enable them to experience well-being. In the next and final chapter of this thesis I will consider further the contribution of this study to occupational therapy knowledge and practice.

Chapter 8: Implications for knowledge and practice

In the opening chapter of this thesis I argued the importance of gaining a better understanding of the concept of well-being from the perspective of older people themselves, given the growing numbers of older people in the population. Further, I pointed out that there is generally a growing interest in well-being and presented a justification for conducting a qualitative study that sought a rich description of well-being from the older person's perspective. In Chapter 2, I continued to build the rationale for this study by presenting information about the importance of well-being as a central concept within occupational therapy, and identified that this area was not well covered by the professional literature. Thus I set out to answer the research question, what are older people's perceptions and understandings of well-being? Using grounded theory with a theoretical orientation of symbolic interactionism with a focus on social process, the approach allowed me to reveal the core category, 'perceived control' and the basic social problem of not being in perceived control. The basic social process of 'trading off' was used by participants to resolve the basic social problem.

I turn now in this final chapter to review the aim of the study to see if this has been achieved and to consider the limitations of the study. Furthermore, whilst suggestions for application of the findings to occupational therapy practice have been made throughout the preceding 3 chapters, in this chapter I will present a distillation of the ideas and discuss further the implications for practice at individual, group and community levels.

Reviewing the aim

The aim of this study was to generate a mid-range theory of well-being from the perspective of older people living in the community in metropolitan Adelaide. My theory of well-being as

understood by older people, explicated over the last 3 chapters, involves older people using 'trading off' to achieve perceived control and experience well-being. In the introduction and literature review chapters I argued that there was a lack of agreement in the professional literature as to what was meant by the term well-being. I also argued that the perspective of the older person was missing. The articulation of the emergent mid-range theory from this study contributes knowledge that was previously unarticulated and forms a basis for further empirical work. Further knowledge about well-being is important given the growing numbers of older people in the population and the increasing likelihood that occupational therapists will be working with older people. The major contribution that this study makes to occupational therapy knowledge is an explication of what might be older people's understandings and perceptions of well-being, particularly given that well-being is a central concept within occupational therapy. To be able to use 'trading off', older people need to be supported by 'personal resources', have an attitude of 'it's up to me', and 'feel comfortable and secure' in their environment. 'Trading off' results from a challenge to equilibrium that first, involves the person reassessing their capacities, both physical, mental and material, and the match between such capacities, and what it is they want to do. Second, the choices, or options available to the older person for addressing the mis-match between the demands of the environment and their capacities are canvassed and appraised, before third, the older person takes action in the form of 'trading off'.

Given this new knowledge about the importance of perceived control occupational therapists can look for ways of working with older people to ensure they have the perception that they are in control and are able to use trading off. An understanding of the conditions that provide support for perceived control is required together with ideas of how to work with older people to build supportive conditions. The strategies include use of routine, having choice and maintaining independence, as well as the conditions from the major categories of 'personal

resources', 'up to me', and 'feeling comfortable and secure'. It became apparent to me that knowledge gained from this study can be applied by occupational therapists at three different levels: individual, group and community. I will now address each of these levels in turn in more detail.

Implications for occupational therapy practice with individuals, groups and communities

Occupational therapists typically work with older people on a one to one basis. Usually the older person is referred to an occupational therapist when there has been a change or a decline in health status. The occupational therapist assesses the occupational performance of the older person and an intervention plan is put in place, which may include, for example, the prescription of assistive devices. If the occupational therapist employs a client-centred approach as advocated in the previous chapter then they will be working in partnership with the older person to achieve that person's goals. From a position of perceived control the person will be able to exercise choice and use 'trading off' to incorporate the use of the assistive device within their daily occupations, whilst continuing to perceive that they are in control. What this study foregrounds is the importance of having choices and being able to exercise choice, and the importance of perceived control for well-being. Most of the suggestions that have been made thus far for ways in which the findings from this study could be put into practice have involved the older person working with an occupational therapist on an individual one-to-one basis. However, occupational therapists can consider working with small and larger groups of older people to improve well-being.

Occupational therapists also have a long tradition of working with groups of older people. In the early days of occupational therapy the therapist would have a group of older people all engaged in some sort of craft activity (Schwartz 2003). The particular craft activities were

usually prescribed by the occupational therapist, who carefully matched the features of the craft with the therapeutic needs of the person, for example, the use of basket weaving for strengthening hand function.

Later as occupational therapists sought to be "more scientific" they moved away from using craft and leisure occupations. More recently occupational therapy groups with older people have tended to have a focus on disability. Self-help and educational groups are often used to provide occupational therapy treatment following a stroke, or a cardiac event, and for management of other chronic diseases such as arthritis and Parkinson's disease. Other examples of occupational therapy groups are memory groups and falls prevention groups. Whilst these groups are valuable and would contribute to the health and well-being of the participants I suggest the idea of educational groups could be extended to address the issues related to perceived control and well-being.

Clark et al (1997) have advocated for more occupational therapists to be involved in occupation lifestyle redesign groups. Their landmark study, the first occupational therapy study to be reported in the Journal of the American Medical Association, demonstrated that a program of lifestyle redesign delivered by occupational therapists had significantly better results for a group of older people living in Los Angeles than a social group and a control group. The gains were across the domains of health, function and quality of life suggesting that occupational therapy has an important part to play in health promotion for older people. The gains were also maintained at 6 months (Clark et al. 2001). The occupational therapy groups involved didactic presentations, peer discussion and experiential components (Jackson et al. 1998) covering topics such as the power of occupation; ageing, health and occupation; transportation; safety; social relationships; cultural awareness and finances. Group activities included such things as planning low cost leisure activities and planning how to get there,

which are examples of using 'trading off' and the use of planning to increase a sense of perceived control. Group members learnt from their peers and had the support of their peers as they tackled new challenges. Australian occupational therapists could work with older people in groups like that reported above. Not only does the lifestyle re-design group have demonstrated efficacy on measures of health, but it also addresses a number of the issues that the participants in this study raised, such as safety. Groups such as the occupation lifestyle redesign program described here could be conducted by occupational therapists to address the issues raised in the findings of this thesis. Particular attention would be given to ways of increasing perceived control and using 'trading off' to enhance well-being. Group sessions could include sharing narratives collected from people who have successfully used 'trading off' to improve their well-being.

Whilst occupational therapists working with individuals and small groups is valuable and needed, for occupational therapists to have a greater impact on the well-being of older Australians they could consider not only working with individuals and groups of older people, but working at a population health level. Baum and Law (1998) have argued that as society's definition of health changes the occupational therapy profession needs to shift from a biomedical to a more sociomedical context and to take an active role in building health communities. The participants in this study viewed the community as a place that wasn't supportive of their well-being citing such things as violent acts against people as evidence. So how do occupational therapists make the shift to population health and working with communities?

Wilcock and Whiteford (2003) suggest the use of the Ottawa charter (World Health Organisation 1986) as a framework to guide occupational therapy practice in health

promotion at the community level. This landmark document in health promotion suggests action in 5 key areas:

1. Developing personal skills;
2. Strengthening community action;
3. Creating supportive environments;
4. Building healthy public policy; and
5. Re-orientation of health services.

These key areas within the Ottawa Charter offer a range of starting points to approach working with communities. An example of an occupational therapist working with older people to strengthen community action comes from Letts (2003). She conducted an action research project with a group of older people in Canada during which the Toronto Seniors Council was formed. The council had a mission to be actively involved in working for an improved quality of life and well-being of all older people in the city of Toronto. Participation in the council offers older people an opportunity for civic engagement, and the establishment of the Council provided an organizational structure that ensured the views of older people were expressed to the local government. This is a good example of an occupational therapist working on community development.

Wilcock (1998a) defines community development as "community consultation, deliberation, and action to promote individual, family, and community-wide responsibility for self-sustaining development, health and well-being." (p. 238). It involves working with a community, or representatives of the key stakeholders in cycles of identifying needs, planning actions, program implementation and evaluation. Notions of social justice and equity underpin community development. The outcome of the intervention needs to be sustainable so that the program doesn't fall away once the professionals leave.

In shifting the focus of occupational therapy from individuals to communities necessitates a reconsideration of the environment or the context in which older people live. The environmental context is more than the immediate physical environment and how it supports, limits or denies engagement in occupations by older people. Environment has come to be thought of more broadly to include social and socio-political aspects. These too impact on the way that older people go about their occupations, particularly in terms of perceived control. For example, walking is one occupation that older people like to do to keep fit, however if one lives isolated from friends and neighbours in a community that has a high crime rate, then it is unlikely that you will keep up the exercise routine of going for a walk.

A number of authors have made connections between the environment and the notion of social capital where social capital is defined as "features of social organization such as networks, norms, and social trust that facilitate coordination and cooperation for mutual benefit" (Putnam, Leonardi & Nanetti 1993, p. 67). Identified in this literature is how social capital might contribute in the fields of public health (Baum 1998), and gerontology (Robert 2002). The idea of social capital as a result of, or as a form of occupation has received less attention in the literature. Christiansen and Townsend (2004) suggest voluntarism, civic participation, social and political involvement, and community engagement are all occupations through which trust, networks and norms are all facilitated within communities. Further discussion of social capital is beyond the bounds of this thesis, however it appears to be a field that occupational therapists could explore further and perhaps take up the challenge of building social capital in occupational ways. It may well be possible that by enabling people to contribute to making the community a safer place, which is more supportive of older people, it would be much easier for older people to perceive they are in control and to experience well-being.

Occupational therapy students would benefit from considerable exposure to the ideas of working not just with individual older people but also with groups and communities. If this is not embedded in their education and the students exposed to role models and examples of use by occupational therapists then it is unlikely that many students will see their future careers working at a community public health level. Information about using community development principles and how to build work with communities in occupational ways would equip graduates with marketable skills for future practice.

Thus far in this chapter I have reviewed the aim of the study, to generate a mid-range theory, and how it has been achieved. I have drawn together possible implications to occupational therapy practice into individual, group and community approaches. I have advocated for occupational therapists to move into more community and public health approaches to have any real influence on well-being and older people. I turn now to examine the some of the unexpected findings and how they contribute to the development of theoretical knowledge.

Occupational adaptation

I will begin with considering occupational adaptation before moving to knowledge related to person/environment/occupation models. I began to explore how my study extended the theory of occupational adaptation in chapter 7. Adaptation is a word that recurs in definitions and descriptions of occupational therapy, yet there appears to be little consensus about what it exactly is. The lack of consensus is further complicated by the use of the word "as a verb, denoting a process; an abstract noun denoting an outcome; and as a concrete noun, denoting a modification, such as an aid or assistive device" (Pollock & McColl 2003, p. 65).

As early as 1984 Montgomery defined adaptation as flexible behaviour to meet the changing needs of a changing environment. The inclusion of flexibility of behaviour seems to have

been lost in later descriptions, yet the findings of this study highlighted the importance of flexibility in the use of trading off to achieve perceived control. The older person not only needs to be flexible in their response to a dynamic environment, but also in response to changes in their own capacities. The findings of my study suggest that the notion of flexibility needs to be re-introduced to any theoretical discussion of occupational adaptation.

The first authors to coin the term occupational adaptation in the occupational therapy literature were Schkade and Schultz (1992) and referred to it as 'a state of competency in occupational functioning towards which humans aspire' (p. 831). The definition includes the dual aspects of competency and aspiration. My study highlights the need to think of competency much more broadly than the older person being personally capable of tackling and completing their daily tasks to a level that they are satisfied with. In addition, competency for older people includes a more cognitive component of perceiving that they are in control to employ trading off. The older person weighs up the choices available to them, and may choose to involve someone else in completing the task for them, but they still have the self-perception of being competent in their environment and being adaptive. This addition of a cognitive perception of control level of competence is quite different from how occupational therapists have traditionally thought and written about competence.

Schultz and Schkade (1997) attempt to resolve the dilemma of how occupational adaptation is used by offering separate definitions for the state and the process:

> Occupational adaptation (the process) is a series of actions, internal to the individual, which unfold as the individual is faced with an occupational challenge. The individual engages this process with the intention to produce a response that will result in an experience of relative mastery over the challenge.

> Occupational adaptation (the state) is a state of competency toward which human beings aspire. The existence and strength of this state in an individual is a function of the extent to which occupational responses have been effective in producing relative mastery over occupational challenges and the extent to which such responses have successfully generalized to a variety of occupational challenges *(p. 474).*

Since the early 90's when Schkade and Schultz published their work there has been further examination of occupational adaptation by other theorists. Spencer, Davidson and White (1996) added that occupational adaptation was a cumulative process emanating from one's life history. Later, Kielhofner (2002) argued that based on empirical and theoretical work, a person's adaptation consists of the two distinct elements, identity and competence. He defines occupational identity as 'a composite sense of who one is and wishes to become as an occupational being generated from one's history of occupational participation' (p. 119). A person's occupational identity is a combination of their habits and routines, sense of mastery, interests, roles, values and perceptions of the environment. In contrast, 'occupational competence is the degree to which one sustains a pattern of occupational participation that reflects one's occupational identity' (p. 120). Occupational competence involves putting one's occupational identity into action including maintaining routines, fulfilling ones roles, and participating in a range of occupations that are satisfying and fulfilling. Occupational adaptation, according to Kielfhofner is 'the construction of a positive occupational identity and achieving occupational competence over time in the context of one's environment' (p. 121).

What is not made clear to the reader is how occupational identity and occupational competence inter-relate to achieve occupational adaptation. Kielhofner does acknowledge that the degree of success in occupational adaptation varies over time. He further acknowledges that at times in people's lives they will experience threats or problems in occupational adaptation requiring the rebuilding of their occupational identity and

occupational competence. Kielhofner contends that when faced with disability people craft their new occupational identity through the use of narrative. It does seem however that Kielhofner is using the word adaptation as a noun describing an outcome rather than a process. This highlights the difficulty with the lack of consensus in the literature as to what occupational adaptation is. In contrast to Kielhofner referring to occupational adaptation as an outcome, the knowledge from my study about the use of 'trading off' to maintain perceived control contributes to a theoretical construction of occupational adaptation as a process rather than an outcome.

Another notable occupational therapy theorist who has written about occupational adaptation is Nelson (Nelson & Jepson-Thomas 2003). In a recent text Nelson uses diagrams that appear very similar to chemical formulas and equations to illustrate his theoretical propositions. The presentation of these formulas gives a very linear view of the relationship between elements, which I am not convinced is Nelson's intention. He begins with a person with a unique developmental structure who encounters an occupational form. An occupational form is 'the objective set of physical and socio-cultural circumstances, external to the person, at a particular time. The occupational form guides, structures, or suggests what is to be done by the person' (p. 90). From that encounter the person experiences meaning and from meaning develops a sense of purpose. Having a sense of purpose causes voluntary engagement in occupational performance. From the occupational performance the person has an impact on the world around them and may create new opportunities in the new occupational form. The person's occupational performance also creates a change in him or herself, or adaptation. Nelson asserts "one beneficial occupational adaptation leads to the next" (p. 120). In Nelson's theory adaptation appears to be referring to something similar to learning or the development of the person. This is further evidence that the word adaptation is used in several different ways. Nelson's ideas are however about process. This points to the need for

future discussions about occupational adaptation to clarify for the reader the perspective taken. The reader needs to know if the authors are writing about occupational adaptation as a process or as an outcome.

As I was finalising the writing of this chapter in my thesis I became aware of a Dutch phenomenological study of occupational adaptation by older people with physical disabilities by Bontje et al (2004). They found that occupational adaptation was a process triggered by the participants who expected that they could identify solutions to the problems arising from their disability. Participants drew on personal resources such as familiar problem-solving strategies and personal experience to identify potential solutions to their challenges. Having intact intellectual functioning was an important pre-requisite for being able to identify potential solutions. Three different approaches were used to create solutions, including giving of a role to another person and use of technological adaptations such as environmental modifications or use of adaptive equipment. Both of these strategies are used in what I have named as 'trading off'. The third strategy they identified involved physical and mental effort in consideration of the options available, weighing up of the pros and cons and trial and error. A possible outcome was the lowering of expectations, for example, accepting that wearing wrinkled clothes was alright if one could not do the ironing. Again this strategy has striking similarity to the phases in the process of 'trading off'.

From my study occupational adaptation appears to be a process of matching the person's capacities to the demands of the environment and the occupation they wish to perform. If there is a mis-match between the demands and the capacities the person will examine the choices available and may use trading off. That is, they could choose to give up that occupation and perform an alternative one, do that occupation differently or less often, change their standards about how occupations are performed, or they could choose to have someone

else perform that occupation for them. The choice of action is made after examining the choices available; therefore having some flexibility in the occupations performed and in one's attitude is important. The key point to the adaptation in this case is for the person to have perceived control. If the person perceives they are in control they are able to maintain a sense of well-being.

The findings from my study have contributed knowledge about the process of occupational adaptation and its importance to well-being. It particularly highlights the need for flexibility, and that the process is on-going with constant re-negotiation as the circumstances of the person change. The work of Bontje et al (2004) who set out to specifically study occupational adaptation of older people with physical disabilities, has such resonance with the findings of my study that it appears to confirm the basic social process of 'trading off' as the process of occupational adaptation which is necessary for older people to experience well-being.

Having considered the contribution of the findings to theory on occupational adaptation I turn now to discuss the person/environment/occupation theoretical models in occupational therapy and the contributions of the findings from this study to further development of those models.

Person environment occupation models

In writing my thesis and in considering the findings from my study it became apparent to me that there is a fundamental interaction between the person, the occupation and the environment. Even the occupational adaptation theories discussed thus far involve these three elements. A number of other such models exist in occupational therapy and in the gerontological literature. I now will consider each of these and how the findings from this study extend that knowledge.

Two main person/environment/occupation models exist within the occupational therapy literature. The first, the Person Environment Occupational performance model described by Christiansen and Baum has a theoretical base in systems theory (Christiansen & Baum 1991). The focus is on open systems interacting within their environment. The model was revised in 1997 to reflect a more transactional relationship between the person, the occupation and the environment, and the influence of intrinsic and extrinsic factors on occupational performance, health and well-being (Christiansen & Baum 1997).

Secondly, the Person Environment Occupation Model (Law et al. 1996) of occupational performance was built on previous literature such as the Canadian guidelines for client centred practice (Canadian Association of Occupational Therapists 1991) and the Canadian Occupational Performance Measure (Law et al. 1990). Law et al's model describes occupational performance as the product of a dynamic, interwoven relationship that exists among people, their occupations and roles, and the environments in which they interact. The authors suggest that what people do is influenced by and cannot be separated from the context, temporal factors, and physical and psychological characteristics of the person.

