An exploration of how community dwelling older adults enhance their wellbeing

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Abstract

Aim and objectives: To explore community dwelling older adults approaches to enhancing their psychological wellbeing.

Background: Older adults who are living with long term or chronic health conditions are particularly at risk of experiencing low psychological wellbeing. Little attention has been paid to preventive strategies that enhance psychological wellbeing and, in particular, to understanding how older adults enhance their own wellbeing.

Methods: Using Seligman's PERMA model of wellbeing (2011) as an organisational framework, this qualitative study interviewed 48 older people aged between 66 and 99 years. Of these, 17 men and 20 women participated in semi-structured interviews. Additionally, 11 women, all widows with a mean age of 81 years, participated in a focus group. The data were analysed with reference to the five aspects of PERMA (Positive emotion, Engagement, Relationships, Meaning, Accomplishment) with a focus on identifying what actions the older people were taking to enhance their wellbeing. Further analysis involved coding the data into processes or practices and also influencing factors.

Findings: Most participants used a range of strength-based strategies or practices to enhance their wellbeing. For a small number of participants ($n = 3$) these practices were supported by the presence of partners as carers. However, using PERMA as our conceptual

model illustrated that despite Seligman's view that individuals can take positive action within each of the five aspects of PERMA to enhance wellbeing, external factors, for example economic circumstances or mobility, can influence the ability of older adults to undertake wellbeing practices.

Conclusions: Older adults have a range of strategies or practices that they use to enhance their wellbeing. However, wellbeing is not a static concept and it is important to recognise the influence of health, social and environmental factors as enablers and enhancers of wellbeing.

Implications for practice: Nurses can play a central role in supporting older adults who may be at risk of lower wellbeing. Nurses can do this by developing interventions to enhance wellbeing and ensuring better person-activity fit of strategies and practices. Our findings support the need for nurses to be involved in providing opportunities for older people to discuss wellbeing to support the development of individual, as well as community, models of wellbeing.

Keywords: community dwelling, positive psychological interventions, positive psychology interventions, psychological wellbeing, PERMA, positive aging

SUMMARY STATEMENT OF IMPLICATIONS FOR PRACTICE

What does this research add to existing knowledge in Gerontology?

- Older adults are active in enhancing their wellbeing and have a number of strategies or practices that work for them.
- These practices can be supported when older adults have choices and they can be supported in their choices via person-activity fit.

What are the implications of this new knowledge for nursing care with older people?

- Nurses can explore older adults understanding of wellbeing and work with them to enhance the wellbeing practices they already have in place and provide evidence based approaches in support of these practices.

- Nurses can help identify preventative strategies to support the transition associated with certain losses, such as driving, and thereby limit the negative impact on wellbeing.
- Wellbeing is not a static concept but is influenced by health, social and environmental factors. As such, assessing wellbeing using models such as PERMA can form the basis of ongoing practice with older adults, particularly those at risk.

How could the findings be used to influence policy or practice or research or education?

- Recognise the impact of environmental, social, local community factors in limiting the wellbeing strategies or practices of older adults, eg. Transport.
- Further research is required with those individuals who could be identified as at risk of lower wellbeing, in particular older adults who are receiving home support and care, and also those who are at risk of social isolation.
- The findings highlight how specific models of wellbeing, such as PERMA, can be useful for engaging older people in conversations about what wellbeing means for them and can form the basis of co-constructing individual, as well as community, contextually relevant models of psychological wellbeing.

1.INTRODUCTION

Internationally, as the population ages and the demands on the health system increase, knowing what maintains and improves older adults wellbeing is vital (Mackay, 2015). Within New Zealand from 2001 to 2031 the population aged 65 years plus will have increased by 145%, with the growth rate highest in the 85 years plus group (Statistics New Zealand, 2012). Enhancing the wellbeing of older people is evident in international policy, influenced to a certain extent by the increase in life expectancy of older people and concerns about the incidence of poor mental health (World Health Organization, 2015). Importantly ill-being (such as depression and anxiety) are costly to the health system, whereas promoting wellbeing could lead to cost savings (Aked & Thompson, 2010). Older adults who are living with long term conditions, whether physical, mental or both, 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 older adults 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).

