Interest in enhancing the wellbeing of older adults is driving international policy and research, influenced to a certain extent by the increase in life expectancy of older adults and concerns about the incidence of poor mental health (World Health Organization, 2015). Older adults who are living with multi-morbidity are particularly at risk of experiencing low psychological wellbeing (Mercer, Salisbury, & Fortin, 2014, Xiang, Ruopeng & Heinemann, 2018 ). However, management of mental health concerns among older adults is also complicated by a reluctance to seek help for non-physical health problems (Dear et al., 2012; Grime, Richardson, & Ong, 2010; Roy & Giddings, 2012) and the attribution of symptoms to ‘normal ageing’ (Borg, Hallberg, & Blomqvist, 2006).

There are many different theories of psychological wellbeing and it is beyond the scope of this paper to review these. Flourishing is a widely accepted term to denote high levels of wellbeing (Hone, Jarden, Schofield, & Duncan, 2014). Studies measuring wellbeing acknowledge both the eudemonic (such as the presence of meaning and developing one’s potential) and hedonic (such as positive emotions and satisfying needs) dimensions (Hone et al. 2014). Increasing wellbeing can have positive outcomes on health (Bartholomaeus, Van Agteren, Iasiello, Jarden & Kelly, 2018). Despite this evidence, when it comes to older adults there has been more of a focus on sustaining physical functioning and improving or preventing deterioration in cognitive function rather than a focus on wellbeing (Cantarella et al., 2017).

A number of studies have identified how specific psychological interventions can impact positively on older adults’ wellbeing (Cantarella, Borella, Marigo & De Beni 2017, Salces-Cubero, Ramirez-Fernadez & Ortega-Martinez, 2018). A systematic review of eight studies found that reminiscence interventions were the most prevalent, but other studies included life review, self-management bibliotherapy, with some studies using a combination of approaches, such as gratitude and savouring (Sutipan, Intarakamhang & Macaskill, 2017). Whilst the studies held promise of positive outcomes, such as, increasing happiness and minimising depressive symptoms the reviewers noted the need for further research to consider efficacy and acceptance of the interventions by older adults. Overall the review found that most of the participants in the studies were healthy older adults with an age range of 71 to 76 years. That older adults may respond to different interventions, such as savouring, is acknowledged (Smith & Smith, 2015). A specific community based wellbeing program for older adults (Bartholomaeus, Van Agteren, Iasiello, Jarden & Kelly, 2018) also found positive outcomes for some dimensions of wellbeing, but not all, further highlighting the need for further research to explore these differences.

The need for research to identify strategies to enhance psychological wellbeing has been largely accepted (Ministry of Health, 2016; Smith & Hollinger-Smith, 2015) and studies exploring how older adults perceive wellbeing, that is what it means and which aspects are important, provide insight into the multidimensional nature of the concept (Douma, Steverink, Hutter & Meijering, 2015). However, there appears to be a gap between the studies that measure wellbeing of older adults and those that measure the effectiveness of psycholgoical interventions with older adults. This study begins to address this gap by exploring “how do older adults’ achieve wellbeing?

The aim of this research was to explore community dwelling older adults’ approaches to enhancing their psychological wellbeing.

**Design and Methods**

In this qualitative descriptive study we adopted a strength based approach informed by Appreciative Inquiry and underpinned by social constructionism (Cooperider & Whitney, 2005) to explore strategies used by participants to enhance their psychological wellbeing. Our semi structured interview questions were based on Seligman’s (2011) PERMA theory of wellbeing, as it considers both the eudemonic and hedonic dimensions of wellbeing that underpin flourishing and acknowledges complexity and adaption as components of health and ageing (Sturmberg, 2013).

Participant Recruitment

Participants were recruited to participate in either an individual interview or a focus group via local and national community organisations and local retirement villages. Adults aged over 65 years were eligible to participate if they were English speaking and living in the community but not living in a care home. Snowballing methods were used to maximise participation rates.

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 (Seligman, 2011) PERMA theory of wellbeing, which includes the five pillars of: Positive emotion, Engagement, Relationships, Meaning, and Accomplishment. However, as interviewers we were flexible, following up on cues and letting participants tell their stories. Hone et al (2014) 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. We commenced the interview by asking participants for their understanding of what wellbeing and flourishing meant to them? The interviewers then followed this by asking questions from the semi-structured interview guide, including questions about positive emotions, engagement in activities, relationships, meaning in life and achievements, accomplishments.

Interviews lasted between one and three hours in duration, and were conducted either by an experienced nurse researcher or a psychologist. 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.

Ethical considerations

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).

**Data collection and analysis**

Initial analysis involved sorting the data into the five pillars of PERMA. From this initial sort further coding was grounded in the data (Creswell, 2014). In line with established practice, frequent meetings took place between SW and Dr to review transcripts, compare codes and resolve any discrepancy by consensus. As participants appeared to find answering the questions about accomplishments challenging, we continued to ask that question, however following consultation with our research team we started to ask about what participants saw as their ‘strengths’. This change still proved a difficult question, but elicited more responses. Their answers were aided by the interviewer reflecting on what the participants had already spoke about in their interview.