Both of the models described above are occupational therapy practice models that apply equally well to practice with any client as they do to practice with older people. On reviewing the literature it is also apparent that there is a similar model in gerontology and has been for some time. Lawton (1982) wrote as early as 1982 of behaviour being a function of the capacities of the person and the environmental press of the situation, encapsulated in the formula $B=f(P,E)$. Environmental press is the potential demands of the environmental context on the person. Interestingly, environmental press is a concept that exists within occupational therapy with the same meaning, yet I have not seen the concept within occupational therapy literature attributed to Lawton. Lawton went on to write that the behaviour of a person of any

given level of competence when faced with environmental press would be either adaptive or maladaptive. The older person with reduced competence and strong environmental press is less likely to be able to execute behaviour that is adaptive. High competence is associated with a relative independence of the individual from the behavioural effects of environmental press, while low competence implies a relative vulnerability to environmental press. This seems consistent with the findings of my study. Participants with physical and mental capacities and adequate incomes to engage in the occupations they wished were able to perceive they were in control and thus manage both favourable and unfavourable environments. In contrast, older people with lowered competence in any of these areas have difficulty coping with the demands of the environment. What my study has added to Lawton's conceptualisation of the person/environment/behaviour model is the use of 'trading off' as a process used to manage the mis-match between competence and the environmental demands.

To summarise how my study adds to the knowledge of PEO models, I contend that I have added information about the various components of the models and the transactional nature of the interactions between the components. In terms of the "person" component I have contributed further information about the 'personal resources' that equip older people to face challenges to their equilibrium, such as 'being connected' with family and friends and 'keeping engaged' and busy. I have also revealed the need for older people to take an attitude of 'it is up to me' in order to be successful in maintaining perceived control. Knowledge has also been added about the 'environment' component. My study has revealed how important it was for the participants to feel comfortable and secure. An environment that is supportive and feels safe enhances a sense of control. My study has also added information about the transaction, 'trading off' that is used to manage the situation when the demands of the environment or the occupation are greater than the capacities of the person. Before now there

existed descriptions of the person/environment/ occupation models but very little seems to have been written about the transactional relationship between elements of the model, or the process.

Variations of the person/environment/ occupation (PEO) models provide a theoretical underpinning to what the occupational therapist does in practice. They also guide the therapist's approach to practice. The occupational therapist has a range of options, in that they can address issues from either the perspective of the person, the environment or the occupation, or a combination of any of these. I will illustrate these options with an example. If an occupational therapist was to work with Radlee to address some of the difficulties she has because of Parkinson's disease, they could boost personal capacities by teaching her and her husband strategies to overcome freezing. At the same time they can make changes to the environment such as reducing clutter or rearranging furniture in the home to make it easier for the person to walk around and perhaps reduce the number of incidents of freezing. The features of an occupation that the person is finding difficult can be altered of 'traded off', for example, Radlee and her husband now hold afternoon tea parties instead of dinner parties. From this example you can see how addressing all three areas with the model would help Radlee to feel more in control and thus experience well-being. The PEO models describe usual occupational therapy practice with older people. What has been added by my study is the use of trading off within the person/environment/occupation transaction and the focus on the older person perceiving they are in control.

Occupational therapy ideas about the environment have changed over the last 20 years. Environment is not only the immediate physical built and natural environment but is viewed in a broader way to encompass psycho-social, societal, political, cultural, institutional and international factors (Canadian Association of Occupational Therapists 1997). The

environment is dynamic and can have an enabling or a constraining effect on the performance of occupations. The expanded notion of environment calls for occupational therapists to consider the impact of all of these types of environment on their clients' participation in occupations. The key contribution of the findings from my study is to the transactional nature of the relationships between the elements of the model. Consequently when there is a mis-match between the demands of an occupation and the capacities of the person they are able to use 'trading off' to achieve well-being. The knowledge about 'trading off' provides direction for occupational therapy practitioners to work with their clients on increasing perceived control and thus well-being.

Summary

In this section of the thesis I have discussed the contribution of the findings to the development of knowledge in two areas – occupational adaptation and person/environment/occupation models. These findings were unexpected highlighting the contribution of conducting a qualitative study. I set out to study older people's understandings of well-being, not occupational adaptation or PEO models. Yet by going to older people themselves knowledge has been revealed that contributes to the theoretical construction of occupational adaptation as a process and to the dynamic transactional nature of the interaction between the older person, their occupations and the environment.

Transferability

According to Lincoln and Guba's (1985) suggestions to enable transferability of findings I have provided here a detailed description of each stage of the research study. I have given explicit details of participants, how and why they were recruited, how the date were gathered and how it was analysed. This enables the reader to make their own decision about the transferability of the findings to their setting. A sample size of 15 is within acceptable limits

for a grounded theory study. Similar grounded theory studies have had a sample size of between 7 (Ludwig 1997), 8 (Farber 2000) to 10 (Bye 1998; Primeau 1998), 18 (Tamm 1999) and up to 30 (Sweeney, Webley & Treacher 2001).

Glaser suggests that the true test of a grounded theory is whether it has "grab and fit". By the term, Glaser means that it makes sense to the reader and fits with their knowledge of the situation being studies. Whenever I have presented the findings at student colloquiums or professional conferences there has been a general acceptance of the ideas and resonance with individuals. I suggest that the nods of agreement in the audience are consistent with Glaser's description of "grab and fit". I would suggest that "grab and fit" are not the key measures of transferability, but an additional measure to the others already discussed.

However, a cautionary note is needed here. This study was conducted with the participants drawn from a sample of older people living in a metropolitan area and thus does not include older people from rural and remote areas. As discussed in chapter 3 the decision to study older people from a metropolitan area was based on evidence that differentials in health exist between older people in metropolitan and rural areas. A similar study needs to be conducted now with older people from rural and remote areas to see if the assumption that the health differential would impact on perceptions and understandings of well-being is accurate, or if the basic social process of 'trading off' is used by older people regardless of geographic location.

Further, all of the participants in my study spoke fluent English. Some of the participants were migrants from other countries, including one from a non-English speaking country, but the sample was not culturally diverse. It may be that well-being is something different for other cultural groups that reside in Australia. This study was conducted by a single researcher

in one location in Australia. There would be great benefit from further study by additional researchers in other parts of Australia, and indeed the world. Whilst the study is of use and value in itself, it could also be used as a platform for other studies.

Application to a multi-disciplinary context

The whole of this thesis has been clearly and deliberately situated within the context of occupational therapy and occupational science. The findings do however have wider application to a multi-disciplinary audience. Other health professionals could well use the ideas of enabling 'trading off' through client-centred practice as discussed in the previous chapter. There is considerable body of literature about client-centred practice in occupational therapy but the ideas are not unique to that profession. Other disciplines such as nursing or social work may well use principles of client-centred or patient-centred care within their practice. The key elements are to keep the client's expressed needs and priorities the focus of intervention and to assist the client to make their own decisions.

Occupational therapists are well placed to enable older people to examine their capacities and the match or mis-match between the demands of the task and the environmental influences and to consider the potential for 'trading off'. They are however not the only people. Other health professionals, for example, physiotherapists work with older people to consider their mobility needs, and the match with the demands of the environment. A social worker may well assist an on older person to examine their finances of accommodation options and the match with their needs, and to consider the potential for 'trading off' as part of that process.

In reality, occupational therapists usually work in a multi-disciplinary context where there is sharing and blurring of roles, or cross referral to each other acknowledging the particular expertise of each discipline. By working together with other disciplines and other

professionals such as urban planners and architects we can build a community that is "older person friendly" and enables older people to maximise their capacities, and remain an active participating member of the community.

Concluding remarks

In bringing this study and this thesis to a close I return to the opening quote of the introduction by Carl Jung. Jung suggested that humans would not live to be in their late seventies and beyond if there was no meaning to longevity for the species. Further, Jung wrote that the afternoon of life must have its own significance and not be a mere appendage to life's morning. In this thesis I have articulated a grounded theory of well-being from the perspective of a group of older people living in the community in an Australian city. If occupational therapists are able to put the findings from this thesis into practice by enabling their clients to perceive that they are in control and use 'trading off', then their late adulthood will be a sunny afternoon and not a black night or a pitiful appendage to a bright morning.

References

American Heritage Dictionary 1980, *Roget's New Thesaurus*, Houghton Mifflin Co, Boston, Mass.

Andrews, FM & McKennell, AC 1980, 'Measures of self-reported well-being: Their affective, cognitive, and other components.' *Social Indicators Research,* vol. 8, pp. 127-155.

Andrews, FM & Withey, SB 1976, *Social indicators of well-being. Americans' perceptions of life quality*, Plenum Press, New York.

Annells, M 1996, 'Grounded theory method: Philosophical perspectives, paradigm of inquiry, and postmodernism.' *Qualitative Health Research,* vol. 6, no. 3, pp. 379-393.

Australian Bureau of Statistics 2002, *4364.0 National Health Survey - Summary of results, Australia*, Australian Bureau of Statistics, viewed February, 4th 2003, <http://www.abs.gov.au/ausstats/abs>.

Australian Bureau of Statistics 1999a, *Australia Now - A Statistical Profile*, Australian Bureau of Statistics, viewed 18th February 2000, <http://www.statistics.gov.au/websitedbs.../D982DF9AAC4EDCF3CA25684F0021FD2A>.

Australian Bureau of Statistics 1999b, *Australian Social Trends 1999*, Australian Bureau of Statistics, Canberra, viewed 19th May 2005, <http://www.abs.gov.au/Ausstats/abs@.nsf/0/0a47979ad5e28b11ca25699f0005d636?OpenDocument>.

Australian Bureau of Statistics 2003, *Year Book Australia, Population, Deaths*, updated 26 May 2004, Australian Bureau of Statistics, viewed 31st August 2004, <http://www.abs.gov.au/Ausstats>.

Bailey, DM & Jackson, JM 2003, 'Qualitative data analysis: Challenges and dilemmas related to theory and method.' *American Journal of Occupational Therapy,* vol. 57, pp. 57-65.

Bar-Tur, L, Levy-Shiff, R & Burns, A 1998, 'Well-being in aging: Mental engagements in elderly men as a moderator of losses.' *Journal of Aging Studies,* vol. 12, no. 1, pp. 1-17.

Baum, C & Christensen, C 1997, 'The occupational therapy context: Philosophy- Principles-Practice.' in *Occupational therapy. Enabling Function and well-being*, 2nd edn, eds. C Christensen & C Baum, Slack Inc, Thorofare, NJ, pp. 27-45.

Baum, C & Law, M 1998, 'Community health: A responsibility, an opportunity and a fit for occupational therapy', *American Journal of Occupational Therapy,* vol. 52, pp. 7-10.

Baum, F 1998, *The new public health: An Australian perspective*, Oxford University Press, Melbourne.

Beck, CT 1993, 'Teetering on the edge: A substantive theory of postpartum depression.' *Nursing Research,* vol. 42, no. 1, pp. 42-48.

Bennett, KM 1997, 'A longitudinal study of wellbeing in widowed women.' *International Journal of Geriatric Psychiatry,* vol. 12, pp. 61-66.

Bing, R 1986, 'The subject is health: Not of facts, but of values', *American Journal of Occupational Therapy,* vol. 40, pp. 667-671.

Bisconti, TL & Bergeman, CS 1999, 'Perceived social control as a mediator of the relationships among social support, psychological well-being, and perceived health.' *The Gerontologist,* vol. 39, no. 1, pp. 94-103.

Blenner, JL 1990, 'Passage through infertility treatment: A stage theory.' *IMAGE: Journal of Nursing Scholarship,* vol. 22, no. 3, pp. 153-158.

Blumer, H 1969/1986, *Symbolic interactionism: Perspective and method,* University of California Press, Berkley, CA.

Bonder, BR 1997, 'Coping with psychological and emotional challenges.' in *Occupational Therapy. Enabling function and well-being,* eds. C Christiansen & C Baum, Slack Inc, Thorofare, NJ.

Bontje, P, Kinebanian, A, Josephsson, S & Tamura, Y 2004, 'Occupational adaptation: the experiences of older persons with physical disabilities', *American Journal of Occupational Therapy,* vol. 58, no. 2, pp. 140-149.

Bowers, BJ 1988, 'Grounded theory', in *Paths to knowledge. Innovative research methods for nursing,* ed. B Sarter, National League for Nursing, New York, p. 238.

Bowsher, JE & Gerlach, MJ 1990, 'Personal control and other determinants of psychological well-being in nursing home elders.' *Scholarly Inquiry for Nursing Practice,* vol. 4, no. 2, pp. 91-102.

Bradley, N & Poppen, W 2003, 'Assistive technology, computers and internet may decrease sense of isolation for homebound elderly and disabled persons', *Technology and Disability,* vol. 15, no. 1, pp. 19-25.

Brennan, M & Cardinali, G 2000, 'The use of preexisting and novel coping strategies in adapting to age-related vision loss', *The Gerontologist,* vol. 40, no. 3, pp. 327-334.

Bye, RA 1998, 'When clients are dying: Occupational therapists' perspectives', *Occupational Therapy Journal of Research,* vol. 18, no. 1, pp. 3-24.

Canadian Association of Occupational Therapists 1997, *Enabling occupation: An occupational therapy perspective,* 1st edn, Canadian Association of Occupational Therapists, Ottawa.

Canadian Association of Occupational Therapists 1991, *Occupational therapy guidelines for client-centred practice,* CAOT Publications ACE, Toronto, Ontario.

Carlson, M, Fanchiang, S-P, Zemke, R & Clark, F 1996, 'A meta-analysis of the effectiveness of occupational therapy for older persons', *American Journal of Occupational Therapy,* vol. 50, pp. 89-98.

Carlson, ME & Clark, FA 1991, 'The search for useful methodologies in occupational science.' *American Journal of Occupational Therapy,* vol. 45, no. 3, pp. 235-241.

Carpenter, C & Hammell, KW 2001, 'Evaluating qualitative research', in *Using qualitative research. A practical introduction for occupational and physical therapists*, eds. KW Hammell, C Carpenter & I Dyck, Churchill Livingstone, Edinburgh, pp. 107-119.

Carpenter, DR 1995, 'Grounded theory research approach', in *Qualitative research in Nursing*, eds. HJ Streubert & DR Carpenter, J. B. Lippincott, Philadelphia, pp. 145-161.

Carswell, A, Carson, LJ, Walop, W & Zgola, J 1992, 'A theoretical model of functional performance in persons with Alzheimer disease.' *Canadian Journal of Occupational Therapy,* vol. 59, pp. 132-140.

Chamberlain, K 1988, 'On the structure of subjective well-being.' *Social Indicators Research,* vol. 20, pp. 581-604.

Chamberlain, K & Zika, S 1988, 'Religiosity, life meaning and wellbeing: Some relationships in a sample of women.' *Journal for the Scientific Study of Religion,* vol. 27, no. 3, pp. 411-420.

Chamberlain, K & Zika, S 1992, 'Stability and change in subjective well-being over short time periods.' *Social Indicators Research,* vol. 26, pp. 101-117.

Chang, L & Hasselkus, BR 1998, 'Occupational therapists' expectations in rehabilitation following stroke: Sources of satisfaction and dissatisfaction.' *American Journal of Occupational Therapy,* vol. 52, no. 8, pp. 629-637.

Charmaz, K 1994, 'The grounded theory method: An explication and interpretation.' in *More grounded theory methodology: A reader*, ed. BG Glaser, Sociology Press, Mill Valley, Ca, pp. 95-115.

Christiansen, C & Baum, C (eds) 1997, *Occupational therapy. Enabling function and well-being*, 2nd edn, Slack Inc, Thorofare, NJ.

Christiansen, C & Baum, C (eds) 1991, *Occupational therapy: Overcoming human performance deficits*, Slack Incorporated, Thorofare, NJ.

Christiansen, C & Townsend, E 2004, 'The occupational nature of communities', in *Introduction to occupation: The art and science of living*, eds. C Christiansen & E Townsend, Prentice Hall, Upper Saddle River, NJ.

Christiansen, CH, Backman, C, Little, BR & Nguyen, A 1999, 'Occupations and well-being: A study of personal projects.' *American Journal of Occupational Therapy,* vol. 53, pp. 91-100.

Clark, F 1993, 'Occupation embedded in a real life: Interweaving occupational science and occupational therapy. 1993 Eleanor Clarke Slagle Lecture', *American Journal of Occupational Therapy,* vol. 47, pp. 1067-1078.

Clark, F, Azen, S, Carlson, M, Mandel, D, LaBree, L, Hay, J, Zemke, R, Jackson, J & Lipson, L 2001, 'Embedding health-promoting changes into the daily lives of independent-living older adults: Long term follow up of occupational therapy intervention', *Journal of Gerontology,* vol. 56B, no. 1, pp. 60-63.

Clark, F, Azen, SP, Zemke, R, Jackson, J, Carlson, M, Mandel, D, Hay, J, Josephson, K, Cherry, B, Hessel, C, Palmer, J & Lipson, L 1997, 'Occupational therapy for independent-living older adults. A randomized controlled trial', *Journal of American Medical Association,* vol. 278, pp. 1321-1326.

Clark, F, Carlson, M, Zemke, R, Frank, G, Patterson, K, Ennevor, BL, Rankin-Martinez, A, Hobson, L, Crandall, H, Mandel, D & Lipson, L 1996, 'Life domains and adaptive strategies of a group of low-income, well older adults.' *American Journal of Occupational Therapy,* vol. 50, no. 2, pp. 99-108.

Clarke, PJ, Marshall, VW, Ryff, CD & Rosenthal, CJ 2000, 'Well-being in Canadian seniors: Findings from the Canadian study of health and aging', *Canadian Journal on Aging,* vol. 19, no. 2, pp. 139-159.

Cohn, E, Miller, LJ & Tickle-Degnen, L 2000, 'Parental hopes for therapy outcomes: Children with sensory modulation disorders.' *American Journal of Occupational Therapy,* vol. 54, pp. 36-43.

Coleman, P, Ivani-Challian, C & Robinson, M 1998, 'The story continues: Persistence of life themes in old age.' *Ageing and Society,* vol. 18, pp. 389-419.

Corbin, J 1986, 'Qualitative data analysis for grounded theory', in *From practice to grounded theory*, eds. WC Chenitz & J Swanson, Addison-Wesley Publishing Co, Menlo Park, Ca, pp. 91-101.

Corner, L & Bond, J 2004, 'Being at risk of dementia: Fears and anxieties of older adults', *Journal of Aging Studies,* vol. 18, pp. 143-155.

Creswell, JW 1998, *Qualitative inquiry and research design. Choosing among five traditions*, Sage Publications, Thousand Oaks, Ca.

Cusick, A 2001, 'The experience of clinician-researchers in occupational therapy', *American Journal of Occupational Therapy,* vol. 55, pp. 9-18.

Cutcliffe, J 2000, 'Methodological issues in grounded theory', *Journal of Advanced Nursing,* vol. 31, no. 6, pp. 1476-1484.

de la Rue, M & Coulson, I 2003, 'The meaning of health and well-being: Voices from older rural women', *Rural and Remote Health,* vol. 3, http://rrh.deakin.edu.au.