2. BACKGROUND

Increasing psychological wellbeing can have positive outcomes on health (Bartholomaeus, Van Agteren, Iasiello, Jarden & Kelly, 2018), although poor physical health may not necessarily decrease wellbeing given the influence of other factors, such as economic circumstances (Aked & Thompson, 2010). There are also factors which are protective of wellbeing, such as having meaning and purpose in life, good social relationship and strong connections (Yeung et al. 2018).

Flourishing is a widely accepted term to denote high levels of wellbeing (Hone, Jarden, Schofield, & Duncan, 2014). Studies measuring flourishing and 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). Seligman's (2011) PERMA model of wellbeing is a well-established model and 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). As such this model fits well with the life course model of ageing (Wister, et al. 2016) and has been used in previous studies on positive ageing (e.g., Bartholomaeus, Van Agteren, Iasiello, Jarden & Kelly, 2019). Central to the PERMA model of wellbeing are five domains: Positive emotion, Engagement, Relationships, Meaning, and Accomplishment. Seligman (2011) notes how an individual can take positive action within each aspect to enhance their wellbeing.

A need for research to identify strategies to enhance psychological wellbeing has been identified (Ministry of Health, 2016; Smith & Hollinger-Smith, 2015). Studies exploring how older adults perceive wellbeing, that is what wellbeing means and which aspects are important, can provide insight into the multi-dimensional nature of the concept (Douma, Steverink, Hutter & Meijering, 2015; Jarden, Sandham, Siegert, & Koziol-McLain, 2018). That older adults may respond to different interventions to enhance their wellbeing is also acknowledged (Smith & Smith, 2015). For example, a specific community-based wellbeing and resilience program for older adults found improvements in overall wellbeing, but only for the PERMA aspect of 'accomplishment' in the older adult sample (Bartholomaeus, Van Agteren, Iasiello, Jarden & Kelly, 2019). However, for the older carer group who had lower baseline levels of wellbeing, improvements were found across all five aspects of PERMA. Whilst this study adds to our understanding of the potential impact of wellbeing interventions for older adults, it also illustrates that individuals can respond differently to wellbeing interventions. That older adults have strategies that they use in their daily lives to enhance wellbeing is evident in the research on resilience (Revich & Shatte, 2002). However, there is

a lack of this type of evidence when it comes to psychological wellbeing, particularly with older adults and very much needed giving the growing older population. As such, the aim of this research was to explore community dwelling older adults' approaches to enhancing their psychological wellbeing; in effect, what are they doing and what is working well for them? In doing so we acknowledge that our focus is on psychological wellbeing informed by one prominent model of wellbeing (PERMA) and providing further exploration of such a complex topic is beyond the scope of this particular study. However, we believe that the PERMA model of wellbeing offers a unique contribution on the topic of wellbeing and older adults.

3. METHOD

This study utilised the PERMA model of wellbeing (Seligman, 2011) as an organising framework to explore the approaches older adults were using to enhance their wellbeing. A measure of wellbeing, called the PERMA Profiler, has been developed and validated to measure PERMA (Butler & Kern, 2016). The PERMA Profiler includes the five domains of: Positive emotion, Engagement, Relationships, Meaning, and Accomplishment. However, in this descriptive qualitative study we wanted to explore with older adults what they were doing or had done to enhance their wellbeing. As such, we used PERMA as a guide for data collection and to develop semi-structured interview questions. We adopted a strength-based approach informed by Appreciative Inquiry (Cooperrider & Whitney, 2005) and underpinned by social constructionism. As such, the Appreciative Inquiry (AI) approach, noted as lacking in Reed's (2010) literature search seeking papers specifically on AI and older adults, informed our approach to interviewing and focusing on what was working well.

3.1 Participant Recruitment

The study took place in a region of the North Island of New Zealand. The region is the third least-deprived in New Zealand. Life expectancy is 85.1 years overall, the highest in the country. Participants were recruited for 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 fluent English speaking and living in the community, but not living in a care home. Potential participants were excluded if they could not take part in a face-to-face interview and sign a consent form. We did not screen potential participants for any specific physical or psychological problems. 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 contacted 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 in Auckland, New Zealand.