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 provide feedback. All transcripts were returned with some minor modifications. For example, some participants removed personal data that could identify them or other people. Once all the data were analysed we sent out a copy of the findings and arranged a group meeting to discuss the findings with all those participants who could attend. This gave us the opportunity of seeking further feedback, clarifying issues and eliciting thoughts on what should happen next.

**Participants**

Forty eight older adults aged between 66 and 99 years participated in the study. Of these, seventeen men and twenty women participated in semi-structured interviews (n = 37; see Table 1). Eleven women, all widows with a mean age 81 years, participated in the focus group. 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 anxiety; all were aware this could reoccur. Five participants were receiving home support services, two of whom were reliant on their wives to provide care and support in the home.

**Findings**

We termed our key finding ‘intentional activity’ which reflected how participants actively thought about, and then chose behaviours to enhance their wellbeing and this included their health. Most participants used a range of strength based strategies or ‘practices’. For a small number of participants (n = 3) these practices were supported by the presence of partners as carers who were clearly co-ordinating activities.

Positivity

Positive emotion in PERMA refers to general tendencies toward positive feelings, such as contentment and joy (Butler & Kern, 2016). 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 said they felt depressed or anxious and three had received treatment for depression and were aware depression or anxiety challenges could occur again. 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 as the following male participant shared.

*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. (M36. 95. W).*

Participants held the view that being positive was important to them. All had ways of regulating negative emotion, such as thinking about something positive they were looking forward to, or distracting themselves by completing an activity. Being positive was not always an easy process and took effort which was reflected in the language participants used.

*I am buggered actually. I can’t do my exercises without feeling exhausted all the time. (M37. 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 by engaging the person in activities or thinking about the positive aspects of a situation. The following male participant reflected on how his wife managed his somewhat negative attitude.

*Several times (……….wife’s 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.* (M3. 71. M)

As deduced from the above, participants acknowledged how they were feeling, e.g. anger or depression and then took action to change their feelings and mood. 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 (Butler & Kern, 2016). Participants viewed control, choice and autonomy as critical to engagement in activities, whether this involved being with other people or having time by themselves. The environment and 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: (M29.85. M)*

The provision of a specific swimming class for people with multiple sclerosis was found valuable by one of our participants as the following quote illustrates, however, attendance was dependent on her husband being able to drive her to the facility.

*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.* (F10. 75. M)

Not being able to drive anymore was identified as frustrating because of the limitations this imposed on independence. Valued and worthwhile activities were limited and this was particularly difficult when these involved contributing in some way to the community. For example, the following participant shared his frustration at no longer being able to drive.

*I like being independent. I like doing what I want to do. I’m annoyed now you see. I used to go up to ……..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.* (M33.90. M).

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.

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 supported by engaging in a range of activities 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. (M31. 87.W)*

The ability to engage in activities reflected the participants motivation, personal choices and availability of activities within their community, whether this was a retirement village or their local community.

**Relationships**

Relationships refers to being socially connected, feeling supported and cared about and experiencing satisfaction from those connections (Butler & Kern, 2016). 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 and involved finding the right group to join. A widow spoke about moving to a different region and searching to find a similar group that she could join. Information was not always available but seeking help from other sources, such as the citizen’s advice bureau was helpful to her. Some groups were relinquished if they no longer had any meaning or generated negative feelings as the following participant indicated.

*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.* (M26 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. Relationships contributed to the meaning in the older adults’ lives and engagement, whether being with others in a group, or maintaining a one-to-one relationships with a friend were positive influencing factors.

**Meaning**

A sense of meaning refers to having a sense of direction and purpose (Seligman, 2011). In the context of meaning 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.

*I do quite a bit of driving for people in the village* (F30. 85. W)

For some of our participants their Christianity provided a strong sense of meaning and purpose; 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. (F1. 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 although was not set around goal setting, but rather 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 by those who had worked in a managerial, leadership type of role in the past as the following male participant illustrates.

*I set out to make myself future proof, that’s my goal and that’s what I have done*. (M26. 84. W)

*My strengths I suppose it gets back to this sort of people, yes, I suppose that is my main strength now.* (F21. 79. W)

However, for those participants whose health was more challenging, achievements and accomplishments centred on achieving basic but critical functional tasks. 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 (Su, Tay, & Diener, 2014). 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. From this we found that participants had ways of thinking positively and engaging in activities that were important and meaningful to them. Our key finding related to the ‘intentional activity’ participants undertook to maintain or enhance their wellbeing. Some participants found this more challenging, particularly those with reduced mobility and deteriorating health. This is similar to the findings in the Sovereign Wellbeing Study (Mackay, 2015) which found lower levels of wellbeing in those reporting poor physical health and number of long term conditions. Importantly, wellbeing is a dynamic concept reflecting a continuum from high levels of wellbeing referred to as flourishing, to lower levels of wellbeing. As one participant shared with SW at a follow up visit, “I am not flourishing as much today …….” Maintaining health or preventing further deterioration in health was important and participants engaged in or attempted to engage in activities that research has identified can and do influence health (Ghosh & Deb, 2017; Steptoe, Deaton, & Stone, 2015).

