**Investigating psychological wellbeing (flourishing) with community dwelling older adults with multimorbidity - identifying strength based interventions.**

**Introduction**

Addressing the increasing incidence of poor mental health is an international priority [1]. Older people who are living with multi-morbidity are particularly at risk of experiencing low psychological wellbeing [2]. However, management of mental health concerns among older people is complicated by reluctance to seek help for non-physical health problems [3, 4, 5] and the attribution of symptoms to ‘normal ageing’ [6]. In addition there has been little attention to preventive strategies that promote psychological wellbeing [7].

There are many different theories of psychological wellbeing and flourishing. Psychological flourishing involves high levels of wellbeing and psychological wealth reflecting the complexity of the concept [8]. Seligman’s [9] PERMA theory of wellbeing (flourishing) considers both the eudemonic (presence of meaning and developing one’s potential) and hedonic (positive emotions and satisfying needs) dimensions of wellbeing and acknowledges complexity and adaption [10].

Whilst there has been a focus on sustaining physical functioning in older adults and improving or preventing deterioration in cognitive function, less attention has been paid to enhancing wellbeing [7]. The need for research to identify strategies to enhance psychological wellbeing has been recognised [11,12].

The aim of this research was to explore with community dwelling older adults the approaches they use to enhance their psychological wellbeing (flourishing).

**Methods**

A qualitative descriptive design informed by Charmaz’s [13] constructivist grounded theory approach was adopted. The research was also informed by Appreciative Inquiry [14] as we wanted to adopt a strength based approach to explore strategies participants were currently using to enhance their wellbeing.

Participants were recruited to participate in either an individual interview or a focus group via local and national community organisations and local retirement villages. The inclusion criteria comprised: adults aged over 65 years, English speaking and living in the community but not living in a care home. Snowballing methods were also used to maximise participation.

Information about the study was sent to potential participants by email or posted information sheets, and flyers. Interested respondents were followed up with a phone call from a member of the research team to provide further information and arrange an interview date and time. All individual interviews took place at the participant’s home and the focus group at a local community centre. The interview and focus group discussion guides were structured around Seligman’s [9] PERMA theory of wellbeing including the five pillars of: Positive emotion, Engagement, Relationships, Meaning, Achievement/Accomplishment. However, as interviewers we were flexible, following up on cues and letting participants tell their stories. Hone et al [15] note that inviting people to define what wellbeing means for them is important so they do not become alienated by the theoretical language of wellbeing. Therefore, before we introduced PERMA, we asked participants what wellbeing (flourishing) meant for them, followed by a brief explanation of Seligman’s five pillars of wellbeing. Interviews lasted between one and three hours in duration, and were conducted either by an experienced nurse interviewer (SW) or a psychologist (DR). All interviews were audio recorded and transcribed by an external transcription service. Demographic data were also collected including: age, gender, marital status, ethnicity, and type and number of long term conditions.

All participants received an individual participant information sheet and consent form before commencing. Approval to conduct the study was obtained via the University of Auckland Ethics Committee (Ref. 018277).

**Recruitment**

**Data collection and analysis**

Initial analysis involved sorting the data into the five pillars of PERMA. From this further coding was grounded in the data [13]. Frequent meetings took place between SW and DR to review transcripts, compare codes and resolve any discrepancy by consensus [16]. Constant comparative analysis was a recurring process and informed further questions for subsequent interviews. Data relating to participants gender, followed by their code, age and marital status are reported here in brackets. As participants appeared to find answering the questions about accomplishments challenging we continued to ask that question, but following consultation with our research team we started to ask about what participants saw as their ‘strengths’. Even this proved a difficult question, but elicited more responses. This was aided by the interviewer reflecting on what the participant had previously talked about.

After the first five interviews had been completed, we presented our emerging findings at the end of each interview and to the focus group, to seek feedback on what we had found so far.

Following the transcription of each individual interview the participants were sent a copy of the transcript and asked to give feedback. All transcripts were returned with some minor modifications; some participants removed personal data that could identify them or other people.

**Participants**

Seventeen men and 31 women aged between 66 and 99 years participated in the study (*n* = 48: see Table 1). Whilst participants reported a mean of two long-term conditions, most did not want to discuss these, despite reporting, for example, extensive surgeries. Some of our participants did not refer to specific conditions or medical diagnoses, but spoke about having knee and hip problems, balance issues and having had frequent falls which were attributed to ageing. These issues were often referred to as grumbling or frustrating concerns. Two participants were living with disabilities arising from accidents and both had prostheses Three participants reported experiencing depression and one with anxiety; all were aware this could happen again. Five participants were receiving home support services, two of whom were reliant on their wives to provide care and support in the home.