3.2. Data collection

The semi-structured interview and focus group discussion guides were structured around the PERMA model of wellbeing (Seligman, 2011) and adapted for a face-to-face interviews. However, as interviewers (identifiers removed) we were flexible, following up on cues and letting participants tell their stories and integrating the questions as part of their narrative. 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. So we commenced the interview by asking participants for their understanding of what wellbeing and flourishing meant to them. This conversation provided a link into the interview as we asked questions from the semi-structured interview guide about positive emotions, engagement in activities, relationships, meaning in life, and achievements and accomplishments. Examples of questions included; Meaning, 'what is important for you at this time in your life?' Accomplishments, 'what are your accomplishments, or achievements in your life?' 'What are your accomplishments, achievements in your daily life?' As participants appeared to find answering the questions about accomplishments challenging, we continued to ask that question, however we started to ask about what participants saw as their 'strengths'. This change still proved a difficult question, but elicited more responses, especially when the interviewer reflected with the participant about what they had already talked about in their interview.

Interviews lasted between one and three hours in duration and were conducted either by an experienced nurse researcher or a psychologist. Both researchers attended the focus group interview. All interviews were audio recorded and transcribed by an external transcription service. The transcripts were then reviewed by either (removed identifiers) to check the accuracy of the transcripts, as well as aiding in the first phase of familiarising ourselves with the data (Braun & Clark, 2006). Demographic data were also collected including: age, gender, marital status, ethnicity, and type and number of long term conditions (mental or physical). We also asked a general question about the participant's health, "How would you describe your health?" The interviews took place from March to September 2017. The focus group interview took place after eight individual interviews providing the opportunity to explore some of the preliminary analysis.

Ethical considerations

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

3.3. Data analysis

The data were analysed with reference to the five aspects of PERMA with a focus on identifying what actions the older adults were taking to maintain or enhance their wellbeing (Steptoe, Deaton, & Stone, 2014). Further analysis involved coding the data into processes or practices, and influencing factors within each of the five aspects (Charmaz, 2014). For example, within the POSITIVE emotion aspect a participant stated; *"I find if I'm starting to feel a bit low in that sense I decide the best thing is to get a bit of exercise, go for a walk."* This practice involved exercise, and something that the participant knew worked for them with regard to their wellbeing. An influencing factor was the participant's ability to leave their home and walk safely outside. Within the Relationship aspect a participant stated; *I can't bear being with people who really just want to talk about their own problems."* Such a statement was coded as a practice that involved the participant being selective about who they had relationships with. An influencing factor was the participant's ability to have choice about their relationships and that, for some people, this level of choice may not be possible.

3.4. Rigour

In line with established practice for qualitative research (Tong, Sainsbury & Craig, 2007), frequent meetings took place between (identifiers removed) to review transcripts, compare codes and resolve any discrepancies by consensus. With the exception of the Focus Group, the participants were sent a copy of the transcript and asked to provide feedback on accuracy and any further insights or questions they had. All transcripts were returned with some minor modifications. After the first five interviews had been completed, we presented our preliminary analysis of this data at the end of subsequent interviews, giving participants the further opportunity of discussing the emerging findings.

Once all the data were analysed we sent a copy of the findings to participants and also arranged a group meeting to discuss the findings with all those participants who could attend ($n = 22$). This meeting gave us the opportunity to seek further feedback, clarify issues, and elicit thoughts on further research. None of the findings were altered based on the discussions at the meeting, however the participants suggested that the findings should be presented at local council boards and at policy level.

4. FINDINGS

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 ($n = 37$; Table 1). Age range 66-99, mean age 79.7 years. Of the twenty women, age range 66-92, mean age 76.7 years and the 17 men, age range 72-99, mean age 83.7 years. Eleven women, all widows with a mean age 81.0 years (77-87), participated in the focus group. Some of our participants did not refer to or disclose specific conditions or medical diagnoses, but spoke about having previous surgery, knee and hip problems, balance issues and having had frequent falls which were attributed to ageing. The latter 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.

Our findings reflect the cognitive and behavioural practices that participants were using 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. Despite using Appreciative Inquiry to focus on the positive aspects and the domains within PERMA, neither we nor our participants were ignoring or discounting the current difficulties some of our participants were experiencing in their lives and we identified the future challenges to wellbeing based on potential changes in physical, social or economic circumstances.