Delbaere, K, Crombez, G, Vanderstraeten, G, Willems, T & Cambier, D 2004, 'Fear-related avoidance of activities, falls and physical frailty. A prospective community-based cohort study', *Age and Ageing,* vol. 33, pp. 368-373.

Denzin, NK 1989, *The research act. A theoretical introduction to sociological methods*, 3rd edn, Prentice Hall, Englewood Cliffs, NJ.

Denzin, NK & Lincoln, YS 1989, 'Introduction. Entering the field of qualitative research.' in *The research act*, 3rd edn, eds. NK Denzin & YS Lincoln, Prentice Hall, Englewood Cliffs, NJ, pp. 1-17.

Department of Education Science and Training 2003, *National research priorities*, updated 22nd December 2003, Commonwealth of Australia, viewed 20th November 2004, <http://www.dest.gov.au/priorities/>.

Department of Family and Community Services 1999, *Home and residence choices for older people*, Commonwealth of Australia, Canberra.

Department of Health and Aging 2003, *National strategy for an Ageing Australia*, Commonwealth Government of Australia, Canberra, viewed 30th November 2004, <http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/ageing-ofoa-agepolicy-nsaa-nsaabk.htm>.

DePoy, E & Gitlin, LN 1998, *Introduction to research. Understanding and applying multiple strategies.*, 2nd edn, Mosby, St Louis.

Diener, E 1984, 'Subjective well-being', *Psychological Bulletin,* vol. 95, no. 3, pp. 542-575.

Diener, E, Emmons, RA, Larsen, R & Griffen, S 1985, 'The satisfaction with life scale', *Journal of Personality Assessment,* vol. 49, no. 1, pp. 71 - 75.

Drake, V & Irurita, V 1997, 'Clarifying ambiguity in problem fieldwork placements: Picking up and dealing with problem signals.' *Australian Occupational Therapy Journal,* vol. 44, pp. 62-70.

Dubouloz, C-J, Egan, M, Vallerand, J & von Zweck, C 1999, 'Occupational therapists' perceptions of evidence-based practice.' *American Journal of Occupational Therapy,* vol. 53, pp. 445-453.

Ducharme, F & Rowat, K 1992, 'Conjugal support, family coping behaviours and the well-being of elderly couples.' *Canadian Journal of Nursing Research,* vol. 24, no. 1, pp. 5-22.

Eaves, YD 2001, 'A synthesis technique for grounded theory data analysis', *Journal of Advanced Nursing,* vol. 35, no. 5, pp. 654-663.

Eisenhandler, S 1990, 'The asphalt identikit: Old age and the driver's licence.' *International Journal of Aging and Human Development,* vol. 30, no. 1, pp. 1-14.

Euler, BL 1992, 'A flaw in gerontological assessment: The weak relationship of elderly superficial life satisfaction to deep psychological well-being', *International Journal of Aging and Human Development,* vol. 34, no. 4, pp. 299-310.

Fagerhaugh, S 1986, 'Analyzing data for basic social processes', in *From practice to grounded theory. Qualitative research in nursing*, eds. WC Chenitz & J Swanson, Addison-Wesley Publishing Company, Menlo Park, Ca, pp. 133-145.

Farber, RS 2000, 'Mothers with disabilities: In their own voice.' *American Journal of Occupational Therapy,* vol. 54, no. 3, pp. 260-268.

Feldman, S 1999, 'Please don't call me "dear": Older women's narratives of health care.' *Nursing Inquiry,* vol. 6, pp. 269-276.

Feldman, S, Kamler, B & Snyder, I (eds) 1996, *Stories of women growing older. Something that happens to other people*, Random House, Sydney.

Finlay, L 2003, 'The reflexive journey: mapping multiple routes', in *Reflexivity. A practical guide for researchers in health and social sciences*, eds. L Finlay & B Gough, Blackwell Science, Oxford, pp. 3-20.

Fonda, S, Wallace, R & Herzog, AR 2001, 'Changes in driving patterns and worsening depressive symptoms among older adults.' *Journals of Gerontology: Series B,* vol. 56B, no. 6, pp. S343-351.

Fontana, A & Frey, JH 1998, 'Interviewing: The art of science', in *Collecting and interpreting qualitative materials*, eds. NK Denzin & YS Lincoln, Sage publications, Thousand Oaks, Ca, pp. 47-78.

Fox, MT & Gooding, BA 1998, 'Physical mobility and social integration: Their relationship to the well-being of older Canadians.' *Canadian Journal on Aging,* vol. 17, no. 4, pp. 372-383.

Francis-Connolly, E 1998, 'It never ends: Mothering as a lifetime occupation.' *Scandinavian Journal of Occupational Therapy,* vol. 5, pp. 149-155.

Francis-Connolly, E 2000, 'Toward an understanding of mothering: A comparison of two motherhood stages.' *American Journal of Occupational Therapy,* vol. 54, no. 3, pp. 281-289.

Frank, G 1997, 'Is there life after categories? Reflexivity in qualitative research.' *Occupational Therapy Journal of Research,* vol. 17, no. 2, pp. 84-98.

Friedman, M 1997, 'Social support sources among older women with heart failure: Continuity versus loss over time.' *Research in nursing and health,* vol. 20, pp. 319-327.

Fry, P 2000, 'Whose quality of life is it anyway? Why not ask seniors to tell us about it?' *International Journal of Aging and Human Development,* vol. 50, no. 4, pp. 361-383.

Gillham, B 2000, *The research interview*, Continuum, London.

Glaser, BG 1992, *Basics of grounded theory analysis. Emergence vs forcing.*, Sociology Press, California.

Glaser, BG 1978, *Theoretical sensitivity*, Sociology Press, California.

Glaser, BG & Strauss, AL 1965, *Awareness of dying*, Weidenfeld and Nicolson, London.

Glaser, BG & Strauss, AL 1967, *The discovery of grounded theory*, Aldine de Gruyter, New York.

Golledge, J 1968, 'Distinguishing between occupation, purposeful activity and activity, part 1: review and explanation', *British Journal of Occupational Therapy,* vol. 61, no. 3, pp. 100-105.

Government of South Australia 2004a, *Department for families and communities*, Government of South Australia, Adelaide, viewed 30th November 2004, <http://www.familiesandcommunities.sa.gov.au/>.

Government of South Australia 2004b, *South Australia's strategic plan*, Government of South Australia, Adelaide, viewed 8th May 2005, <http://www.stateplan.sa.gov.au/home.php>.

Graham, K & Schmidt, G 1999, 'Alcohol use and psychosocial well-being among older adults.' *Journal of Studies on Alcohol,* vol. 60, no. 3, pp. 345-351.

Grbich, C 1999, *Qualitative research in health. An introduction.*, Allen & Unwin, Sydney.

Guba, E 1981, 'Criteria for assessing the trustworthiness of naturalistic inquiries', *Educational Resources Information Center Annual Review Paper,* vol. 29, pp. 75-91.

Hammell, KW & Carpenter, C 2001, 'Introduction to qualitative research in occupational therapy and physical therapy', in *Using qualitative research: A practical introduction for occupational and physical therapists*, eds. KW Hammell, C Carpenter & I Dyck, Churchill Livingstone, Edinburgh, pp. 1-12.

Hasselkus, BR 1995, 'Beyond ethnography: Expanding our understanding and criteria for qualitative research.' *Occupational Therapy Journal of Research,* vol. 15, no. 2, pp. 75-84.

Hasselkus, BR 1997, 'Occupation and well-being in dementia: The experience of day-care staff.' *American Journal of Occupational Therapy,* vol. 52, no. 6, pp. 423-434.

Headey, B 1999, 'Old age is not downhill: The satisfactions and well-being of older Australians', *Australasian Journal on Ageing,* vol. 18, no. 3, pp. 32-37.

Heidrich, S 1998, 'Older women's lives through time.' *Advanced Nursing Science,* vol. 20, no. 3, pp. 65-75.

Heidrich, SM & D'Amico, D 1993, 'Physical and mental health relationships in the very old.' *Journal of Community Health Nursing,* vol. 10, no. 1, pp. 11-21.

Heidt, PR 1990, 'Openness: A qualitative analysis of nurses' and patients' experiences of therapeutic touch.' *IMAGE: Journal of Nursing Scholarship,* vol. 22, no. 3, pp. 180-186.

Hill, R, Campbell, B, Thomas, L & Soo-Tho, KM 1998, 'Perceptions of well-being in older smokers.' *Journal of Mental Health and Aging,* vol. 4, no. 2, pp. 271-280.

Hilleras, PK, Jorm, A, Herlitz, A & Winblad, B 1999, 'Activity patterns in very old people: a survey of cognitively intact subjects aged 90 years or older', *Age and Ageing,* vol. 28, pp. 147-152.

Hutchinson, S 1993a, 'Grounded theory: The method', in *Nursing research. A qualitative perspective*, eds. PL Munhall & C Oiler Boyd, National League for Nursing Press, New York.

Hutchinson, S 1993b, 'People with bipolar disorders quest for equanimity: Doing grounded theory.' in *Nursing research. A qualitative perspective*, eds. PL Munhall & C Oiler Boyd, National League for Nursing Press, New York.

Hutchinson, S & Wilson, H 1994, 'Research and therapeutic interviews: A poststructuralist perspective', in *Critical issues in qualitative research methods*, ed. J Morse, Sage publications, Thousand Oaks, Ca.

Irurita, V 1992, 'Transforming mediocrity to excellence: A challenge for nurse leaders', *The Australian Journal of Advanced Nursing,* vol. 9, no. 4, pp. 15-25.

Jacelon, CS 2003, 'The dignity of elders in an acute care hospital', *Qualitative Health Research,* vol. 13, no. 4, pp. 543-556.

Jacelon, CS 1997, 'The trait and process of resilience', *Journal of Advanced Nursing,* vol. 25, pp. 123-129.

Jackson, J 1996, 'Living a meaningful existence in old age', in *Occupational Science. The evolving discipline*, eds. R Zemke & F Clark, F.A. Davis, Philadelphia, pp. 339-362.

Jackson, J, Carlson, M, Mandel, D, Zemke, R & Clark, F 1998, 'Occupation in lifestyle redesign: The Well Elderly Study Occupational Therapy program.' *American Journal of Occupational Therapy,* vol. 52, pp. 326-336.

Jeeawody, B & Bevan, C 1998, 'Introduction: The philosophical framework.' in *Successful ageing. Perspectives on health and social construction*, eds. C Bevan & B Jeeawody, Mosby, Sydney, pp. XXI-XXVII.

Johnson, JA 1986, *New dimensions in wellness: A context for living*, SLACK Inc, Thorofare, NJ.

Jonsson, A-LT, Moller, A & Grimby, G 1999, 'Managing occupations in everyday life to achieve adaptation.' *American Journal of Occupational Therapy,* vol. 53, pp. 353-362.

Jonsson, H, Borell, L & Sadlo, G 2000, 'Retirement: An occupational transition with consequences of temporality, balance and meaning of occupations', *Journal of Occupational Science,* vol. 7, no. 1, pp. 29-37.

Jorm, AF, Christensen, H, Henderson, AS, Jacomb, PA, Korten, AE & Mackinnon, A 1998, 'Factors associated with successful ageing.' *Australasian Journal on Ageing,* vol. 17, no. 1, pp. 33-37.

Kahana, E, Redmond, C, Hill, G, Kercher, K, Kahana, B, Johnson, JR & Young, R 1995, 'The effects of stress, vulnerability, and appraisals on the psychological well-being of the elderly.' *Research on Aging,* vol. 17, no. 4, pp. 459-489.

Kampfe, CM & Smith, SM 1998, 'Intrapersonal aspects of hearing loss in persons who are older.' *Journal of Rehabilitation,* vol. 64, no. 2,

Kendig, H, Browning, CJ & Young, AE 2000, 'Impacts of illness and disability on the well-being of older people', *Journal of Disability and Rehabilitation,* vol. 22, no. 1/2, pp. 15-22.

Kielhofner, G 2002, 'Challenges and directions for the future of occupational therapy', paper presented at the 13th World Congress, Stockholm, Sweden.

Kielhofner, G 1997, *Conceptual foundations of occupational therapy.*, 2nd edn, FA Davis, Philadelphia.

Kielhofner, G 2002, 'Dimensions of doing', in *Model of human occupation. Theory and application*, 3rd edn, ed. G Kielhofner, Lippincott, Williams and Wilkins, Baltimore, Maryland, pp. 114-123.

Kielhofner, G (ed.) 1985, *A model of human occupation, Theory and application*, Williams & Wilkins, Baltimore, Md.

Kielhofner, G 1982, 'Qualitative research: Part two Methodological approaches and relevance to occupational therapy', *Occupational Therapy Journal of Research,* vol. 2, no. 3, pp. 151-164.

Korten, AE, Jacomb, PA, Jiao, Z, Christensen, H, Jorm, AF, Henderson, AS & Rodgers, B 1998, 'Predictors of GP service use: A community survey of an elderly Australian sample.' *Australian and New Zealand Journal of Public Health,* vol. 22, no. 5, pp. 609-615.

Krause, N & Thompson, E 1998, 'Cognitive functioning, stress, and psychological well-being in later life.' *Journal of Mental Health and Aging,* vol. 4, no. 1, pp. 155-169.

Krefting, L 1991, 'Rigor in qualitative research: The assessment of trustworthiness.' *American Journal of Occupational Therapy,* vol. 45, no. 3, pp. 214-222.

Kvale, S 1996, *Interviews. An Introduction to qualitative research interviewing*, Sage Publications, Thousand Oaks, Ca.

LaLiberte Rudman, D, Cook, J & Polatajko, H 1997, 'Understanding the potential of occupation: A qualitative exploration of seniors' perspectives on activity.' *American Journal of Occupational Therapy,* vol. 51, no. 8, pp. 640-650.

Lapierre, S, Bouffard, L, Dube, M, Labelle, R & Bastin, E 2001, 'Aspirations and well-being in old age', in *Life goals and well-being. Towards a positive psychology of human striving*, eds. P Schmuck & KM Sheldon, Hogrefe & Huber, Seattle, pp. 102-115.

Larsen, R, Diener, E & Emmons, R 1985, 'An evaluation of subjective well-being measures.' *Social Indicators Research,* vol. 17, pp. 1-17.

Larson, EA 1996, 'The story of Maricela and Miguel: A narrative analysis of dimensions of adaptation', *American Journal of Occupational Therapy,* vol. 50, pp. 286-298.

Law, M, Baptiste, S, McColl, MA, Opzoomer, A, Polatajko, H & Pollock, N 1990, 'The Canadian Occupational Performance Measure: An outcome measure for occupational therapy.' *Canadian Journal of Occupational Therapy,* vol. 57, pp. 82-87.

Law, M, Cooper, B, Strong, S, Stewart, D, Rigby, P & Letts, L 1996, 'The person-environment-occupation model: A transactive approach to occupational performance.' *Canadian Journal of Occupational Therapy,* vol. 63, pp. 9-23.

Law, M, Polatajko, H, Baptiste, S & Townsend, E 1997, 'Core concepts of Occupational Therapy', in *Enabling occupation. An Occupational Therapy perspective*, ed. CAoO Therapists, Canadian Association of Occupational Therapists, Ottawa, Canada, pp. 29-56.

Law, M, Steinwender, S & Leclair, L 1998, 'Occupation, health and well-being', *Canadian Journal of Occupational Therapy,* vol. 65, no. 2, pp. 81-91.

Lawrence, AR & Schigelone, ARS 2002, 'Reciprocity beyond dyadic relationships.' *Research on Aging,* vol. 24, no. 6, pp. 684-704.

Lawton, MP 1982, 'Competence, environmental press, and the adaptation of older people', in *Aging and the environment. Theoretical approaches*, eds. MP Lawton, P Windley & T Byerts, Springer Publishing Company, New York, pp. 33-59.

Lawton, MP 1983, 'Environment and other determinants of well-being in older people.' *The Gerontologist,* vol. 23, pp. 349-357.

Lawton, MP, Moss, MS, Winter, L & Hoffman, C 2002, 'Motivation in later life: Personal projects and well-being', *Pscyhology and Aging,* vol. 17, pp. 539-547.

Letts, L 2003, 'Enabling citizen participation of older adults through social and political environments', in *Using environments to enable occupational performance*, eds. L Letts, P Rigby & D Stewart, Slack, Thorofare, NJ.

Liddle, J, March, L, Carfrae, B, Finnegan, T, Druce, J, Schwarz, J & Brooks, P 1996, 'Can occupational therapy intervention play a part in maintaining independence and quality of life in older people? A randomised controlled trial.' *Australian and New Zealand Journal of Public Health,* vol. 20, no. 6, pp. 574-578.

Lincoln, YS & Guba, E 1985, *Naturalistic inquiry*, Sage, Beverly Hills, CA.

Lo, J 1996, 'The relationship between daily occupational affective experiences and subjective well-being.' *Occupational Therapy International,* vol. 3, no. 3, pp. 190-203.

Ludwig, FM 1997, 'How routine facilitates wellbeing in older women', *Occupational Therapy International,* vol. 4, no. 3, pp. 213-228.

Lunt, A 1997, 'Occupational science and occupational therapy: Negotiating the boundary between a discipline and a profession.' *Journal of Occupational Science,* vol. 4, no. 4, pp. 56-61.

Lysack, CL & Seipke, HL 2002, 'Communicating the occupational self: A qualitative study of oldest-old American women.' *Scandinavian Journal of Occupational Therapy,* vol. 9, pp. 130-139.

Malcolm, M, Mann, W, Tomita, M, Fraas, L, Stanton, K & Gitlin, L 2001, 'Computer and internet use in physically frail elders', *Physical & Occupational Therapy in Geriatrics,* vol. 19, no. 3, pp. 15-32.

Martin, K 1998, *When a baby dies of SIDS*, International Institute of Qualitative Methodology, Edmonton, Canada.

Maslow, A 1954, *Motivation and personality*, Harper & Row, New York.

Mason, J 2002, *Qualitative researching*, 2nd edn, SAGE publications, London.

Matheson, L & Bohr, P 1997, 'Occupational competence across the life span', in *Occupational Therapy. Enabling function and well-being*, eds. C Christiansen & C Baum, SLACK Inc, Thorofare, NJ.

McCuaig, M & Frank, G 1991, 'The able self: Adaptive patterns and choices in independent living for a person with cerebal palsy.' *American Journal of Occupational Therapy,* vol. 45, pp. 224-234.

Meddin, JR 1998, 'Dimensions of spiritual meaning and well-being in the lives of ten older Australians.' *International Journal of Aging and Human Development,* vol. 47, no. 3, pp. 163-175.

Merriam-Webster 2002, *Merriam-Webster's collegiate dictionary*, Merriam-Webster, viewed 8th April 2002, <http://www.m-w.com/cgi-bin/dictionary>.

Meyer, A 1922, 'The philosophy of occupational therapy.' *Archives of Occupational Therapy,* vol. 1, pp. 1-10.