Insert Table 1 here.

**Findings**

We termed our key finding ‘intentional activity’ which reflected the active choices participants were making to take action to enhance their wellbeing. This did not necessarily mean physical activity, but action that could involve a change of attitude or way of thinking about something. Most participants used a range of strength based strategies or ‘practices’. For a small number of participants these practices were supported by the presence of partners as carers who were clearly co-ordinating activities.

Our participants understandings of ‘wellbeing’ and ‘flourishing’ focused on being or maintaining their health, independence, keeping active, having choice and control, experiencing contentment and happiness.

Positivity

Positive emotion in PERMA refers to general tendencies toward positive feelings, such as contentment and joy [17]. Not all our participants viewed themselves as positive people; the reality of their lives meant experiencing negative emotion at times, and at some points feeling lonely, sad, anxious, and angry. Some had experienced depression in the past and three were still living their lives with depression and one with anxiety. One of our participants shared that twice in her life she had considered suicide. Participants lives were scattered with periods of loss, including the loss of a child, partner, friends or activities. For some, long-term illness had presented earlier in their lives leading to disability and living with prosthetics had been a constant for many years. Current health issues meant that for some giving up activities that they had completed and loved since childhood was tinged with sadness.

*I’m sorry I’m going to have to give golf up, that, I used to love, for balance reasons. I’ve been playing since I was eight. (M15. 95. W).*

Participants held the view that being positive was important to them. All had ways of regulating negative emotion and had a number of practices that they used to promote a positive way of thinking and being. It was evident that being positive was not always an easy process and took effort which was reflected in the language that they used.

*I am buggered actually. I can’t do my exercises without feeling exhausted all the time. (M19. 99. M)*

For those participants who were dependent on their partners as carers it was clear that the carer played a key role in promoting a positive attitude.

*Several times (……….wifes name) says be positive you know. You’ve got all these things going for you know. Be positive. Well I tend to look over the fence.* (M15. 71. M)

Central to being positive was choosing to take action, and whilst this action varied across our participants, it always involved making a change and doing something different.

*When I do feel a bit mournful, but I usually greet him (deceased son) every morning, the photograph, just think about it and try and quell my anger (M1. 83. M)*

*Even when I’ve been badly depressed I’m still positive that I know that I’m not meant to be like that, and I have to change something to make me get out of it. (M4. 84. W).*

*If you don’t have a positive attitude, I mean you are in trouble. There are days when you’re sort of thinking, you know, life’s a bit low and a bit sad, but no come on and, get up. In one of my non positive days I’ll have a chat to myself and I do quite a bit of walking. (F6. 79. W)*

At times of distress and low mood being able to get out of the house was important, as was being, but not necessarily taking with, other people.

*When my husband died and people said to my daughter how well I was coping, but I didn’t cope well by myself. But I’d get into the car and I’d go off to a mall, and just wander around, I was with people. (F40. 82. W)*

Participants in the focus group and by some of the female interview participants talked about ‘presenting a brave face’ as a means to protect others, predominantly family, from knowing how they were feeling. However, there was the acknowledgment that this was not necessarily a positive strategy.

**Engagement**

Engagementrefers to being absorbed, interested and involved (17). Our participants were engaged in a range of activities which involved both being with other people and having time by themselves. Participants viewed control, choice and autonomy as critical to engagement in activities. Variety was also important, although finding new activities and relinquishing others was easier for some participants than others.

Engagement in physical activity was perceived as essential for maintaining mobility and therefore independence, fitness and strength. For some, physical activity involved taking their dog for a daily walk or gardening (even though this could be difficult). At the other end of the spectrum were participants who reported that going to the gym for a ‘workout’ was part of their daily routine. Being able to access facilities was easier for people who could still drive, or had someone able to drive them.

*We would like to go into town more often on the buses, but then you can’t get a park over at the parking station and it makes it difficult to use the public transport: (M7.85. M)*

The provision of a specific swimming class for people with multiple sclerosis was found valuable for one of our participants.

*I go to water walking. Now that is organised by the MS Society and I go to ……… pool. I'm very proud of the fact that I can actually do 16 lengths of that pool backstroke. I can’t kick my feet but I can do my arms.* (F21. 75. M)

The participants who were living in retirement villages had numerous activities and facilities that they could select and try out. However, beyond the village environment inadequate public transport was identified as a barrier.