4.1 Positivity

Positive emotion in PERMA refers to general tendencies toward positive feelings, such as contentment and joy (Seligman, 2011). Not all our participants viewed themselves as experiencing positive emotion all of the time; the reality of their lives meant experiencing negative emotion, such as 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 that depression or anxiety 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.

Participants held the view that being positive was important to them and to be otherwise was not helpful. As the following participant illustrates:

I think if you don't have a positive attitude, I mean, you're in trouble, (M.85. M)

Being positive was a constant theme in the focus group. All of these women had lost their partners and whilst acknowledging this loss, they spoke about getting on with their lives and focusing on the positive, despite this at times being difficult. As the following focus group participant shared:

Well, I'm a positive, what I would call a positive thinker, and I have had ups and downs in my life, but I still say I'm luck, I'm still here, and a lot of people including my husband, who, they're not here. (FG.F.82)

Participants had ways of regulating negative emotion, such as thinking about something positive they were looking forward to, or distracting themselves by completing an activity, as the following participants illustrate:

I like to watch and read and do things that are positive. I focus on those and not on negatives. (F.85. W)

Well I try not to let myself get down, but if I do get down then that's when it came up with my spending, because that's how I cheer myself up, I go shopping. (F.80. W)

Being positive was not always an easy process and took effort which was reflected in the language participants used. 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 now. Be positive. Well I tend to look over the fence. (M. 71. M)

Sitting with her husband during his interview John's wife, who was his caregiver, encouraged him to talk about his upcoming 100th birthday and the positive celebrations that were being planned with him and his family. (Wife of M.99)

As deduced from the above, participants acknowledged how they were feeling, e.g. anger or depression, and then took action, reflected in their intention to change their feelings and mood. Participants in the focus group, and 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 low.

However, there was the acknowledgment that this was not necessarily a positive strategy for them but they viewed it as a protective factor for their family and not wanting to burden family members.

4.2 Engagement

Engagement refers to being absorbed, interested and involved (Seligman, 2011). Participants viewed control, choice and autonomy as critical to engagement in activities, whether this involved being with other people or having time by themselves. 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. There was the acknowledgement of friends who were now cognitively impaired as the following illustrates:

I've got three friends with dementia in rest homes at the moment. I think, I've got to keep this brain going (FG. 80. F)

Participants were 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 things like that, it's a few fancy steps put into it to, and that keeps the mind active. (M. 87.W)

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

The influence of external factors on participants' ability to engage in activities was evident through their accounts. For example, provision of a specific swimming class for people with multiple sclerosis was found valuable by one of our participants as her comment illustrates, however, attendance was dependent on her husband being able to drive her to the facility which was 30 km away and involved a drive across the city:

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. (F. 75. M)

4.3. Relationships

Relationships refers to being socially connected, feeling supported and cared about and experiencing satisfaction from those connections (Seligman, 2011). 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, where travel was a problem or the facilities were too depressing to visit. Loss of children was spoken about by two of our participants and the impact on relationships is evident in the following:

I had two daughters and one died last year, so that was very sad for me. We all had a great relationship. It is hard, it's one of the hardest things in life to lose a child. (F.79. D).

Relationships with people were initiated and maintained through engagement in activities with others, including younger people. Again this also meant how choice was a factor in determining whether the person had contact or not with other people, as the following participant illustrates:

I like company, but then I like to have me time – Do what I want, when I want it. (FG. 84. W)

Preventing loneliness and isolation was considered important for all our participants who recognised the risk of the negative consequences 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:

I had to search for the information and I rang the Citizen Advice Bureau and then I saw it in the Newspaper. (FG. 82. W)

Some groups were relinquished if they no longer had any meaning or the norms established within a group 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. (M. 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 adult's lives and engagement, whether being with others in a group, or maintaining a one-to-one relationship with a friend were positive influencing factors.

4.4 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. The following illustrates how one participant was involved practically in helping others and how the other participant valued helping others:

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

If you can help someone, even in a miniscule way (F.82. D)

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 as the following illustrates:

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

4.5. 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 types of roles 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. (M. 84. W)

As stated previously we started to ask participants about their strengths. This question usually came much later in the interview so it was relatively easy for the interviewer to reflect on the conversation so far. Strengths reflected values, such as a concern for people and persistence as the following participants indicate:

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

I keep on doing something, and I'll keep on doing it until I've done it, until I've got it right. (M.90. M)

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.