Miller, M & Lago, D 1990, 'The well-being of older women: The importance of pet and human relations.' *Anthrozoos,* vol. III, no. 4, pp. 245-252.

Mills, D & Brown, P 2004, *Art and Wellbeing*, Commonwealth of Australia, Sydney.

Minichiello, V, Aroni, R, Timewell, E & Alexander, L (eds) 1996, *In-depth interviewing. Principles, technques, analysis*, 2nd edn, Longman, Melbourne.

Mookherjee, H 1998, 'Perceptions of well-being among the older metropolitan and nonmetropolitan populations in the United States.' *Journal of Social Psychology,* vol. 138, no. 1, pp. 72-82.

Mookherjee, HN 1997, 'Perception of well-being among older persons in nonmetropolitan America', *Perceptual and Motor Skills,* vol. 85, pp. 943-946.

Morris, DC 1997, 'Health, finances, religious involvement, and life satisfaction of older adults.' *Journal of Religious Gerontology,* vol. 10, no. 2,

Morse, JM (ed.) 1991, *Qualitative nursing research. A contemporary diaglogue.*, 2nd edn, Sage Publications, Newbury Park, Ca.

Mounter, C & Ilott, I 2000, 'Occupational science: Updating the United Kingdome journey of discovery.' *Occupational Therapy International,* vol. 7, pp. 111-120.

Neary, S 1997, 'Room to maneuver: Preserving choice in resilient old age', Graduate School of Nursing, dissertation thesis, Boston College.

Nelson, DL & Jepson-Thomas, J 2003, 'Occupational form, occupational performance, and a conceptual framework or therapeutic occupation', in *Perspectives in human occupation. Participation in life*, eds. P Kramer, J Hinojosa & CB Royeen, Lippincott Williams & Wilkins, Philadelphia.

Neugarten, BL, Havighurst, RJ & Tobin, SS 1961, 'The measurement of life satisfaction.' *Journal of Gerontology,* vol. 16, pp. 134 - 143.

Nilsson, M, Ekman, S-L & Sarvimaki, A 1998, 'Ageing with joy or resigning to old age: Older people's experiences of the quality of life in old age', *Health Care in Later Life,* vol. 3, no. 2, pp. 94-110.

Ong, B & Jordan, K 1997, 'Health experiences of elderly people in an outer London area.' *Sociological Research Online,* vol. 2, no. 1, viewed 1 January 2003, http://www.socresonline.org.uk/socresonline/2/1/5.html.

Onyx, J & Warbuton, J 2003, 'Volunteering and health among older people: A review.' *Australasian Journal on Ageing,* vol. 22, no. 2, pp. 65-69.

Orem, DE 1995, *Nursing. Concepts of practice*, 5th edn, Mosby, St Louis.

Patton, MQ 1990, *Qualitative evaluation and research methods*, 2nd edn, Sage publications, Newbury Park, Ca.

Pearson Scott, J & Butler, MH 1997, 'Subjective well-being of rural adults 75 years of age or older: A longitudinal evaluation.' *Family and Consumer Sciences Research Journal,* vol. 25, no. 3, pp. 251-268.

Peters, A & Liefbroer, A 1997, 'Beyond marital status: Partner history and well-being in old age.' *Journal of Marriage and Family,* vol. 59, pp. 687-699.

Pierce, D 2000, 'Maternal management of the home as a developmental play space for infants and toddlers', *American Journal of Occupational Therapy,* vol. 54, no. 3, pp. 290-299.

Piskur, B, Kinebanian, A & Josephsson, S 2002, 'Occupation and well-being: A study of some Slovenian people's experiences of engagement in occupation in relation to well-being.' *Scandinavian Journal of Occupational Therapy,* vol. 9, pp. 63-70.

Pollock, N & McColl, MA 2003, 'How occupation changes', in *Theoretical basis of occupational therapy*, eds. MA McColl, M Law, D Stewart et al, Slack Incorporated, Thorofare, NJ, pp. 63-80.

Price-Lackey, P & Cashman, J 1996, 'Jenny's story: Reinventing oneself through occupation and narrative configuration', *American Journal of Occupational Therapy,* vol. 50, pp. 306-314.

Primeau, LA 1998, 'Orchestration of work and play within families.' *American Journal of Occupational Therapy,* vol. 52, no. 3, pp. 188-195.

Putnam, R, Leonardi, R & Nanetti, R 1993, *Making democracy work: Civic traditions in modern Italy*, Princeton University Press, Princeton, NJ.

Ranzijn, R & Luszcz, M 1999, 'Acceptance: A key to well-being in older adults?' *Australian Psychologist,* vol. 34, no. 2, pp. 94-98.

Reed, K 2005, 'Appendix B An annotated history of the concepts used in occupational therapy', in *Occupational therapy. Performance, participation, and well-being*, eds. C Christensen & C Baum, SLACK Inc, Thorofare, NJ.

Reed, KL & Sanderson, SN (eds) 1999, *Concepts of occupational therapy*, 4th edn, Lippincott, Williams & Wilkins, Philadelphia.

Richards, TJ & Richards, L 1998, 'Using computers in qualitative research', in *Collecting and interpreting qualitative materials*, eds. NK Denzin & YS Lincoln, Sage publications, Thousand Oaks, Ca, pp. 211-245.

Robert, SA 2002, 'Communty context and aging', *Research on Aging,* vol. 24, no. 6, pp. 579-599.

Roberts, K & Taylor, B 1998, *Nursing research processes: An Australian perspective*, Nelson, Melbourne.

Roos, NP & Havens, B 1991, 'Predictors of successful aging: A twelve-year study of Manitoba elderly.' *American Journal of Public Health,* vol. 81, no. 1, pp. 63-68.

Rose, L, Mallinson, RK & Walton-Moss, B 2002, 'A grounded theory of families responding to mental illness.' *Western Journal of Nursing Research,* vol. 24, no. 5, pp. 516-536.

Rovner, B & Casten, R 2002, 'Activity loss and depression in age-related macular degeneration.' *American Journal of Geriatric Psychiatry,* vol. 10, no. 3, pp. 305-310.

Rowe, JW & Kahn, RL 1998, *Successful aging*, Dell Publishing, New York.

Ruffing-Rahal, M 1998, 'Individuation and varieties of well-being experience among older women.' *Advanced Nursing Science,* vol. 20, no. 3, pp. 13-20.

Russell, C 1999, 'Interviewing vulnerable old people: Ethical and methodological implications of imagining our subjects.' *Journal of Aging Studies,* vol. 13, no. 4, pp. 403-417.

Russell, C, Fitzgerald, M, Williamson, P, Manor, D & Whybrow, S 2002, 'Independence as a practice issue in occupational therapy: The safety clause.' *American Journal of Occupational Therapy,* vol. 56, pp. 369-379.

Ryff, CD 1989, 'Happiness is everything, or is it? Explorations on the meaning of psychological well-being.' *Journal of Personality and Social Psychology,* vol. 57, no. 6, pp. 1069-1081.

Ryff, CD & Keyes, CLM 1995, 'The structure of psychological well-being revisited.' *Journal of Personality and Social Psychology,* vol. 69, no. 4, pp. 719-727.

Ryff, CD & Singer, B 1996, 'Psychological well-being: Meaning, measurement, and implications for psychotherapy research.' *Psychotherapy and Psychosomatics,* vol. 65, pp. 14-23.

Sable, P 1995, 'Pets, attachment, and well-being across the life cycle.' *Social Work,* vol. 40, no. 3, pp. 334-341.

Scherer, MJ & Frisina, DR 1998, 'Characteristics associated with marginal hearing loss and subjective well-being among a sample of older adults.' *Journal of rehabilitation research and development,* vol. 35, no. 4, pp. 420-426.

Schkade, J & Schultz, S 1992, 'Occupational adaptation: Toward a holistic approach for contemporary practice, Part 1.' *American Journal of Occupational Therapy,* vol. 46, no. 9, pp. 829-837.

Schultz, S & Schkade, J 1997, 'Adaptation', in *Occupational therapy. Enabling function and well-being*, 2nd edn, eds. C Christensen & C Baum, SLACK Inc, Thorofare, NJ, pp. 450-481.

Schulz, R, Wrosch, C & Heckhausen, J 2003, 'The life span theory of control: Issues and evidence', in *Personal control in social and life course contexts*, eds. SH Zarit, LI Pearlin & KW Schaie, Springer Publishing Company, New York.

Schwartz, KB 2003, 'The history of occupational therapy', in *Willard and Spackman's Occupational Therapy*, 10th edn, eds. E Blesedell Crepeau, E Cohn & B Boyt Schell, Lippincott, Williams & Wilkins, Philadelphia.

Seale, C 1999, *The quality of qualitative research.*, Sage Publications, London.

Searle, MS, Mahon, MJ, Iso-Ahola, SE, Adam Sdrolias, H & van Dyk, J 1995, 'Enhancing a sense of independence and psychological well-being among the elderly: A field experiment.' *Journal of Leisure Research,* vol. 27, no. 2, pp. 107- 124.

Searle, MS, Mahon, MJ, Iso-Ahola, SE, Adam Sdrolias, H & van Dyk, J 1998, 'Examining the long term effects of leisure educaton on a sense of independence and psychological well-being among the elderly.' *Journal of Leisure Research,* vol. 30, no. 3, pp. 331-340.

Segal, R 2000, 'Adaptive strategies of mothers with children with attention deficit hyperactivity disorder: Enfolding and unfolding occupations.' *American Journal of Occupational Therapy,* vol. 54, no. 3, pp. 300-306.

Shenk, D, Kuwahara, K & Zablotsky, D 2004, 'Older women's attachments to their home and possessions', *Journal of Aging Studies,* vol. 18, pp. 157-169.

Shmotkin, D, Blumstein, T & Modan, B 2003, 'Beyond keeping active: Concomitants of being a volunteer in old-old age.' *Psychology and Aging,* vol. 18, no. 3, pp. 602-607.

Silveira, E & Ebrahim, S 1998, 'Social determinants of psychiatric morbidity and well-being in immigrant elders and whites in East London.' *International Journal of Geriatric Psychiatry,* vol. 13, pp. 801-812.

Spencer, J, Davidson, H & White, V 1996, 'Continuity and change: Past experience as adaptive repertoire in occupational adaptation', *American Journal of Occupational Therapy,* vol. 50, no. 7, pp. 526-534.

Stanley, L & Wise, S 1990, 'Method, methodology and epistemology in feminist research processes', in *Feminist praxis. Research, theory and epistemology in feminist research,* ed. L Stanley, Routledge, London, pp. 20-60.

Stanley, M 1995, 'An investigation into the relationship between engagement in valued occupation and life satisfaction for elderly South Australians.' *Journal of Occupational Science: Australia,* vol. 2, no. 3, pp. 100-114.

Stanley, M & Cheek, J 2003a, 'Grounded theory: Exploiting the potential for occupational therapy.' *British Journal of Occupational Therapy,* vol. 66, no. 4, pp. 143-150.

Stanley, M & Cheek, J 2003b, 'Well-being and older people: A review of the literature.' *Canadian Journal of Occupational Therapy,* vol. 70, no. 1, pp. 51-59.

Stapleton, T & Mulholland, L 2004, 'Assessment of a fatigue management programme for people with multiple sclerosis', *International Journal of Therapy and Rehabilitation,* vol. 11, no. 12, pp. 547-553.

Stephenson, S & Wiles, R 2000, 'Advantages and disadvantages of the home setting for therapy: Views of patients and therapists.' *British Journal of Occupational Therapy,* vol. 63, no. 2, pp. 59-64.

Stern, PN 1980, 'Grounded theory methodology: Its uses and processes.' *IMAGE: Journal of Nursing Scholarship,* vol. 12, pp. 20-23.

Steultjens, EM, Dekker, J, Bouter, LM, Jellema, S, Bakker, EA & van den Ende, CH 2004, 'Occupational therapy for community dwelling elderly people: A systematic review', *Age and Ageing,* vol. 33, pp. 453-460.

Strauss, A & Corbin, J 1990, *Basics of qualitative research,* Sage Publications Inc, Newbury Park, Ca.

Strong, J, Unruh, A, Wright, A & Blaxter, G 2002, *Pain: A textbook for therapists,* Churchill Livingstone, New York.

Suto, M 2001, 'Issues related to data collection', in *Using qualitative research. A practical introduction for occupational and physical therapists,* eds. KW Hammell, C Carpenter & I Dyck, Churchill Livingstone, Edinburgh, pp. 35-46.

Sweeney, G, Webley, P & Treacher, A 2001, 'Supervision in occupational therapy, Part 1: the supervisor's anxieties.' *British Journal of Occupational Therapy,* vol. 64, no. 7, pp. 337-345.

Takahashi, K, Tamura, J & Tokoro, M 1997, 'Patterns of social relationships and psychological well-being among the elderly.' *International Journal of Behavioral Development,* vol. 21, no. 3, pp. 417-430.

Tamm, M 1999, 'Relatives as a help or hindrance - A grounded theory study seen from the perspective of the occupational therapist', *Scandinavian Journal of Occupational Therapy,* vol. 6, pp. 36-45.

Tamm, M & Skar, L 2000, 'How I play: Roles and relations in the play situations of children with restricted mobility.' *Scandinavian Journal of Occupational Therapy,* vol. 7, pp. 174-182.

Tetley 2004, *Health and wellbeing*, Tetley, viewed 17th September 2004, <http://www.tetley.com.au>

Thompson, M 1996, 'Computer technology: how it impacts on the lives of older adults', *Aging International,* vol. 23, no. 1, pp. 85-91.

Thorne, S, Griffin, C & Adlersberg, M 1986, 'How's your health? Well seniors' perceptions of their health and well-being.' *Gerontion. A Canadian review of geriatric care,* vol. 1, no. 5, pp. 15-18.

Turner, A, Foster, M & Johnson, S (eds) 1996, *Occupational therapy and physical dysfunction: Principles, skills and practice*, 4th edn, Churchill Livingstone, New York.

United Nations, DfSPaD 2000, *United Nations Principles for Older Persons*, updated 14th March, 2000, United Nations, viewed 18th December 2000, <http://www.un.org/esa/socdev/iyop/iyoppop.html>.

Van Willigen, M 2000, 'Differential benefits of volunteering across the life course.' *Journal of Gerontology: Social Sciences,* vol. 55B, pp. S308-S318.

Webster, JD 1997, 'Attachment style and well-being in elderly adults: A preliminary investigation.' *Canadian Journal on Aging,* vol. 16, no. 1, pp. 101-111.

Wilcock, A & Whiteford, G 2003, 'Occupation, health promotion, and the environment', in *Using environments to enable occupational performance*, eds. L Letts, P Rigby & D Stewart, Slack, Thorofare, NJ, pp. 55-70.

Wilcock, AA 1998a, *An occupational perspective on health*, SLACK Inc, Thorofare, NJ.

Wilcock, AA 1998b, 'Reflections on doing, being and becoming.' *Canadian Journal of Occupational Therapy,* vol. 65, no. 5, pp. 248-256.

Wilcock, AA, van der Arend, H, Darling, K, Scholz, J, Siddall, R, Snigg, C & Stephens, J 1998, 'An exploratory study of people's perceptions and experiences of wellbeing', *British Journal of Occupational Therapy,* vol. 61, no. 2, pp. 75- 82.

Wilson, HS & Hutchinson, SA 1996, 'Methodologic mistakes in grounded theory.' *Nursing Research,* vol. 45, no. 2, pp. 122-124.

Wilson, S & Morse, JM 1991, 'Living with a wife undergoing chemotherapy.' *IMAGE: Journal of Nursing Scholarship,* vol. 23, no. 2, pp. 78-84.

Wood, V, Wylie, M & Sheafor, B 1969, 'An analysis of a short self-repot measure of life satisfaction: Correlation with rater judgements.' *Journal of Gerontology,* vol. 24, pp. 465-469.

Woolhead, G, Calnan, M, Dieppe, P & Tadd, W 2004, 'Dignity in old age: What do older people in the United Kingdom think?' *Age and Ageing,* vol. 33, pp. 165-170.

World Federation Occupational Therapists 2004, *WFOT definition of occupational therappy*, World Federation of Occupational Therapists, viewed 20th August 2004, <http://wfot.org>.

World Health Organisation 1998, *Ageing and health*, World Health Organisation, viewed 14th November 2000, <http://www.who.int/ageing/htm>.

World Health Organisation 1999, *Definition of health*, World Health Organisation, viewed 30th January 2001, <http://www.who.int/wha-1998/WHA99/PDF99en24.pdf>.

World Health Organisation, HaWC, & Canadian Public Health Association 1986, *Ottawa Charter for Health Promotion*, World Health Organisation, viewed 14th November 2000, <http://www.who.int/hpr/docs/ottawa.htm>.

Appendix A: Recruitment letter

University of South Australia

Educating Professionals • Creating and Applying Knowledge • Serving the Community

January, 2003

Dear

I am writing to you to invite you to participate in a research study that I am conducting. I am interested in talking to people over the age of seventy-five about their lives as older people living in the community and their ideas about well-being. The study will enable me to complete a Doctorate of Philosophy at the University Of South Australia.

I have enclosed an information sheet about the study for you to read. I will telephone you a few days after you have received this letter to see if you wish to participate in the study. We can then make a mutually suitable time for an interview.

Yours sincerely,

Mandy Stanley

North Terrace
Adelaide
South Australia 5000

Appendix B: Information sheet

University of South Australia

Educating Professionals • Creating and Applying Knowledge • Serving the Community

Older people's perceptions and understandings of well-being

Mandy Stanley BappSc, MHlthSc(OT)
Ph. 8302 2705

This study aims to gain an understanding of well-being from the older person's perspective, a perspective which is missing from the current literature, particularly Australian. As Australia has an aging population it is imperative that we gain more knowledge about well-being so that older people will not just live longer, but also live well. The information collected will enable health care providers to provide a higher quality service to older people and social planners to provide services that are more targeted to the needs of older people.

If you are over the age of 75 and live in the community in metropolitan Adelaide you are invited to be a participant in this study. For the purposes of this study living in the community means not living in a high or low care facility or in a rest home, so you may be living by yourself or with family and/or friends, with varying levels of support from private and government agencies.

Participation in the study will involve you in one or two interviews of approximately one hour each at a time and place that suits you. In the interview you will be asked to talk about how you spend your time and the things that benefit or hinder you from experiencing well-being. The interviews will be audiotaped and then typed up word for word. You will have the opportunity to choose a pseudonym to protect your anonymity. Once you have viewed the transcript and certified that it is an accurate record of the interview the audiotapes will be destroyed. On completion of the study the transcripts will be kept in a locked cupboard in the Centre for Research into Nursing and Health Care for seven years. All personal information collected will be confidential and the results will be reported in such a way as to not identify individuals.