The impact of not being able to drive anymore was identified as frustrating because of the limitations this now had on their independence; limiting activities that they had valued and found worthwhile, particularly if this involved contributing in some way to the community.

*I like being independent. I like doing what I want to do. I’m annoyed now you see. I used to go up to MOTAT and help restore the stuff. I spent over 25-odd years on the Lancaster. But now I can’t do anything like that. Well I couldn’t drive out there you see.* (M16.90. M).

For the majority of our participants there was concern that their memory was not what it used to be and they had thought about the impact of this in the future. Keeping mentally active was acknowledged as critical and involved a number of strategies, from completing the daily newspaper crossword to other activities that tested their memory. For one couple being members of a singing group meant being able to remember a repertoire of songs. The following participant shared his memory improvement practice.

*The dance teacher used to be a qualified dance teacher. So it’s not just straight simple waltzes and thing like that, it’s a few fancy steps put into it to, and that keeps the mind active. (M12. 87.W)*

**Relationships**

For those participants who had family, staying close to them was important, if sometimes challenging. Many reported ‘losing friends’, not only because they had died, but also because they were not able to connect with them anymore. For example if their friends were cognitively impaired, or living in a rest home.

Relationships with people were initiated and maintained through engagement in activities with others, including younger people. Preventing loneliness and isolation was considered important for all our participants who recognised the risk of loneliness and isolation with ageing. A sense of belonging was achieved from group participation and connecting with others. Finding the ‘right fit’ was a process of trial and error and assessing whether they would fit or not with an established group.

*I don’t go to the RSA anymore. I’ve never been an RSA socialising guy, I don’t like sitting there drinking liquor for the sake of some old codger telling his war stories.* (M4. 84. W).

Keeping connections was not necessarily about being present in a face to face relationship, but also involved telephone calls, or email for those who wanted to use that medium.

**Meaning**

A sense of meaning refers to having a sense of direction and purpose (9). Participants reported a number of ways in which they helped and cared about others. These activities included driving someone to a hospital appointment, sewing and altering someone’s clothes for them, knitting for charities, checking that someone in their apartment block was safe, being a mentor for children or creating a neighbourhood project that celebrated the contribution of other people in their community. For some of our participants their Christianity provided a strong sense of meaning and purpose in their lives as they also engaged in activities associated with the church in a group, or spent time alone in prayer.

*My Christian faith gives me meaning for life and no fear of death. (F2. 66. M)*

**Accomplishment/achievements/strengths**

Reflecting on their accomplishments or achievements was not something that came easily to any of our participants. Women spoke of their families and bringing up children, sometimes without the support of a partner. Men also referred to their children, but their achievements at work were uppermost in their minds. Having a future orientation was a consistent theme but was not set around goal setting, but about maintaining health and wellbeing and having something to look forward to. Only one of our participants considered ‘goal setting’ as something they consciously did. The language of goal setting was not commonly used, apart from those who had worked in a managerial, leadership type of role in the past.

*I set out to make myself future proof, that’s my goal and that’s what I have done*. (M4. 84. W)

*My strengths. I suppose it gets back to this sort of people, yes, I suppose that is my main strength now.* (F6. 79. W)

However, for those participants whose health was more challenging, achievements and accomplishments centred on some basic but critical functioning. For example, some explained how just being able to get out of bed in the morning was a major accomplishment.

Discussion

Understanding how older adults are maintaining their wellbeing is important as wellbeing impacts on quality of life, life satisfaction, health and mortality [18]. In this qualitative study we were able to engage older adults in exploring psychological wellbeing using Seligman’s PERMA theory of wellbeing as a framework. Our key finding related to the ‘intentional activity’ (Figure 1) participants undertook as they lived their lives as older adults. Some participants found this more challenging, particularly those with reduced mobility and deteriorating health. Flourishing was also a dynamic concept; some days you maybe flourishing more than other days. Our participants were engaged in activities that can and do influence their health [18,19].