4.6 Influencing factors

A number of influencing factors, including social, environmental and health, were identified that could impact on participants' wellbeing. In particular, 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. (M.85. 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 if the participant had been contributing in their 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 toand 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. (M.90. M).

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. (M.95. W).

Deterioration in health was becoming more pronounced for two of our participants and was severely impacting on what they wanted to achieve. Both of these participants were living with their wives who were their main carers.

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

Despite this, the participant was working hard on preparing for a speech for his 100th birthday celebrations with his family.

Economic circumstances were referred to by some participants, indicating that for now their financial situation enabled them to live their lives fully, however, that there may be future financial challenges that could impact on their lives was acknowledged as the following indicates:

If I didn't earn the money I don't quite know what I'd do. It's important to me to have enough money to survive. (F.75 W)

In summary, social, environmental and health were all influencing factors that impacted on psychological wellbeing and will now be considered further in the discussion.

5. 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 study we were able to engage older adults in exploring their psychological wellbeing, using Seligman's PERMA model of wellbeing as an organising framework, and articulating how the model and domains influenced this qualitative study (Bradbury-Jones, Taylor, & Huber, 2014). We found that participants had ways of thinking positively and engaging in activities that were important and meaningful to them, and that they undertook practices to enhance their wellbeing. Some participants found thinking positively and engaging in activities more challenging, particularly those with reduced mobility and deteriorating health. Previous research on wellbeing has found an inverse trend in wellbeing when a person has reported poor health due to the number of long-term or chronic health conditions (Mackay, 2015), however the age limit for participants in that study was 74 years. The age of our participants ranged from 66 – 99 years offering the perspective of a greater range of older adults. Importantly, wellbeing is a dynamic concept reflecting a continuum from high levels of wellbeing often referred to as flourishing, to lower levels of wellbeing often referred to as languishing. As one participant shared with (identifier removed) at a follow up visit, "*I am not flourishing as much today ...*" Maintaining physical or mental health or preventing further deterioration in health was important and participants engaged in, or attempted to engage in, activities that can and do influence their physical and mental health, such as exercise including physical and mental exercises (Ghosh & Deb, 2017; Steptoe, Deaton, & Stone, 2015).

This research has identified that experiencing positive emotions was fundamental to wellbeing, as was 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. Participants had ways of knowing what worked for them. 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-Fernandez & Ortega-Martinez, 2018). A systematic review of eight studies found that reminiscence interventions were the most prevalent, and less common 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. Support maybe required to achieve a shift in thinking by savouring some positive event or accomplishment in the older person's lives, or being supported to engage in an activity that is meaningful to them. In our research we identified how the wives in roles as caregivers also attempted to do this with their husbands. Working with caregivers may also be an area for further research, including the strategies they can use in supporting partners who may be at risk of low wellbeing. However, we acknowledge that the strategies that are advocated have a strong evidence base. We are not about promoting a populist positive thinking approach, as there can be a dark side to focusing on positive emotion (Gruber & Moskowitz, 2014). Our participants also recognised that some of the strategies they use, such as, 'presenting a brave face' to protect others, can be maladaptive and not beneficial (Gruber & Moskowitz, 2014).

Previous research (Scheibe & Carstensen, 2010) has identified emotional regulation as a strategy that older adults use to create a positivity effect, selecting their environments and using cognitive strategies. Certainly within our study environmental factors were an influencing factor, such as being able to access facilities and resources. 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. Acknowledging that person-activity fit has implications for health professionals and in this context nurses,

particularly gerontology nurses who have a key role in assessing older adults and supporting them to access resources that are a 'fit for them' and resources that are not imposed. Currently resources and choices maybe limited in some health systems, however internationally there is a shift in policy and directives identifying the need to prioritise physical and emotional wellbeing, especially for those older adults with multiple conditions (Parker, et al, 2019).