North Terrace
Adelaide
South Australia 5000

You will be free to withdraw from the study at any time. It is not anticipated that you will be exposed to any risk by participation in this study, nor will you benefit directly from participation in the study. You may also be asked to recommend someone you know who may have some valuable information to contribute to the study, but you are free to choose whether to do so.

If you have any questions about the study please contact me on 8302 2705, or if you have any specific concerns you can contact my supervisor Prof Julianne Cheek on 8302 2675 or the Executive officer of the Human Research Ethics committee, Vicki Allen on 8302 3921.

Appendix C: Ethical approval

UNIVERSITY OF SOUTH AUSTRALIA

RESEARCH SERVICES
...helping research happen...
Telephone: (08) 8302 3956
Facsimile: (08) 8302 3997

The Levels Campus
Mawson Lakes Boulevard
Mawson Lakes
South Australia 5095

30 March 2000

Ms Mandy Stanley
C/- School of Occupational Therapy
City East Campus

Dear Mandy

Human Research Ethics Committee met on 27 March 2000 and considered your protocol (P039/00) **Older people's perceptions and understandings of well-being**. I am pleased to be able to tell you that your protocol was approved.

In considering your protocol HREC provided the following suggestions for your consideration:

- In order to avoid a completely homogenous group HREC suggests that you attempt to get people who more broadly represent the population from which a sample is taken.
- HREC expressed concern about the font size of recruitment material, information sheet and consent form. As participants will be over the age of 75, it is suggested that the material be provided in large print.

Human Research Ethics Approval is always made on the basis of a number of conditions. It is important that you are familiar with, and abide by, these conditions.

- **Any serious or unexpected adverse effects on research participants must be reported immediately to the Ethics Officer.**

- **Any unforseen events which might affect the continued ethical acceptability of the research project must be reported immediately to the Ethics Officer.**

- **The Ethics Committee must be notified of, and approve, any changes to the original protocol.**

- **The Ethics Committee must be notified of any changes in membership of the research team.**

- **In Australia there is a legal obligation for raw data arising from human research to be held securely**. The University requires that research data be retained for a period of seven years. If your data are not stored by your school, the school must be aware of their location.

- **Information for participants should include the name of the chair of the Human Research Ethics Committee** as a person who is able to discuss any concerns about the research. These details should read Ms Linley Hartmann, telephone (08) 8302 0327, fax (08) 8302 0512.

- **Approval is for a period of twelve months only.**
  Masters by Research and PhD students will be granted extensions, if necessary, through the annual review of progress process. Other researchers should make annual requests

The Levels Campus
Mawson Lakes Boulevard
Mawson Lakes
South Australia 5095

for extension using the Application for Extension form available at http://www.unisa.edu.au/orc/WebDocuments/Linkpages/ethics.htm

- **A project completion report** must be made to the Human Research Ethics Committee or Divisional Ethics Committee (whichever granted the original approval) within three months of the project's completion. The Project Completion form is available at http://www.unisa.edu.au/orc/WebDocuments/Linkpages/ethics.htm

I hope that your research goes well.

Yours sincerely

Eimear Muir-Cochrane
Acting Chair, Human Research Ethics Committee

Cc Julianne Cheek

Appendix D: Consent form

CONSENT FORM

Project Title **Well-being and older people**

Researcher's name **Mandy Stanley**

Supervisor's name **Prof Julianne Cheek**
(if the researcher is a student)

- I have received information about this research project.
- I understand the purpose of the research project and my involvement in it.
- I understand that I may withdraw from the research project at any stage.
- I understand that while information gained during the study may be published, I will not be identified and my personal results will remain confidential.
- I understand that I will be audiotaped during the interview
- I understand that I may not benefit directly from the study.

Name of participant .....

Signed ..... **Date** .....

I have provided information about the research to the research participant and believe that he/she understands what is involved.

Researcher's signature and date .....

North Terrace
Adelaide
South Australia 5000

Appendix E: Published journal articles

Well-being and older people: A review of the literature

Mandy Stanley ▪ Julianne Cheek

Key words

- Well-being
- Aged
- Literature review

Abstract

Background. *Most countries in the world are experiencing an expansion in their population of older people. As people now expect to live longer, they also seek continuing health and well-being throughout their extended old age. Occupational therapists are involved in working towards the attainment of well-being with their older clients. However, their understandings of what well-being for older people entails seems varied, as this examination of the occupational therapy and related gerontological literature reveals.* ***Results.*** *Three key points emerge from the literature review: first, the definition of well-being is usually assumed, or is lacking in clarity, and a range of similar terms, such as happiness and life satisfaction, are used interchangeably; second, well-being has been measured in research using various scales, which may not capture the complexity of the concept; and third, the perspective of the older person is often missing in discussions of well-being.* ***Clinical Implications.*** *It is suggested that one way of moving occupational therapists' understanding of well-being forward is to conduct research into what older people themselves understand or perceive well-being to be.*

Résumé

Description générale. *Dans la plupart des pays du monde entier, on observe une croissance de la population âgée. Comme leur espérance de vie est plus longue, les personnes âgées cherchent à conserver leur santé et leur bien-être tout au long du troisième âge et du quatrième âge. Les ergothérapeutes participent à la recherche et à l'atteinte du bien-être de leurs clients âgés. Cependant, la perception de ce que le bien-être signifie pour la personne âgée varie grandement d'un ergothérapeute à l'autre, comme l'indique le recensement des écrits en ergothérapie et en gérontologie.* ***Résultats.*** *Trois points clés émergent de la littérature : premièrement, la définition du bien-être est habituellement présumée ou elle n'est pas claire et une gamme de termes semblables tels que bonheur et satisfaction envers la vie sont utilisés de manière interchangeable; deuxièmement, dans le domaine de la recherche, le bien-être a été mesuré à l'aide de diverses échelles qui ne saisissent pas nécessairement toute la complexité du concept; troisièmement, la perspective de la personne âgée est souvent absente dans les discussions sur le bien-être.* ***Conséquences cliniques.*** *Les résultats de cette étude suggèrent que l'un des moyens de faire progresser les connaissances des ergothérapeutes sur le bien-être est de mener des recherches sur les façons dont les personnes âgées comprennent et perçoivent le bien-être.*

Mandy Stanley, BAppSc, MHlthSc(OT) is a lecturer at the School of Occupational Therapy, University of South Australia, North TCE, Adelaide, 5000. E-mail: mandy.stanley@unisa.edu.au

Julianne **Cheek, PhD** is the Dean of Graduate Studies, Head of Centre for Research into Nursing and Health Care, University of South Australia.

The world's population is ageing. With the population growing at an annual rate of 1.7%, the population over age 65 is increasing by 2.5% per year (World Health Organisation (WHO), 1998). While some countries with the oldest populations are in Europe, rapid changes are also being seen in some developing countries. The numbers and proportion of the very old is also increasing, with the fastest growing population group in most countries being those who are 80 years and older (World Health Organisation, 1998). With respect to Canada, the proportion of Canada's population over the age of 65 is projected to increase from 12.5% in 2000 to approximately 21% by 2026 (Statistics Canada, 2000). Five and a half percent of the Canadian population is currently 75 years and older (Statistics Canada, 2001b). The prevalence of disability and chronic health problems increase with age. Approximately one in four Canadians over the age of 65 report a health problem that limits activity, which increases to one in three people over the age of 75 (Statistics Canada, 2001a).

As people are living longer, levels of morbidity are rising. This has resulted in growing numbers of consumers of medical and health services. Because of the increase in occupational needs of an ageing population it is likely that occupational therapists all over the world will continue to have more contact with older people than ever before. The need is compounded by government policies that aim to keep older people living in the community, and the disappearance of traditional inter-generational relationships. If the occupational needs of the older person are not met, there is potentially a great social and economic cost to both the person and the community.

Occupational therapy with older people is not only about enabling them to meet their occupational needs, but also to experience optimal health and well-being. Indeed, well-being is often stated to be an outcome of occupational performance. Therefore, it is important that therapists explore what is understood by well-being to ensure clinical practice is founded on clear evidence-based principles. However, before doing so we pause to consider why we believe this is of relevance to the practicing occupational therapist.

The philosophy of the profession of occupational therapy was built on the ideas of people such as Meyer, who observed that engagement in occupations was a powerful force in maintaining well-being (Meyer, 1922). Occupational therapists working with older people focus on what older people can do, whether they can do what they need to do, and whether their lives are meaningful and satisfying (Bonder, 1997). This focus on doing is based on the assumptions that:

- occupations with meaning to the person contribute to well-being; and
- a positive sense of self-efficacy is essential, to enable engagement in new challenges and the experience of mastery that contributes to well-being (Baum & Christensen, 1997).

In a broader context, the United Nations' General Assembly endorsed a set of Principles for Older Persons (United Nations, 2000) in the hope that governments will be encouraged to incorporate them into their national programs wherever possible. The principles emphasise the rights of older people:

- to maintain independence and autonomy;
- to be integrated in society for all ages and actively participate in policies that directly affect their well-being;
- to protect human rights and dignity for all;
- to pursue opportunities for the full development of potential; and
- to maintain the highest level of physical, mental and emotional well-being.

There is also great resonance between the United Nation's principles and the philosophy of the occupational therapy profession. Of particular note here is the prominence that well-being receives. It is interesting that these principles were put forward by the United Nations as part of an International Plan of Action in 1982 and yet are just as relevant today, nearly 20 years later. In the introduction to their recent text, Bevan and Jeeawody (1998) state that "It is essential that professional providers of care to elderly people and political decision makers, as well as society in general, understand clearly the relationship between ageing, health and well-being" (p. XXI). This particularly applies to occupational therapists, as a key goal of occupational therapy with older clients is to enable them to experience optimal health and well-being.

Well-being is thus an important concept in the philosophy underpinning occupational therapy, and subsequently the clinical practice on which it is built. Given this, it is important for occupational therapists to consider what understandings of well-being are in play in the way they construct their practice and explore whether there is congruence between understandings of well-being held by health practitioners such as occupational therapists and the clients with whom they deal. If the concept of well-being is not well understood, or if there is incongruence between what is understood as well-being on the part of the occupational therapist with the understandings of the client, then it may be an elusive goal of clinical practice. Occupational therapists need to be clear about what well-being is before they can effectively enable their clients to work towards it. Further, given the population's increasing proportion of older people in many countries, it is even more imperative to understand what well-being is for older people.

The aim of this paper is to describe the results of a search of the occupational therapy and gerontological literature to explore and/or answer the following questions:

What is well-being, how is it conceptualised, and does the conceptualisation include the perspective of the older person?

Defining well-being

According to the *Merriam-Webster's Collegiate Dictionary* (Merriam-Webster, 2002), well-being is "the state of being happy, healthy, or prosperous"(p. 1971). *In The Original Roget's Thesaurus* (Roget, 1987), well-being is associated with words like happiness and euphoria. Another logical port of call when looking at how well-being is defined and understood in occupational therapy practice is the texts conveying and teaching about that practice. Surprisingly, few precise definitions of well-being can be found in occupational therapy texts. Christiansen and Baum (1997) in their glossary define well-being as "a subjective sense of overall contentment, thought to be defined by affective state and life satisfaction" (p. 606). Reed and Sanderson (1999) include well-being as a central concept for occupational therapy, and they state that well-being is "feeling good"(p. 72). However, there is no further expansion of the concept in their text.

In her text explicating the relationship between engagement in occupation and health, Wilcock (1998) states that the feeling of well-being "is as intangible and amorphous a concept as charm and style"(p. 98). It seems somewhat incongruous that a leading occupational therapy theorist finds it difficult to define well-being. Given the centrality of the concept to occupational therapy, this alone strongly points to the need for more research. Wilcock suggests however that there are three aspects of well-being, in alignment with the World Health Organisation's definition of health (WHO, 2001), which are, physical, mental and social well-being. The occupational theory of human nature described by Wilcock proposes that people need to make use of their physical capacities in order to enjoy physical well-being, and that this can be through engagement in individually motivating and ongoing occupations. To achieve mental well-being, individuals need to experience a range of occupations that will enable each person to be creative, with a balance of occupations that provide intellectual challenges, spiritual experiences, emotional highs and lows, and relaxation. Social well-being results when the range of each individual's occupations and roles enables maintenance and development of satisfying personal social relationships. Within her theory, physical, mental and social well-being cannot be easily separated, as they are part of an integrated system. Wilcock cites some empirical evidence to support her theory; however, some of the evidence cited comes from studies on happiness or life satisfaction, and one could argue that these concepts cannot be directly equated with well-being, as is discussed later in this paper.

Well-being literature review

Search process

From occupational therapy texts the search moved to the occupational therapy and gerontological literature. Using the key words wellbeing or well-being, in the English language, the following bibliographic databases were searched: Sociological Abstracts, Medline, CINAHL, Ageline, Psychlit, Current Contents, Expanded Academic ASAP and AMED. In the larger databases, this resulted in many thousands of citations, so the search was then further limited to the years since 1990, with the inclusion of the key word, elderly. Despite the limitations on the search some databases still returned approximately 2,000 records. The search did not include well-being from a macro-economic perspective, or caregiver well-being as that was considered beyond the bounds of this exploration. The focus of this search was on well-being for individuals, which is usually how the concept is used in occupational therapy (Reed & Sanderson, 1999). As is evident it was not feasible to obtain every journal article, but as many as possible were obtained and read. For those not able to be accessed the abstract was used. Some articles published before 1990 were included as they appeared to be seminal articles. On reviewing the literature obtained it became evident that, first, the definition of well-being is usually assumed, or is lacking in clarity, and a range of similar terms, such as happiness and life satisfaction, are used interchangeably. Second, well-being has often been measured in research using various scales, which may not capture the complexity of the concept. Finally, the perspective of the older person is often missing in discussions of well-being. Each of these points will be further explored in the discussion to follow.

Occupational therapy literature

In the occupational therapy literature, an Australian study, one of the few examples of an attempt to ask people for their definition of well-being, (Wilcock et al., 1998) surveyed 7 groups of people (N=138) asking them how they would describe well-being. This convenience sample consisted of high school students, residents of a retirement village, members of family units, residents of a suburban neighbourhood, shoppers in a city shopping mall, churchgoers, and 4th year occupational therapy students. The four most common responses described well-being as having a sound mind, having a physically good body, being happy, and feeling good about oneself. Half of the sample said that they experienced a feeling they would describe as well-being frequently. The subjects associated feelings of well-being with environments or situations, with 56% associating well-being with relationships and 37% with surroundings. The majority of the sample were women who were fit, single

and young, and the authors recommended that the study be replicated with a more representative sample of the general population.

Law, Steinwender and Leclair (1998) conducted a review of 22 studies that examined the relationship between occupation and health, and well-being. The authors state that well-being refers to the integration of a person's physical, mental, emotional, spiritual and social characteristics, which has some resonance with Wilcock (1998), in that it acknowledges the combination of physical, mental and social elements. The authors drew on the nursing literature and used Orem's (1995) definition of well-being as: "a perceived state of harmony in all aspects of one's life. It is a state characterised by experiences of contentment, pleasure, by spiritual experiences, and a sense of happiness" (p. 83). However, the operationalisation of the concept in the review was unclear; for instance, the authors appear to include the term life satisfaction in reference to the same construct as well-being. They conclude that there is moderate to strong evidence that occupation has an important influence on health and well-being.

Ageing successfully

Another term that is used interchangeably with well-being, one that emerged in the gerontological literature of the late 1990's, is successful ageing. In writing about successful ageing, Bevan and Jeeawody (1998) suggest that "the notion of wellbeing rests on a fulcrum which creates a balance for individuals to enjoy life to the full, irrespective of the conditions which affect them or the situation in which they find themselves" (p.xxv), and that successful ageing implies an optimum level of well-being. In a 12-year longitudinal study, Roos and Havens (1991) defined successful ageing in terms of positive self perception of health, independence in self care and mobility, competent cognitive function, and minimal receipt of home services.

Jorm et al. (1998) commented that a major problem in researching successful ageing was that the concept could be operationalised in different ways. Some researchers have defined successful ageing purely in physical terms, while others have included both physical and cognitive dimensions, and still others have only included psychological dimensions. Rowe and Kahn (1998) in reporting the MacArthur Foundation Study of Ageing defined successful ageing as "growing old with health and vitality" (p. 23), in contrast to usual ageing which is older people who are functioning well but who have a heightened risk for age-associated disease or disability. They suggested that there are three characteristics of successful ageing: low risk of disease and disease-related disability; high mental and physical function; and active engagement in later life.

Differentiating between concepts such as well-being and successful ageing is difficult; however, it appears that successful ageing implies an external evaluation on certain criteria, whereas well-being is a state experienced by the individual. The distinction is subtle, and there is currently not enough information to distinguish the terms further. Feldman, Kamler, and Snyder (1996) warn against the creation of impossible stereotypes of what they call super-ageing, and conversely, the use of the term successful can be viewed as value laden and implies that some older people are ageing poorly or unsuccessfully.

It is evident, from the literature reviewed thus far, that agreement is lacking in the literature on what well-being is; and at times there is a lack of clarity about how the term is being used, particularly with respect to its seeming interchangeability with other terms. It is also frequently assumed that the reader will share the same definition as the author. This lack of clarity on what well-being is gives cause for concern, as it leads to a lack of clarity in measurement. If the term is not well defined, how will occupational therapists know when their clients achieve a sense of well-being?

Social science, medical and allied health literature

As in the occupational therapy literature, the majority of the studies reviewed in the social sciences, medical and allied health literature do not specifically define well-being, other than to explain how it is operationalised in the study. "Prior to the early 1980's, life satisfaction, morale, and happiness were concepts used in the research literature to reflect a subjective approach to the study of psychological well-being in the elderly" (Bowsher & Gerlach, 1990, p. 93). The topic appears to have gained popularity, and there are now numerous studies of subjective or psychological well-being. Lawton (1983) suggests that psychological well-being is made up of four domains: perceived congruence between desired and attained goals, sometimes referred to as life satisfaction; positive affect; negative affect; and happiness. The domains offered reflect how, in the literature, the words well-being, life satisfaction and happiness are often used interchangeably, which again leads to a lack of clarity of the concepts.

Well-being is usually measured using one or more quantitative scales, either as a single item global measure, or as multiple item scales. All of the single item scales ask participants to respond to a single global question about how happy they are, or to rate how satisfied they are with their life, on a certain scale. Single item scales have obvious appeal because of their brevity and ease of administration; however, there are also disadvantages. Scores tend to be skewed, with most answers falling in the happy categories (Andrews & Withey, 1976). Single items cannot cover all

aspects of subjective well-being; however, Diener (1984) suggests, "they are adequate if a very brief measure of global well-being is required"(p. 544). This means that researchers often turn to multiple item scales in an attempt to overcome the drawbacks of the single item measure.