Experiencing positive emotions was fundamental to wellbeing and being motivated to change negative thinking, negative emotion and engage in positive behaviours either with other people or on their own. In effect participants were illustrating positive selectivity (Scheibe & Carstensen, 2010) by 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 a shift in thinking by savouring some positive event or accomplishment in their lives, or being supported to engage in an activity that was meaningful to them. Previous research (Scheibe & Carstensen, 2010) has identified emotional regulation is a strategy that older adults use to create a positivity effect, selecting their environments and using cognitive strategies, however, there is the suggestion that high levels of stress can impact on cognitive performance but further research is required to explore this (Scheibe & Carstensen, 2010). From their earlier research, Lyubomirsky et al (2013) developed a positive-activity model illustrating how simple positive activities generated positive emotion, positive thoughts and increased wellbeing. Furthermore, they identified that in order to achieve these positive outcomes and increased wellbeing there had to be a person-activity fit. In a similar way our participants were motivated and engaging in activities that were meaningful to them.

Importantly, having the ability to choose and access activities, whether collective or self-orientated was central. Performance of positive activities increases positive emotions and behaviours which in turn builds other resources (Lyubomirsky & Layous, 2013). This fits with Fredrickson’s Broaden and Build Theory (Cohn & Fredrickson, 2010), reflecting participants’ attitudes towards avoiding negativity and addressing this with specific strategies. Choosing to take action or changing negative thinking, for example, feeling low or sad indicates that older adults are already using strategies that are successful which could be usefully shared with others (their peers) and could form the basis of peer support training programs. The strategies used by the participants in our study are similar to, but also complement, the range of interventions that have been tested with older adults to enhance positive emotion and wellbeing (Cantarella et al., 2017; Quoidbach, Berry, Hansenne, & Mikolajczak, 2010; Smith & Hollinger-Smith, 2015). For example, our participants were contributing with acts of kindness, being grateful, and savouring, which involved having activities they could look forward to. Similar to other research (Wiles & Jayasinha, 2013) 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, sense of accomplishment and meaningfulness in their lives when there are risks of further losses is paramount (Cantarella et al., 2017).

Integrating wellbeing to design public policy is proposed (Adler & Seligman, 2016) and we would suggest that wellbeing 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 (Adler & Seligman, 2016), there are still few studies that show how theories of wellbeing such as, PERMA, are useful when considering older adults 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.

We found that there are environmental factors that can limit or enhance the older person’s choices that impact on wellbeing (Tuckett, Banchoff, Winter, & King, 2018), 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 (Musselwhite, 2010), and the need to plan for future changes in mobility (Goins, et. al., 2015)

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 Lyubomirsky et al. (2013) person-activity fit model and the autonomy, control and motivation that are central to achieving this.

There is a risk of lower wellbeing if the older person’s perception of wellbeing is limited (Hone, Schofield, & Jarden, 2015), and in addition if the older person associates negativity with ageing (Roy & Giddings, 2012). Using a model such as PERMA enabled us to consider aspects of wellbeing that are not a normal part of a traditional health assessment of older adults. We were taking a strengths based approach, identifying what was working well which we believe fits more with a positive approach to ageing (World Health Organization, 2015).

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 (Mackay, 2015), however the age limit for participants in this study was 74 years. The age of our participants ranged from 66 – 99 years offering the perspective of older adults. However, there are limitations to our study as the ethnicity of our participants was largely New Zealand European. We did identify differences in those participants who were strongly reliant on their wives as carers and it was clear these older adults had more limitations in enhancing wellbeing.

As the population ages and the demands on the health system increase, knowing what is driving and enabling older adults’ wellbeing is vital (Mackay, 2015). 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 at risk of social isolation. Research is required to consider certain losses associated with ageing, such as driving and the development of programs that support the transition when losses are predicted, so that preventative strategies maybe taken. 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.

**Conclusion**

We found using PERMA to guide our qualitative research enabled us to identify the strength based strategies and practices that our participants were using to enhance their psychological wellbeing. Intentional activity was a key finding and a means by which the older adults in our study were achieving wellbeing and contributing within their communities. This finding provides the opportunity to support older adults who may be at risk of lower wellbeing to develop their resources and also to consider how health professionals working with older adults can incorporate wellbeing into their practice. Importantly if high levels of wellbeing, that is flourishing, are to be seen as a normal part of ageing well, then creating more conversations with older adults about wellbeing and wellbeing practices is required. This offers the opportunity for community engagement with older adults to co-construct models of wellbeing that fit their context.

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Table 1.

*DEMOGRAPHICS*