Experiencing positive emotions was fundamental to wellbeing and demonstrated by X??, and we identified strategies or practices that participants were using when they were experiencing negative emotions, or as a way of preventing these from arising. In effect this was about positive selectivity [20], with participants consciously choosing to be positive and optimistic about their lives. For most, these practices were self-generated in shifting to a positive way of thinking and feeling. However, for others support was required to achieve this. Whilst previous research has identified emotional regulation is a strategy that older adults use instead of behavioural strategies [21]. Our findings showed how intentional activity was the key to achieving this, choosing to do something, whether this was a self-orientated activity or collectivist activity. This fits with Lyubomirsky et als [22] positive-activity model as individuals were able to select an appropriate person-activity fit.

For some participants a combination of collective and self-orientated activities was working for them; importantly having the ability to choose and access activities was central. Performance of positive activities increases positive emotions and behaviours which in turn builds other resources [23]. This fits with Fredrickson’s Broaden and Build Theory [23], reflecting participants’ attitudes towards avoiding negativity and addressing this with specific strategies when it occurred. It indicates that older adults are already using strategies that are successful which could be usefully shared with others (their peers). These strategies are similar to, but also complement, the range of interventions that have been tested with older adults to enhance positive emotion and wellbeing, such as savouring [12, 24], or specific training in wellbeing [7]. For example, our participants were contributing with acts of kindness, being grateful, and savouring, which involved having activities they could look forward to. As in other research [25] we identified that older adults contribute within their communities which enhances their sense of wellbeing. However, we also found that support may be required to help older adults identify their strengths and the contributions they make at an individual and community level. Enabling older adults to sustain their contribution when there are risks of further losses is paramount [7].

Importantly, integrating wellbeing to design public policy is proposed [26] and we would suggest that wellbeing and ‘flourishing’ can become part of the health assessment of older adults. Whilst there are a number of studies that explore how older adults adapt to ageing or foster resilience [25], there is a gap in the literature regarding how ideas about wellbeing, particularly flourishing are useful when considering older adults and in particular those with multiple morbidity and how they maintain and sustain their wellbeing. Although not all of our participants had multiple long term conditions, they were experiencing other issues that they found to some extent limiting and frustrating, so we would agree with Ford and Ford [27] that a focus on multimorbidity could be limiting.

There are environmental factors that can limit or enhance the older person’s choices that impact on wellbeing [28], such as transport facilities or the availability of activities in certain areas. Managing the transitions of loss, e.g. driving, proved challenging for some if there were no other options available for them. Certainly the loss of driving is recognised as a key factor impacting on independent living for older adults [29]. The loss of partners, friends and their associated networks is a challenge for older adults and can lead to social isolation. Although all of our participants made use of other networks, such as a widow/widower group, not all our participants were wanting to engage in activities with other groups. This again fits with the person-activity fit model and the autonomy and control that are central to achieving this.

There is a risk of lower wellbeing if the older person’s perception of wellbeing is limited [15], and adding further to this is the older person’s perception of ageing and the negative stereotypes associated with this [5]. Using a model such as PERMA enabled us to consider aspects of wellbeing that are not a normal part of a traditional health assessment. We were taking a strengths based approach which we believe fits more with a positive approach to ageing [1].

Although this is one of the first studies to explore how older adults view wellbeing, flourishing and in particular the strategies or practices they themselves use, there are limitations to this study. The ethnicity of our participants was largely New Zealand European. All our participants had families that they had some contact with. Most of our participants were able to make choices as they were living independently, although some had home support services. We did identify differences in those participants who were strongly reliant on their wives as carers and it was clear these older people had more limitations in their positivity-activity fit.

As the population ages and the demands on the health system increase, knowing what is driving and enabling older adults’ wellbeing is vital [30]. Research in New Zealand on wellbeing found an inverse trend in wellbeing when a person reported poor health due to the number of long term conditions[30], however the age limit for participants in this study was 74 years. Further research is required with those individuals who could be identified at risk of lower wellbeing and from our study we would identify those older adults who are receiving home support and care and also those who are socially isolated. Exploring how the practices we identified can become part of a community approach to wellbeing is required. Working with local community agencies offers the opportunity of integrating PERMA alongside the positivity-activity model, as an approach to assessment of individuals and communities. Our approach to community engagement with older adults to co-construct models of wellbeing will be driven by their participation and involvement.

**Conclusion**

We found using PERMA to guide our qualitative research enabled us to identify the strength based strategies/practices that our participants were using to enhance their psychological wellbeing. Intentional activity was our key finding and a means by which the older adults in our study were living their lives and contributing within their communities. Creating more conversations with older adults about these strategies and practices can further enhance our understanding and offers the opportunity for working within local communities and with local community organisations to develop community models of wellbeing

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