Of the multiple item scales, there are some that measure well-being, while others measure happiness, morale or the balance between positive and negative affect. It is not the intention of this paper to provide a critique of the psychometric and other qualities of the scales of well-being; that is provided elsewhere (for example, see Larsen, Diener, & Emmons, 1985). However, it is evident that there is little agreement about what subjective well-being is, apart from it seeming to be conceptualised as having two main dimensions, that is, (a) a cognitive judgement of one's quality of life (life satisfaction), and (b) the affective experience (happiness) (Andrews & McKennell, 1980; Chamberlain, 1988). Scales of happiness or affect balance are often used in combination with scales of life satisfaction. For example, Christiansen, Backman, Little, and Nguyen (1999) used personal project methodology to explore the relationship between occupation and subjective well-being, by summing the scores of the Affect Balance Scale and the Life Satisfaction Index (Form A) to obtain a single score of well-being. Other examples of combining an affective measure with a measure of life satisfaction can be found in Bowsher and Gerlach (1990), Friedman (1997), and Heidrich and D'Amico (1993).

A surprising finding was the number of studies that included a measure of depression as a measure of well-being, where psychological well-being appears to be measured as it relates to the reported absence of pathology (Bennett, 1997; Graham & Schmidt, 1999; Miller & Lago, 1990; Silveira & Ebrahim, 1998; Takahashi, Tamura, & Tokoro, 1997). Presumably, it is assumed that, in the absence of depression, the individual must be experiencing well-being. That seems to be a somewhat limited and unsatisfactory way of conceptualising well-being for older people.

A large number of studies use various life satisfaction scales to measure well-being (see, for example, Bennett, 1997; Bisconti & Bergeman, 1999; Ducharme & Rowat, 1992; Searle, Mahon, Iso-Ahola, Adam Sdrolias, & van Dyk, 1995). Euler (1992) states that the use of life satisfaction scales exceeds the use of deeper psychological measures, such as depression by a ratio of roughly 4 to 1. The most commonly used scales are the Life Satisfaction Index, Form A (Neugarten, Havighurst, & Tobin, 1961) and Form Z (Wood, Wylie, & Sheafor, 1969), and the Satisfaction with Life Scale (Diener, Emmons, Larsen, & Griffen, 1985). Factor analysis of life satisfaction scales indicates that the measures all seem to be tapping a shared 'satisfaction' construct, which seems to be a somewhat shallow approach to well-being for older people.

Lo (1996) studied the relationship between daily occupational affective experiences and subjective well-being, with a sample of 60 students of occupational therapy and physiotherapy. The students recorded their daily occupational activities in a time diary, and completed two measures of happiness and two of life satisfaction. The results of the study partially supported the hypothesis that the levels of subjective well-being were related to daily occupational experiences, though only the scales that measured the affective component of well-being gave significant correlations. Generalisation from the findings of this study is limited, given the homogeneity of the sample in terms of age, education and socio-economic status. Similar studies of older people have not been found, apart from that reported by Stanley (1995) which attempted to correlate time spent in daily activities with a life satisfaction measure rather than a measure of well-being. She did not find any significant relationship between time spent in valued occupations and life satisfaction, and concluded that qualitative methods would be more useful for accessing information on how older people feel about what they do, and how that contributes to concepts such as life satisfaction or well-being.

The single and multiple item scales included in the tables are the most frequently used for the measurement of well-being, according to the literature reviewed. Simply because of their frequent use, they have become acceptable and recognised ways of measuring well-being, and researchers are likely to continue using them in the future. However, there are disadvantages in using a scale to measure a concept like well-being. One has to question whether the scales have content validity, that is, are they measuring what they purport to measure? The response bias has already been noted for single item scales, and may also be present in the multiple item scale. In many studies, the assumption is made that, if a person's life satisfaction scores and affect scores are both measured, then the researcher will obtain a measure for their well-being. Is this really the case?

Reconceptualising well-being

Concern about the quality of existing scales of well-being led Ryff (1989) to publish a critique of the indices of well-being, concluding that the most popular and most commonly used scales were lacking in theoretical grounding. Having examined the literature, on what Ryff prefers to call positive functioning, she proposed that the concept of well-being was made up of the following aspects:

- self-acceptance representing a positive evaluation of oneself and one's past life;
- positive relations with others;
- a sense of self determination or autonomy;
- environmental mastery being the capacity to manage

one's life and surroundings;
- having meaning and purpose in one's life; and
- a sense of continuing development as a person or personal growth.

She went on to define each of these aspects, operationalise them, and conduct a study comparing the new measures with six previous measures of well-being. Results revealed that four of the measures, positive relations with others, autonomy, purpose in life, and personal growth were not strongly correlated to previous measures of well-being. The results partially supported her claim that key aspects of well-being had not been presently represented in the empirical arena. Ryff suggests that too much emphasis has been given to short-term affective well-being, and not enough attention paid to the ongoing life challenges of sense of purpose, having satisfying relationships with others, and achieving self actualisation – all of which she considers central to psychological well-being. There is some growing interest in the use of Ryff's scales (see Heidrich, 1998 and Heidrich, 1993).

Ryff and Keyes (1995) tested the scales on a nationally representative sample and compared the scores with 3 prominent indicators from prior research, that is, happiness, life satisfaction and depression. There were moderate to strong associations between self-acceptance and environmental mastery with the single and multiple item scales of happiness, life satisfaction and depression. However, the remaining 4 scales showed mixed or weak relationships with the prior indicators. The authors suggested that continued use of the usual indicators results in neglecting key aspects of well-being, and concluded that there is more to well-being than feeling happy and satisfied in life. Subsequently, a national Canadian study has been conducted with a modified version of Ryff's scale, reducing the number of items from 120 to 18, being 3 items for each of the six dimensions of well-being (Clarke, Marshall, Ryff, & Rosenthal, 2000). The reduction in the number of items should make the scales more user friendly.

From the literature, it becomes evident that well-being is perceived and measured as being either physical or psychological. While separate scales of physical and psychological well-being have their place, occupational therapy practice would want to consider well-being for older persons from a more holistic perspective, not divided and reduced to physical and psychological states. Ryff and Singer (1996) proposed that the more richly detailed life histories of individuals would provide a greater explanation of well-being than summary measures of socio-demographic factors. Qualitative forms of inquiry are more likely to reveal a more holistic approach to the construct of well-being, one that is potentially more consistent with the philosophy of the profession and which may inform more holistic practice.

The missing older person's perspective

In returning to one of the original questions that prompted this paper, it can be seen that thus far, the perspective of the older person is conspicuously absent. One of the possibilities offered by qualitative studies is that they give the opportunity for the views of older people themselves, and/or others associated with them, to be present. On reviewing the literature, only four qualitative studies of well-being in older people were found - three in the occupational therapy literature and one in the nursing literature.

Ludwig (1997) reports on how routine facilitated well-being for a sample of seven women over the age of 70 in the United States. The study aimed to gain information about the conditions and processes that enhance occupational meaning. Ludwig proposes that, if occupational therapists can better understand how a client makes meaning of his or her life through engagement in occupations, then they can treat the client more effectively. This grounded theory study has enabled the development of a theoretical model to describe the primary conditions and processes through which routines may be used to maximise well-being. Enhanced understandings of well-being, such as that proposed by Ludwig, thus have the potential to provide the basis for subsequent occupational therapy practice. Routines were linked with nine adaptive outcomes for the participants: meet obligations; maintain activity level; maintain health; anticipate or look forward to things; maintain control; balance work, rest and play; accomplish and achieve; feel good about self; and provide continuity. The outcomes constituted well-being for the study participants. This study was limited to women, because of documented differences in time use by different gender groups, highlighting the need for a study of well-being that includes both genders. However, the results of this study offer useful information to occupational therapists and others about the use of routine by older women; and help to confirm some assumptions that underlie occupational therapy philosophy, and hence practice, about the relationship between engagement in occupations and positive health outcomes. Unfortunately Ludwig, while providing valuable information around the area of well-being, did not precisely define the use of the concept of well-being in her study.

Clark et al. (1996) interviewed 29 residents of an apartment complex for well, older adults with low incomes, to document their perceived life domains of importance and associated strategies of adaptation. The data from the interviews was analysed by the interviewers who developed typologies of life domains and major classes of adaptive strategies. The investigators then further developed the typologies. One of the ten life domains was psychological

well-being and happiness, which concerned living a satisfying and happy life. The adaptive strategies identified were "1. keeping active by engaging in worthwhile activities; 2. using formal professional services to remain happy or well; 3. maintaining a proper, positive state of mind; 4. treating other persons properly"(p. 107). The authors suggest that the adaptive strategies "constitute a collection of helpful hints" (p. 105) available to both older people and occupational therapists who are working with older people. This study needs replication in other settings and contexts.

In another occupational therapy study, Hasselkus (1997) explored the well-being of day care clients with dementia, from the staff's perspective. Hasselkus interviewed day care staff and asked them to describe especially satisfying and dissatisfying experiences of care. The narratives were analysed phenomenologically to gain an understanding of occupation as it was lived by the staff members in these experiences of day care. The staff members described a process of connecting with the individual client, enabling the client to engage in some occupation, which then led to the client appearing to experience well-being. Observable indicators of well-being, as described by the participants, were smiles and laughter, signs of affection and friendliness, attentiveness and more settled behaviour. This study further illuminates the place of occupation in promoting the health and well-being of clients with dementia, when their ability to participate in occupation is diminishing. Studies like this need to be conducted with the participation of older people, to find out how well-being is achieved and maintained from the point of view of the people themselves.

Within the nursing literature, one example was found of a qualitative study utilising grounded theory, which resulted in the author proposing an Ecological Well-being Model (Ruffing-Rahal, 1998). The three core themes that arose from her interviews with older women were activity, affirmation and synthesis. Well-being was characterised by engagement in meaningful activities, perceptions of a positive continuity over the life course, and the reconciliation of negative experiences into an overall personal framework of meaning. A conceptual model was depicted by Ruffing-Rahal; however, in our opinion, while offering much potential, the model needs further development, particularly in helping the practitioner move from the model to its application in practice. One measure of the success or usefulness of a conceptual model is whether other researchers continue to test the model in further studies. At this stage, it does not appear that Ruffing-Rahal's model is being applied or researched by other authors.

One other qualitative study into the related area of the experience of quality of life in old age by some older people in Sweden offers some insights (Nilsson, Ekman, & Sarvimaki, 1998). The results gave a varied picture of experiences of a good life that contrasts with the negative stereotypical images of old age. The qualities that contributed to a positive experience were: strong mental energy, family connectedness, a sufficient number of meaningful activities, and a sense that life had been worthwhile and that they had a meaningful future. The conditions have some resonance with occupational therapy philosophy, as well as the scales devised by Ryff referred to earlier in the paper. This study was about quality of life and not well-being, but serves to illustrate the benefits of a qualitative approach.

This review of qualitative studies of well-being has revealed some important contributions to the literature incorporating aspects of older persons' perspectives on well-being. However, the review has only found a small number of studies about the well-being of older people. The authors suggest that more qualitative forms of inquiry will give older people a presence, and promote acceptance of the views of older participants as legitimate. For example, a phenomenological study would provide a rich description of the experience of well-being, which could lead to better informed health professionals. A grounded theory study would enable the identification of the basic social processes involved in attaining and maintaining well-being, and possibly result in the development of a theory of well-being for older people. The theory could then be used to further inform and guide occupational therapy practice with older people. The authors are not suggesting that qualitative studies are the only research approach to be used in studying well-being, but rather that the approach adds another dimension to our understandings, a dimension which to date is largely absent.

Conclusion

From this review of the literature, three key points have emerged. First, the definition of well-being is often assumed, or is used interchangeably with other concepts such as life satisfaction. Second, quantitative scales of subjective or psychological well-being are frequently used to measure well-being, even though there is little agreement amongst researchers about the concept of well-being itself. The third finding is that the older person's subjective perspective is lacking in all but a few studies. Use of qualitative studies that incorporate the perspective of the older person, to generate theories about well-being for older people could lead to the development of new research instruments and approaches. Such research may be of great use to practitioners and researchers, as the research will be grounded in the reality of human experience.

Researchers in occupational therapy need to aim for consensus about the definition of well-being so that there is increased clarity about the concept. This is particularly

important given the centrality of well-being in the understandings of occupational therapy practice. If such consensus is not possible, each author should at least be expected to define the concept as they understand it. In addition there is a need to understand well-being from older persons' perspectives, as this is currently an under-researched area in the literature. Single item or multiple item scales of well-being, while they do have a place and use, need to be examined critically, and the shortcomings of each scale recognised. Particular emphasis should be given to whether the scale really does measure well-being, or is it measuring some other related concept?

As the world's population is ageing and people are living longer, it is becoming more important to ensure that older people enjoy a quality of life, and experience well-being, not just quantity of life. This points to the need for more qualitative studies to investigate well-being as an experience, not to replace other approaches, but rather to enhance them. Qualitative studies will enable older persons to make a contribution to the research, thus gaining the potential to add life to their years and not just years to life. In so doing the philosophy underpinning occupational therapy of taking a holistic client-centred view of well-being will be better achieved.

Acknowledgment

The authors would like to thank Dr Louise Farnworth for her comments on an earlier draft of this paper, and Trish McLaine for her editorial expertise and encouragement.

References

Andrews, F. M., & McKennell, A. C. (1980). Measures of self-reported well-being: Their affective, cognitive, and other components. *Social Indicators Research, 8*, 127-155.

Andrews, F. M., & Withey, S. B. (1976). *Social indicators of well-being. Americans' perceptions of life quality.* New York: Plenum Press.

Baum, C., & Christensen, C. (1997). The occupational therapy context: Philosophy- Principles- Practice. In C. Christensen & C. Baum (Eds.), Occupational therapy. *Enabling Function and well-being.* (2nd ed., pp. 27-45). Thorofare, NJ: Slack .

Bevan, C. & Jeeawody, B. (1998). Introduction: The philosophical framework. In C. Bevan & B. Jeeawody (Eds.), *Successful ageing. Perspectives on health and social construction.* (pp. XXI-XXVII). Sydney: Mosby.

Bennett, K. M. (1997). A longitudinal study of wellbeing in widowed women. *Internation Journal of Geriatric Psychiatry, 12*, 61-66.

Bisconti, T., & Bergeman, C. (1999). Perceived social control as a mediator of the relationships among social support, psychological well-being and perceived health. *The Gerontologist, 39*, 94-103.

Bonder, B. R. (1997). Coping with psychological and emotional challenges. In C. Christiansen & C. Baum (Eds.), *Occupational Therapy. Enabling function and well-being.* Thorofare, NJ: Slack.

Bowsher, J. E., & Gerlach, M. J. (1990). Personal control and other determinants of psychological well-being in nursing home elders. *Scholarly Inquiry for Nursing Practice, 4*(2), 91-102.

Chamberlain, K. (1988). On the structure of subjective well-being. *Social Indicators Research, 20*, 581-604.

Christiansen, C., & Baum, C. (Eds.). (1997). *Occupational therapy. Enabling function and well-being (2nd ed.).* Thorofare, NJ: Slack.

Christiansen, C. H., Backman, C., Little, B. R., & Nguyen, A. (1999). Occupations and well-being: A study of personal projects. *American Journal of Occupational Therapy, 53*, 91-100.

Clark, F., Carlson, M., Zemke, R., Frank, G., Patterson, K., Ennevor, B. L., Rankin-Martinez, A., Hobson, L., Crandell, H., Mandel, D., & Lipson, L. (1996). Life domains and adaptive strategies of a group of low-income, well older adults. *American Journal of Occupational Therapy, 50*, 99-108.

Clarke, P. J., Marshall, V. W., Ryff, C. D., & Rosenthal, C. J. (2000). Well-being in Canadian seniors: Findings from the Canadian study of health and aging. *Canadian Journal on Aging, 19*, 139-159.

Diener, E. (1984). Subjective well-being. *Psychological Bulletin, 95*, 542-575.

Diener, E., Emmons, R. A., Larsen, R., & Griffen, S. (1985). The satisfaction with life scale. *Journal of Personality Assessment, 49*, 71 - 75.

Ducharme, F., & Rowat, K. (1992). Conjugal support, family coping behaviours and the well-being of elderly couples. *Canadian Journal of Nursing Research, 24*(1), 5-22.

Euler, B. L. (1992). A flaw in gerontological assessment: The weak relationship of elderly superficial life satisfaction to deep psychological well-being. *International Journal of Aging and Human Development, 34*, 299-310.

Feldman, S., Kamler, B., & Snyder, I. (Eds.). (1996). *Stories of women growing older: Something that happens to other people.* Sydney: Random House.

Friedman, M. (1997). Social support sources among older women with heart failure: Continuity versus loss over time. *Research in nursing and health, 20*, 319-327.

Graham, K., & Schmidt, G. (1999). Alcohol use and psychosocial well-being among older adults. *Journal of Studies on Alcohol, 60*, 345-351.

Hasselkus, B. R. (1997). Occupation and well-being in dementia: The experience of day-care staff. *American Journal of Occupational Therapy, 52*, 423-434.

Heidrich, S. (1998). Older women's lives through time. *Advanced Nursing Science, 20*(3e), 65-75.

Heidrich, S. M. (1993). The relationship between physical health and psychological well-being in elderly women: A developmental perspective. *Research in Nursing and Health, 16*, 123-130.

Heidrich, S. M., & D'Amico, D. (1993). Physical and mental health relationships in the very old. *Journal of Community Health Nursing, 10*, 11-21.

Jorm, A. F., Christensen, H., Henderson, A. S., Jacomb, P. A., Korten, A. E., & Mackinnon, A. (1998). Factors associated with successful ageing. *Australian Journal on Ageing, 17*(1), 33-37.

Larsen, R., Diener, E., & Emmons, R. (1985). An evaluation of subjective well-being measures. *Social Indicators Research, 17*, 1-17.

Law, M., Steinwender, S., & Leclair, L. (1998). Occupation, health and well-being. *Canadian Journal of Occupational Therapy, 65*, 81-91.

Lawton, M. P. (1983). Environment and other determinants of well-being in older people. The Gerontologist, 23, 349-357.

Lo, J. (1996). The relationship between daily occupational affective experiences and subjective well-being. *Occupational Therapy International, 3*, 190-203.

Ludwig, F. M. (1997). How routine facilitates well being in older women. *Occupational Therapy International, 4*, 213-228.

Merriam-Webster. (2002). Merriam-Webster's collegiate dictionary. Retrieved 8th April, 2002 from http://www.m-w.comcgi-bin/dictionary

Meyer, A. (1922). The philosophy of occupational therapy. *Archives of Occupational Therapy, 1*, 1-10.

Miller, M., & Lago, D. (1990). The well-being of older women: The importance of pet and human relations. *Anthrozoos, III*(4), 245-252.

Neugarten, B. L., Havighurst, R. J., & Tobin, S. S. (1961). The measurement of life satisfaction. *Journal of Gerontology, 16*, 134 - 143.

Nilsson, M., Ekman, S.-L., & Sarvimaki, A. (1998). Ageing with joy or resigning to old age: Older people's experiences of the quality of life in old age. *Health Care in Later Life, 3*(2), 94-110.

Orem, D. E. (1995). *Nursing. Concepts of practice* (5th ed.). St Louis: Mosby.

Reed, K. L., & Sanderson, S. N. (Eds.). (1999). *Concepts of occupational therapy* (4th ed.). Philadelphia: Lippincott Williams & Wilkins.

Roget, P. M. (1987). *The Original Roget's Thesaurus.* New edition, prepared by Betty Kirkpatrick. London: Longman.

Roos, N. P., & Havens, B. (1991). Predictors of successful aging: A twelve-year study of Manitoba elderly. *American Journal of Public Health, 81*(1), 63-68.

Rowe, J. W., & Kahn, R. L. (1998). *Successful aging.* New York: Dell.

Ruffing-Rahal, M. (1998). Individuation and varieties of well-being experience among older women. *Advanced Nursing Science, 20*(3), 13-20.

Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology, 57*, 1069-1081.

Ryff, C. D., & Keyes, C. L. M. (1995). The structure of psychological well-being revisited. *Journal of Personality and Social Psychology, 69*, 719-727.

Ryff, C. D., & Singer, B. (1996). Psychological well-being: Meaning, measurement, and implications for psychotherapy research. *Psychotherapy and Psychosomatics, 65*, 14-23.

Searle, M. S., Mahon, M. J., Iso-Ahola, S. E., Adam Sdrolias, H., & van Dyk, J. (1995). Enhancing a sense of independence and psychological well-being among the elderly: A field experiment. *Journal of Leisure Research, 27*, 107- 124.

Silveira, E., & Ebrahim, S. (1998). Social determinants of psychiatric morbidity and well-being in immigrant elders and whites in East London. *International Journal of Geriatric Psychiatry, 13*, 801-812.

Stanley, M. (1995). An investigation into the relationship between engagement in valued occupation and life satisfaction for elderly South Australians. *Journal of Occupational Science: Australia, 2*(3), 100-114.

Statistics Canada. (2000). Population projections. Retrieved 22nd March, 2001 from http://www.statcan.ca/english/Pgdb/People/Population/demo23c.html

Statistics Canada. (2001a, June, 2001). Health Indicators. Retrieved 27th September, 2001 from http://www.statcan.ca:80/english/freepub/82-221-XIE/00601/stat3. htm#hf3

Statistics Canada. (2001b, March 22, 2001). Population by sex and age. Retrieved 23rd March, 2001 from http:// www.statcan.ca/english/Pgdb/People/Population/demo10a.html

Takahashi, K., Tamura, J., & Tokoro, M. (1997). Patterns of social relationships and psychological well-being among the elderly. *International Journal of Behavioral Development, 21*, 417-430.

United Nations (2000) United Nations Principles for Older Persons. Retrieved 18th December, 2000 from http://www.un.org/esa/socdev/iyop/iyoppop.html

Wilcock, A. A. (1998). *An occupational perspective on health.* Thorofare, NJ: SLACK Inc.

Wilcock, A. A., van der Arend, H., Darling, K., Scholz, J., Siddall, R., Snigg, C., & Stephens, J. (1998). An exploratory study of people's perceptions and experiences of well being. *British Journal of Occupational Therapy, 61*(2), 75- 82.

Wood, V., Wylie, M., & Sheafor, B. (1969). An analysis of a short self-repot measure of life satisfaction: Correlation with rater judgements. *Journal of Gerontology, 24*, 465-469.

World Health Organisation.(2001)Definition of health. Retrieved 30th January, 2001 from http://www.who.int/aboutwho/en/definition.htm

World Health Organisation. (1998). Ageing and health. Retrieved 14th November, 2000 from http://www.who.int/ageing/htm

Occupational therapy possesses few mid-range substantive theories, particularly those that have been derived empirically or generated within the profession. Grounded theory offers a systematic and well recognised approach to study the richness and diversity of human experience, in order to generate relevant theory. This paper describes grounded theory, its theoretical orientation and its elements, and offers a critique of the approach. A selection of grounded theory studies related to occupational therapy and occupational science are reviewed to demonstrate the contribution that the approach has begun to make to, and the potential that the approach offers for, developing empirically derived occupational therapy theories.

Grounded Theory: Exploiting the Potential for Occupational Therapy

Mandy Stanley and Julianne Cheek

Introduction

Qualitative research approaches within an interpretive paradigm, for example ethnography, phenomenology and grounded theory, are well used in disciplines such as anthropology and sociology. Occupational therapy researchers have adopted ethnographic and phenomenological approaches; however, grounded theory appears to have received less attention in the occupational therapy literature.

The aim of grounded theory is to generate theory that is 'grounded' empirically, that is, grounded in the data collected. Occupational therapy, at its current stage of development as a profession, would benefit from generating theories grounded in the reality of practice. An examination of the theories used by the occupational therapy profession suggests that many have been borrowed from other disciplines such as psychology, for example, Maslow's (1954) theory of self-actualisation, or are theories that are logically derived rather than based on empirical studies, for example, Kielhofner's (1985) Model of Human Occupation. It is timely that occupational therapy theorists and researchers develop occupational therapy specific knowledge. Grounded theory offers a systematic and well recognised approach to studying the richness and diversity of human experience, in order to generate theory related to the use of occupations to enhance health and wellbeing.

Hasselkus, writing in 1995, urged occupational therapy researchers to extend their knowledge about, and use of, qualitative research approaches beyond ethnography and suggested that grounded theory was worthy of investigation. This paper picks up on and expands Hasselkus' (1995) point by outlining the major features of grounded theory and highlighting its potential contribution to occupational therapy research. In the first section, the theoretical orientation of grounded theory is described; a definition is presented, together with the various elements and procedures that distinguish grounded theory from other research approaches. The second section offers a critique of the approach. The final section presents a selection of grounded theory studies to illustrate its present contribution to understandings of health and occupational therapy and to highlight the potential for future contributions to occupational therapy research.

Grounded theory

Grounded theory was developed by two sociologists, Barney Glaser and Anselm Strauss, in the 1960s and first articulated in a text published in 1967 (Glaser and Strauss 1967). It is an analytic inductive technique based in the interpretive tradition, which is used to examine social situations and the social construction of reality. For example, grounded theory has been used to study the process of death and dying in hospitals (Glaser and Strauss 1965), women with postpartum depression (Beck 1993) and people with bipolar depression (Hutchinson 1993a). The purpose is to develop a mid-range theory. Mid-range theories, as opposed to grand theories which are complex and explain a broad area within a discipline, consider limited concepts and aspects of the real world.

Grounded theory is informed by symbolic interactionism. Many sociologists, philosophers and psychologists have influenced the development of symbolic interactionism, most notably Mead (1934) and Blumer (1969). Bowers (1988, p36) defined symbolic interactionism as 'a social-psychological theory of social action'. Symbolic interactionism focuses on the individual as a socially constructed being and on the processes of social interaction by which individuals make sense of the world.

Denzin (1989) suggested that there were three basic assumptions behind symbolic interactionism:

1. Each person's reality is a product of his or her social world; interacting individuals produce their own reality, yet shared reality is created through social interaction

2. Humans engage in self-reflection or dialogue with themselves and are capable of influencing their own behaviour and that of others
3. Humans interact with one another and make sense of the world through interaction. Interaction is symbolic because it involves symbols, words, meanings and language.

The researcher from the symbolic interactionist perspective is interested in discovering the realities of the research participants, the nature of the objects in their worlds and how they define and experience their world.

Drawing on the tenets of symbolic interactionism, grounded theory assumes that people order and make sense of their world when it may well appear that it is disordered. Thus reality is a social construct. It is assumed that people sharing a common circumstance will also share some common meanings related to that circumstance. In grounded theory, the researcher looks for processes that are occurring in social situations. Grounded theorists study these social processes in order to arrive at a theory that explains the action in the social context under study (Stern 1980). Therefore, grounded theory is particularly useful in areas where little is known about the phenomenon of interest or there are few adequate existing theories to explain an individual's or a group's behaviour. The focus is on everyday life situations where processes, relationships, meanings and adaptations require explication. The researcher attempts to discover the processes that people use to make sense of their situation. The theory must be 'grounded' in the data, that is, it arises from the data, in contrast to traditional or experimental research, where empirical work is designed to test a hypothesis derived from a theory or model. In other words, it is inductive rather than deductive in approach.

It is important to note at the outset that there are different inflections to grounded theory. These derive largely from developments of the original Glaser and Strauss concept of grounded theory. This paper refers predominantly to what is known as the traditional Glaser and Strauss (1967) and later traditional Glaserian position (Glaser 1992). This point is returned to below.

Elements and procedures of grounded theory

Data collection

Grounded theory questions focus on process and so are often 'how?' questions. For example, how do occupational therapists go about their work, how do occupational therapists think about and understand their work and how do occupational therapists define and use evidence? Grounded theory questions may also be 'what?' questions, such as in the first author's PhD study where the research question is 'What are older people's perceptions and understandings of wellbeing?'

A range of methods and techniques is used to collect data in grounded theory. These often involve in-depth interviews or participant observation, or a combination of both. The interview questions usually move from the general to the particular, in order to elicit information about behaviour as well as about the strategies for and contexts, temporality and consequences of actions. For example, in Farber's (2000) study of mothering with a disability, she began with the 'grand tour' question: 'What is the experience of being a mother with a disability?' Further questions included: 'What was it like for you as a parent in the beginning and what is it like now?' and 'What do you think is most important for anyone to know about parenting?'

If using participant observation, the researcher focuses on the social actors or participants involved, observing who is doing what and who is relating to whom and recording these details in field notes for analysis. The researcher makes notes about both verbal and nonverbal behaviour, together with notes about how space is used and the temporality of events. For example, in a nursing study of therapeutic touch (Heidt 1990), the researcher observed treatment sessions involving therapeutic touch and noted all verbal and nonverbal expressions as well as all the other body movements of the nurse and the patient.

Constant comparative analysis

Data analysis begins with the researcher analysing a transcript or field notes line by line and assigning in-vivo codes. An in-vivo code is a word or a short phrase that describes what is happening, often quite close to the original words of the participant. For example, the line of transcript from the first author's study of older people's perceptions and understandings of wellbeing, 'I think just to, to enjoy your life within your capacity. And everyone has limitations on their capacity haven't they, and limitations on their interest too' (*Joan*), might be coded, 'Enjoy within your capacity'. Codes are then clustered with similar codes into categories. As further data are collected, they too are coded and categorised.

Data collected in a grounded theory study are analysed using constant comparative analysis (Glaser and Strauss 1967). Constant comparative analysis involves coding a unit of data and comparing it with all the other units of data coded in that category. It is a systematic tool for developing and refining the theoretical properties of a category and, if applied rigorously, assists the researcher to move from a simple description of the participants' categories to a theoretical level (Seale 1999).

Theoretical sampling

As early data are analysed and emergent themes arise, theoretical sampling is employed (Glaser and Strauss 1967, Glaser 1992). Where or from whom data are collected next is determined by the categories in the emerging theory. Informants are sought that are thought to be able to contribute further data relating to the important emerging theoretical constructs, so that the constructs can be examined and elaborated further. Glaser and Strauss (1967, p47) suggested:

> The basic question in theoretical sampling is: What groups or subgroups does one turn to next in data collection? And for what theoretical purpose?

Those questions guide the researcher as to which cases to study, people to interview or settings to observe in order to find things that might challenge and/or extend the emerging theory (Seale 1999). For example, in a study of how women managed postpartum depression, Beck (1993) chose to interview a woman who was pregnant for the third time and had had postpartum depression after each of her first two pregnancies to see if things were different from some first-time mothers who refused to take the gamble on having postpartum depression again. Different questions may be asked of different participants as the theory evolves.

Memoing

During a grounded theory analytical process, the researcher writes memos. Memoing is a way of preserving emerging ideas and hypotheses about the data as analysis is conducted. As ideas strike the researcher, they are recorded in the form of a memo. If ideas are not recorded at the time, they may well be forgotten and lost. The ideas arise as a result of analysing the data and are thus grounded in the data.

Bowers (1988, p51) stated, 'Memoing is a crucial process for the grounded theory researcher', and suggested that memoing served several purposes:

1. To record the development of the theory, including decisions about theoretical sampling, changes of focus in interview questions and tentative hypotheses
2. To record categories and ideas that seem to be unrelated to the emerging theory at that time for possible reintegration into the analysis at a later point
3. To record methodological decisions and problems.

Bowers (1988) also suggested that combined theoretical and methodological memos recorded the possible impact of methodological issues on the emerging theory.

Memos are used to raise the data to a level of conceptualisation (Grbich 1999) and to locate the emerging theory within existing relevant theoretical frameworks (Glaser 1978). The memos themselves are also sorted and further memos are written as the theory is developed (Grbich 1999). An example of a memo written in the first author's study of older people's perceptions and understandings of wellbeing is as follows:

> *Memo 28th July, 2001*
>
> Importance of family and friends. What is it about family and friends? Is it connectedness? Continuity? Go back to the quote from Bev, something to do with friends – a sense of shared history.

Core category

Grounded theorists search for the social processes present in human interactions (Hutchinson 1993b). The researcher is trying to identify a core category. A core category arises from the data, linking the various pieces of data together, and explains much of the variation of the data (Hutchinson 1993b). The discovery of a core category is a requirement for a quality grounded theory study (Hutchinson 1993b).

The core category is somewhat like a central theme and becomes the basis for the generation of theory. For example, Jonsson et al (1999), in examining how people with poliomyelitis sequelae managed their occupations in everyday life, identified the core category of 'keeping the balance for the present and the future'. The authors suggested that the strategies identified by the participants would be helpful to occupational therapists in promoting adaptive behaviour in clients with polio sequelae. Once the core category has been identified, theory can be developed. The theory is a result of the interrelationships between the core category and all the other categories (Corbin 1986). It is an explanation of the links and relationships between the concepts.

All studies have a core category, but not all studies reveal a basic social process. The basic social process is similar to a core category, except that it has two or more stages or phases that account for the process or the change over time (Glaser 1978). In a nursing study of postpartum depression (Beck 1993), the basic social problem was 'loss of control' and the basic social process was identified as 'teetering on the edge', which referred to the women's perception of walking a fine line between sanity and insanity. Four stages were used to cope with the problem of loss of control, namely encountering terror, dying of self, struggling to survive and regaining control.

Theoretical saturation and sample size

It is not possible to predict the sample size prior to commencing a grounded theory study. Data are collected until no new codes or categories emerge, thus achieving what is termed saturation. By achieving saturation, the researcher ensures that the theory reflects the situation accurately and the result is a rich 'thick' description. As the researcher sees similarities in the data again and again, there is confidence that the category is saturated. Glaser and Strauss (1967, p63) stated that it is easy to detect an inadequate theoretical sample because the associated theory is 'usually thin and not well integrated, and has too many unexplained exceptions'. Thus the sample is as small or as large as is necessary to achieve theoretical saturation.

The concept of theoretical saturation is an interesting one because one wonders if it is possible to reach a point where no new information is revealed. However, Seale (1999) suggested that knowing when to stop sampling is guided by the pragmatics of ceasing inquiry, when it seems unlikely that further investigation will be fruitful. The researcher needs to balance stopping data collection too early and ending up with a theory that is not well developed, with the potential for spending too much time in data collection and analysis and not completing the research study.

Critiques and trends

Grounded theory continues to develop and evolve. In later years, Glaser and Strauss differed on the developments in the approach to grounded theory, to the point where Strauss

developed a version of grounded theory with Corbin (Strauss and Corbin 1990). Glaser considered that the approach developed by Strauss and Corbin was no longer grounded theory (Glaser 1992); however, others disagree and view it as a development of grounded theory. Other variations have been described by Stern (1980), Charmaz (1994) and Eaves (2001), for example. For a more detailed examination of the differences between the grounded theory by Glaser and that by Strauss and Corbin, see Annells (1996). The occupational therapy researcher who wants to use grounded theory needs to be aware of the nuances in the approach and to take a considered and argued position with respect to the inflection used.

Postmodernists criticise grounded theory for its affinity with positivism (Grbich 1999) because the first step of analysis, coding, decontextualises the data and forces the researcher to adopt a 'narrow' view of the data. According to Seale (1999, p103), postmodernists 'equate grounded theorising with an attempt to impose a single, exclusive interpretation of data', rather than acknowledging that there may be multiple realities. However, such a critique could equally be levelled at other qualitative interpretive approaches. It is as much about philosophy as it is about grounded theory.

Some authors have argued that 'pure' grounded theory is not possible (Stanley and Wise 1990, Henwood and Pidgeon 1995), given that all researchers approach the research study and thus analysis with both personal and professional experience, together with social and cultural values. In many ways, this is also a critique of interpretive qualitative research. This, of course, is not to discount the importance of being aware of the subjectivity that underpins this type of research. Researchers using grounded theory, or any other qualitative approach, need to develop a reflexivity that enables them to acknowledge the role of the researcher in the research process, from design, data collection and analysis through to completion. In grounded theory, such reflexivity assists in and enables the theory to emerge rather than forcing it to fit preconceived ideas. Data analysis decisions need to be made transparent through the use of audit trails and memoing to demonstrate that the theory is grounded in the data and not forced.

Grbich (1999, p180) argued that in the health area researchers have used grounded theory to generate theory 'that is little more than an affirmation of their own biases'. This criticism is as much about 'sloppy method' or 'method slurring' as about grounded theory. Good grounded theory is about generating theory that is grounded in the data and not about imposing preexisting theories. To avoid 'method slurring', researchers are advised to make explicit which version of grounded theory they are using, as well as justifying and describing any deviation from the chosen approach (Cutcliffe 2000). Also, many research studies cite the use of constant comparative analysis while not necessarily doing grounded theory. It seems that, at times, the technique is being used as an analytical tool rather than being embedded within a grounded theory framework and a theoretical orientation drawing on symbolic interactionism. This is further evidence of 'method slurring', which needs to be discouraged because it detracts from the quality of qualitative research.

Like all qualitative approaches, grounded theory is time intensive and may not be the method of choice for research projects that need to be completed in short time frames, for fear of not achieving a point in data collection that approaches theoretical saturation. The resulting theory would suffer because it would be incomplete and lacking in density and would not, therefore, be a useful addition to occupational therapy knowledge.

Use of grounded theory within occupational therapy research

Following a description of grounded theory and a consideration of some critiques of the approach, the contribution of grounded theory studies to occupational therapy is now discussed and suggestions are made for further contributions. A search of the occupational therapy literature using the AMED and CINAHL databases revealed a small number of published grounded theory studies (see Table 1). The studies were considered to be examples of grounded theory if the authors stated that they were using grounded theory, cited key references to do with grounded theory and then used some or all of the elements of grounded theory described in this paper. In this section, a selection of published grounded theory studies in the occupational therapy literature is used to illustrate the contribution of grounded theory to occupational therapy practice, occupational therapy education and occupational science. Suggestions for further studies in those domains are also put forward.

Occupational therapy practice

As can be seen in Table 1, examples in the literature were found relating to diverse areas, such as palliative care, people with poliomyelitis sequelae and older women. The findings from these studies have contributed to occupational therapy practice in various ways. A theoretical framework has been developed that assists occupational therapists working in palliative care to reframe their work so that they are able to make a meaningful and unique contribution to clients' lives and deaths (Bye 1998). From the study by Jonsson et al (1999), strategies have been identified that help clients to adjust to the occupational impact of disability resulting from poliomyelitis sequelae, which could be useful for other occupational therapy clients. If researchers were to build on this work and study the process of adaptation to the occupational impact of a variety of diseases and disabilities using grounded theory, it might be possible to build a formal theory about the process of occupational adaptation. That would be a most significant addition to occupational therapy knowledge.

Grounded theory has also enabled researchers to identify ways of improving information and treatment options for clients. For example, the findings from Ludwig's (1997)

Table 1. Summary of occupational therapy studies using grounded theory method

Author	Domain	Focus of inquiry	Sample	Data generation methods	Findings
Bye (1998)	Practice	Occupational therapists working with clients who are terminally ill	Ten occupational therapists working with clients who are terminally ill	In-depth interview and participant observation	Core category: affirming life, preparing for death
Carswell et al (1992)	Practice	Functional performance of clients with Alzheimer's disease	Eleven professional or family caregivers	Observation of videotape	Model of functional performance
Chang and Hasselkus (1998)	Practice	Satisfactions and dissatisfactions of working with clients after stroke	Random selection of 32 therapists	Thirty-seven narratives from mailed questionnaires and telephone interviews	Core category: expectation, satisfaction when clients fulfilled therapists' expectations
Cohn et al (2000)	Practice	Parents' expectations of sensory integration therapy	Random selection of five parents from larger study sample	Videotaped semi-structured interviews	Three child-focused outcomes and two parent-focused outcomes
Cusick (2001)	Practice	Influences, processes and outcomes for clinicians who do research	Purposive sample, 15 clinicians who do research in acute care hospitals in one city	In-depth interviews	Core category: becoming a clinician-researcher, described process
Drake and Irurita (1997)	Education	Experience of fieldwork supervisors dealing with students with difficulties	Purposeful sample, 17 fieldwork supervisors with experience of phenomenon	Interviews	Core category: ambiguity, process of clarifying ambiguity in three phases
Dubouloz et al (1999)	Practice	Practice and perceptions of evidence-based practice	Theoretical sampling, eight occupational therapists	Semi-structured, in-depth interviews	Evidence-based practice is a process of looking for understanding, involves research and is a potential threat
Farber (2000)	Practice	Women with disabilities engaged in occupation of mothering	Snowball sampling, eight mothers	Interviews	Two themes: maternal self-description and perception of interpersonal environment
Francis-Connolly (1998)	Occupational science	Mothering across the life course	Purposive and snowball sampling, 17 mothers aged 32-83 years	In-depth interviews and focus groups	Two themes: mothering as a lifetime occupation and influence of perfect mother image
Francis-Connolly (2000)	Occupational science	Mothering at two life stages	Convenience and snowball sampling, 20 mothers of a pre-school-aged child and 20 mothers of young adults	In-depth semi-structured interviews and questionnaires	Two themes: immersion in motherhood and mothering as an enfolded occupation
Jonsson et al (1999)	Practice	Adaptation of everyday occupations for people with poliomyelitis sequelae	Theoretical sampling, 22 participants	Interviews on one to three occasions	Eighteen concepts describing adaptive strategies
Ludwig (1997)	Occupational science	How women used routine to influence wellbeing	Theoretical sampling, seven women >70 years of age	Observation, in-depth interviews and autobiography	Theoretical model of process through which routine was used to maximise wellbeing
Pierce (2000)	Occupational science	How mothers manage the space and objects for the development of infants	Stratified sample, 18 mother-infant dyads	Monthly videotape of infants at play and monthly interviews	Maternal work of managing play objects in the home and of organising and maintaining the home space to support development

Table 1 (continued)

Author	Domain	Focus of inquiry	Sample	Data generation methods	Findings
Primeau (1998)	Occupational science	Exploration of parents' play with pre-school-aged children	Ten families (mother, father, first-born pre-school-aged child)	Participant observation and in-depth interview	Identified process of occupational scaffolding
Stephenson and Wiles (2000)	Practice	Patients' and therapists' views of home-delivered and hospital-based therapy	Fifteen participants and six therapists	Semi-structured in-depth interviews and discussion groups for therapists	Five themes: convenience, therapeutic environment, social contact, control and 'grateful recipient?'
Sweeney et al (2001)	Practice	Processes underlying supervision in occupational therapy	Thirty female occupational therapy supervisors	Semi-structured interview	Supervisors adopted an egalitarian approach and used covert strategies
Tamm and Skar (2000)	Practice	How children with restricted mobility play in different situations	Ten children aged 6-12 years, unable to move without aid of wheelchair or walking device	Formal and informal interviews and observations	Core category: How I play, three types of play – with friends (interactive and onlooker), play alone and play with adults, model of characteristics and consequences
Tamm (1999)	Practice	Occupational therapists' view of family caregivers in rehabilitation in the home setting	Eighteen community-based occupational therapists	Open-ended interviews	Core category: existential insecurity, and six categories broadly relatives as 'help or hindrance'

study of how older women used routine to influence their wellbeing highlighted the importance of helping older adults to continue to thread past themes of meaning into present contexts and occupations, particularly those that engendered feelings of achievement and accomplishment. Ludwig (1997) recommended that occupational therapists explore the use of routine with older clients to increase the likelihood of home programmes being adhered to and include others in the routine to increase the likelihood of a client doing certain occupations.

Clinical practice provides numerous situations in which humans interact and about which little is known. Here, grounded theory could be used to study such things as the process of adoption of assistive technology. Knowledge about these processes can lead to improvements in service delivery and better client outcomes. Other service delivery improvement ideas may be obtained from studying client perceptions of, for example, occupational therapy, rehabilitation programmes, educational programmes and support groups.

The first author of this paper is using grounded theory in a study of older people's understandings and perceptions of wellbeing. After critically reviewing the literature (Stanley and Cheek 2003), it became evident that occupational therapists do not have a clear and widely accepted view of what wellbeing is for older people, which seemed incongruous given that wellbeing is a central concept for the profession. Also, the older person's view about wellbeing appears to be absent in both the occupational therapy and the gerontological literature. The study aims to address the gap in the literature and to generate a theory about wellbeing from the older people themselves. It is highly probable that the client's perspective is absent in other bodies of occupational therapy literature. This shortfall in the literature could be addressed with grounded theory studies that give the opportunity to seek the client's perspective.

Another area where grounded theory could be used is in researching issues of importance to the development of the profession. Cusick (2001) has studied the influences, processes and outcomes for occupational therapy clinicians who do research and described the process of becoming a clinician-researcher. The findings are useful for occupational therapists considering doing research in their clinical position and for occupational therapy managers who want to increase the research productivity of the area they manage. Drawing on an example from nursing, Irurita (1992) used grounded theory to study nursing leadership in the west of Australia and identified a core process named 'optimising', which involved phases of 'surviving', 'investing' and 'transforming'. If the nurse leader was unable to optimise, then he or she experienced 'floundering'. Excellence in leadership was revealed when leaders were able to reverse negative situations to bring positive advantages to nursing. A similar study could be conducted of leaders in occupational therapy to facilitate the development of the leaders in the profession and, if the results were similar, it could lead to the development of a formal theory on leadership in the health professions.

Other grounded theory studies of professional issues might include a study of how occupational therapists perceive their role and function when employed in positions that do not have the title 'occupational therapist' or that have some generic functions, such as case managers. The

distinctions and definitions of what is occupational therapy practice are becoming more blurred and this could be perceived as a threat to the profession. Knowledge about how an occupational therapist maintains his or her professional integrity within a generic role would be useful for both students and occupational therapists that are considering taking on such roles.

Occupational therapy education

Only one grounded theory study of occupational therapy education was identified. Drake and Irurita (1997) used grounded theory to explore the experience of a group of Australian occupational therapy fieldwork supervisors dealing with students at risk of failing a fieldwork placement. The core category identified was ambiguity or uncertainty about the student's performance and the basic social process was clarifying ambiguity. Identifying the basic social process enabled the authors to suggest a number of strategies for supervisors to pick up warning signals early in order to enable the clarification process to occur and, it is to be hoped, thereby avoid failure for the student and a sense of failure for the supervisor.

In the education arena, it would be enlightening to use grounded theory to study the process of becoming an occupational therapist and perhaps explore if there are gender differences in that process. Another educational issue is that of providing enough quality fieldwork experiences for students. The issues around deciding to become a fieldwork supervisor could also be investigated using grounded theory. The information gained from such a study would assist schools of occupational therapy to support their fieldwork supervisors better and help to recruit more supervisors, thus alleviating the problem of shortages of clinical placements.

Occupational science

In the domain of occupational science, several grounded theory studies have been made of the occupation of mothering or parenting, thus contributing to the occupational science literature. Two studies have explored the nature of parents' play with children and how it was orchestrated within their daily occupations (Primeau 1998, Pierce 2000). The findings resulted in the naming and framing of a new term in the lexicon of occupational terms, 'occupational scaffolding' (Primeau 1998), and in adding to the knowledge base about how mothers manage space and play objects to facilitate their child's development.

Studies have also been conducted on the tasks and activities involved in mothering (a common occupation) (Francis-Connolly 1998, 2000), the use of adaptive strategies of time use among mothers with children with attention deficit hyperactivity disorder including the concept of enfolded occupations (Segal 2000) and the parenting process for mothers with disabilities (Farber 2000).

As has been demonstrated, grounded theory has already been used in the area of occupational science to study specific occupations and how humans negotiate their daily round of occupations. There are almost endless opportunities for occupational scientists to employ grounded theory to study various occupations in depth, such as fathering, caregiving or shopping, and how these occupations are orchestrated within daily life, thus adding to the body of knowledge about human occupations.

Conclusion

From the examples given, it is evident that grounded theory has application in occupational therapy studies of practice, professional issues and education, as well as in occupational science. In fact, grounded theory is useful in exploring anything about which little is known and that occupational therapists are involved in with people. Grounded theory is an ideal research approach for a profession that is people and socially focused, yet it appears that grounded theory is an approach that is not widely used by occupational therapy researchers. This paper has argued that occupational therapy in its current stage of professional development may benefit from developing its own unique theories and that grounded theory provides a highly suitable approach for doing this. Empirically derived theories pertinent to occupational therapy, grounded in the lives and social situations of the people occupational therapists work with, will be truly client centred and a significant step forward for the profession.

Acknowledgements

The authors would like to thank Dr Claire Ballinger for her helpful comments on earlier drafts of the paper and James Quan for his editorial assistance.

References

Annells M (1996) Grounded theory method: philosophical perspectives, paradigm of inquiry, and postmodernism. *Qualitative Health Research, 6(3),* 379-93.

Beck CT (1993) Teetering on the edge: a substantive theory of postpartum depression. *Nursing Research, 42(1),* 42-48.

Blumer H (1969) *Symbolic interactionism: perspective and method.* Englewood Cliffs, NJ: Prentice-Hall.

Bowers BJ (1988) Grounded theory. In: B Sarter, ed. *Paths to knowledge. Innovative research methods for nursing.* New York: National League for Nursing, 33-59.

Bye RA (1998) When clients are dying: occupational therapists' perspectives. *Occupational Therapy Journal of Research, 18(1),* 3-24.

Carswell A, Carson LJ, Walop W, Zgola J (1992) A theoretical model of functional performance in persons with Alzheimer disease. *Canadian Journal of Occupational Therapy, 59,* 132-40..

Chang L, Hasselkus BR (1998) Occupational therapists' expectations in rehabilitation following stroke: sources of satisfaction and dissatisfaction. *American Journal of Occupational Therapy, 52(8),* 629-37.

Charmaz K (1994) The grounded theory method: an explication and interpretation. In: BG Glaser, ed. *More grounded theory methodology: a reader.* Mill Valley, CA: Sociology Press, 95-115.

Cohn E, Miller LJ, Tickle-Degnen L (2000) Parental hopes for therapy outcomes: children with sensory modulation disorders. *American Journal of Occupational Therapy, 54,* 36-43.

Corbin J (1986) Qualitative data analysis for grounded theory. In: WC Chenitz, J Swanson, eds. *From practice to grounded theory.* Menlo Park, CA: Addison-Wesley Publishing, 91-101.

Cusick A (2001) The experience of clinician-researchers in occupational therapy. *American Journal of Occupational Therapy, 55,* 9-18.

Cutcliffe J (2000) Methodological issues in grounded theory. *Journal of Advanced Nursing, 31,* 1476-84.

Denzin NK (1989) *The research act. A theoretical introduction to sociological methods.* 3rd ed. Englewood Cliffs, NJ: Prentice Hall.

Drake V, Irurita V (1997) Clarifying ambiguity in problem fieldwork placements: picking up and dealing with problem signals. *Australian Occupational Therapy Journal, 44,* 62-70.

Dubouloz C-J, Egan M, Vallerand J, von Zweck C (1999) Occupational therapists' perceptions of evidence-based practice. *American Journal of Occupational Therapy, 53,* 445-53.

Eaves YD (2001) A synthesis technique for grounded theory data analysis. *Journal of Advanced Nursing, 35,* 654-63.

Farber RS (2000) Mothers with disabilities: in their own voice. *American Journal of Occupational Therapy, 54(3),* 260-68.

Francis-Connolly E (1998) It never ends: mothering as a lifetime occupation. *Scandinavian Journal of Occupational Therapy, 5,* 149-55.

Francis-Connolly E (2000) Toward an understanding of mothering: a comparison of two motherhood stages. *American Journal of Occupational Therapy, 54(3),* 281-89.

Glaser BG (1978) *Theoretical sensitivity.* Mill Valley, CA: Sociology Press.

Glaser BG (1992) *Basics of grounded theory analysis. Emergence vs forcing.* Mill Valley, CA: Sociology Press.

Glaser BG, Strauss AL (1965) *Awareness of dying.* London: Weidenfeld and Nicolson.

Glaser BG, Strauss AL (1967) *The discovery of grounded theory.* New York: Aldine de Gruyter.

Grbich C (1999) *Qualitative research in health. An introduction.* Sydney: Allen and Unwin.

Hasselkus BR (1995) Beyond ethnography: expanding our understanding and criteria for qualitative research. *Occupational Therapy Journal of Research, 15(2),* 75-84.

Heidt PR (1990) Openness: a qualitative analysis of nurses' and patients' experiences of therapeutic touch. *IMAGE: Journal of Nursing Scholarship, 22(3),* 180-86.

Henwood K, Pidgeon N (1995) Grounded theory and pyschological research. *The Psychologist, 8,* 115-18.

Hutchinson S (1993a) People with bipolar disorders quest for equanimity: doing grounded theory. In: PL Munhall, C Oiler Boyd, eds. *Nursing research. A qualitative perspective.* New York: National League for Nursing Press.

Hutchinson S (1993b) Grounded theory: the method. In: PL Munhall, C Oiler Boyd, eds. *Nursing research. A qualitative perspective.* New York: National League for Nursing Press.

Irurita V (1992) Transforming mediocrity to excellence: a challenge for nurse leaders. *Australian Journal of Advanced Nursing, 9(4),* 15-25.

Jonsson A-LT, Moller A, Grimby G (1999) Managing occupations in everyday life to achieve adaptation. *American Journal of Occupational Therapy, 53,* 353-62.

Kielhofner G, ed (1985) *A model of human occupation: theory and application.* Baltimore, MD: Williams and Wilkins.

Ludwig FM (1997) How routine facilitates wellbeing in older women. *Occupational Therapy International, 4(3),* 213-28.

Maslow A (1954) *Motivation and personality.* New York: Harper and Row.

Mead GH (1934) *Mind, self and society.* Chicago: University of Chicago Press.

Pierce D (2000) Maternal management of the home as a developmental play space for infants and toddlers. *American Journal of Occupational Therapy, 54(3),* 290-99.

Primeau LA (1998) Orchestration of work and play within families. *American Journal of Occupational Therapy, 52(3),* 188-95.

Seale C (1999) *The quality of qualitative research.* London: Sage.

Segal R (2000) Adaptive strategies of mothers with children with attention deficit hyperactivity disorder: enfolding and unfolding occupations. *American Journal of Occupational Therapy, 54(3),* 300-306.

Stanley L, Wise S (1990) Method, methodology and epistemology in feminist research processes. In: L Stanley, ed. *Feminist praxis. Research, theory and epistemology in feminist research.* London: Routledge, 20-60.

Stanley M, Cheek J (2003) Well-being and older people: a review of the literature. *Canadian Journal of Occupational Therapy, 70,* 51-59.

Stephenson S, Wiles R (2000) Advantages and disadvantages of the home setting for therapy: views of patients and therapists. *British Journal of Occupational Therapy, 63(2),* 59-64.

Stern PN (1980) Grounded theory methodology: its uses and processes. *IMAGE: Journal of Nursing Scholarship, 12,* 20-23.

Strauss A, Corbin J (1990) *Basics of qualitative research.* Newbury Park, CA: Sage.

Sweeney G, Webley P, Treacher A (2001) Supervision in occupational therapy, part 1: the supervisor's anxieties. *British Journal of Occupational Therapy, 64(7),* 337-45.

Tamm M (1999) Relatives as a help or hindrance – a grounded theory study seen from the perspective of the occupational therapist. *Scandinavian Journal of Occupational Therapy, 6,* 36-45.

Tamm M, Skar L (2000) How I play: roles and relations in the play situations of children with restricted mobility. *Scandinavian Journal of Occupational Therapy, 7,* 174-82.

Authors

Mandy Stanley, BAppSc(OT), MHlthSc(OT), Lecturer, School of Health Sciences, Division of Health Sciences, University of South Australia, City East Campus, North Terrace, Adelaide, South Australia 5000, Australia. Email: mandy.stanley@unisa.edu.au

Professor Julianne Cheek, PhD, BEd, DipEd, Director, Socially Sustainable Health Research Centre, University of South Australia.

CORE CATEGORY

PERCEIVED CONTROL

- Routine
- Having choices
- Maintaining Independence

properties of core category

CATEGORIES

PROPERTIES

Challenge to equilibrium	Personal Resources	Up to Me	Comfortable & Secure
- loss of capacities - physical and cognitive - loss of relationships - life is like a yo-yo - gender imbalance - it came out of the blue	- having good health and good fortune - being engaged and active - feeling needed and wanted - being connected - keeping busy	- positive outlook - up to me - realistic about capability - within your capacity - having to accept giving up things	- being comfortable - feeling safe and secure - safe in the environment - financial security

TRADING OFF

BASIC SOCIAL PROBLEM

LACK OF PERCEIVED CONTROL