Indeed, having the ability and autonomy to choose and access activities, whether collective or self-orientated is 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; Quidbach, 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). Changes in mobility and environmental factors can reduce or limit the contributions that the older person can make. We found that there are environmental factors that can limit or enhance the older person's choices that impacts on their 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 recognised (Goins, et. al., 2015).

The loss of partners, friends and their associated networks can lead to social isolation and loneliness which can increase mortality (Holt-Lunstad, Smith, & Layton, 2010). The risk of loneliness as an older person was a risk identified by all our participants. They made use of

other networks, such as a widow/widower group, but not all our participants were wanting to engage in activities with other groups. Our findings are consistent with Lyubomirsky et al. (2013) person-activity fit model, illustrating autonomy, control and motivation. We need to keep in mind that environmental and economic circumstances have a critical part to play and it is not all attributable to the individual. Integrating wellbeing to design public policy is proposed (Adler & Seligman, 2016; Jarden, Jarden, & Oades, 2017), and ways of achieving this require more thought and discussion. Nurses are well placed to contribute to this public policy debate, and gerontology nurses acknowledged as strong advocates for improving services and developing innovative approaches with and for older adults (King, et al, 2018).

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 aging with negativity (Roy & Giddings, 2012). The conversations that we had with our participants provided an in-depth insight into how the language of wellbeing and flourishing is not something that older adults were aware of, or had considered previously. This has implications for how we can engage older adults in these conversations in such a way that they are active participants in co-designing the approaches and creating evidence based messages about wellbeing, which also has implications for policy makers. As we have identified in this study older adults have many strategies or practices that they are already using.

Using PERMA as an organising framework 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) and fits with the five ways of wellbeing (Aked & Young, 2010).

6. LIMITATIONS

The ethnicity of our participants was largely New Zealand European and all were English speaking. 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. However, this latter sample of older adults ($n = 3$) was small and we acknowledge the need for further research with older adults who may be frail and also to collaborate with other cultures to explore the research questions in this study. This is particularly important in a country like New Zealand where Māori are the indigenous population and have culturally specific understandings of wellbeing (e.g., Durie's wellbeing model, 1985). Our qualitative study was based on Seligman's (2011) model of wellbeing, and as a psychological model it does focus on individual processes. However we identified the limitations of this by

identifying the social, economic and environmental factors that influence wellbeing. Other wellbeing models, such as Diener (2006) may have provided different results. Our decision to use PERMA was informed by research using PERMA in community programs for older adults at the Wellbeing and Resilience Centre in South Australia (Bartholomaeus, et al 2018). Noting that our exploration was qualitative rather than quantitative, and making our theoretical stance when using theory in qualitative work visible (Bradbury-Jones, Taylor, & Herber 2014).

7. CONCLUSION

This study has contributed to understanding how older adults are enhancing their wellbeing using Seligman's PERMA model of wellbeing. However, despite Seligman's view that an individual can take positive action within each of the domains of PERMA, we identified that risks to wellbeing can arise from contextual factors, such as environmental and financial, that may limit the positive actions that older adults would want to, or are able to, take. Creating more conversations with older adults about wellbeing and partnering with them to develop wellbeing practices that are meaningful for themselves is required and gerontology nurses are well placed to start such conversations. These findings offer 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

Code	Gender	Age	Marital status	Long term conditions
1	F	66	Married	1
2	F	67	Single	3
3	M	71	Married	3
4	F	72	Married	0
5	F	72	Widow	3
6	M	72	Married	3
7	F	73	Divorced	3
8	F	73	Widow	1
9	F	74	Divorced	3
10	F	75	Married	2
11	F	75	Widow	3
12	M	75	Married	0
13	M	75	Married	2
14	F	76	Divorced	4
15	F	77	Widow	3
16	F	77	Married	1
17	F	77	Widow	1
18	F	77	Widow	2
19	M	78	Divorced	3
20	F	79	Widow	1
21	F	79	Widow	2
22	F	79	Divorced	1
23	M	79	Married	3
24	M	81	Married	3
25	F	82	Divorced	2
26	M	84	Widower	4
27	F	84	Widow	0
28	M	85	Married	2
29	M	85	Married	2
30	F	85	Widow	3
31	M	87	Widow	2
32	M	89	Married	3
33	M	90	Married	3
34	F	92	Divorced	3
35	M	94	Widower	3
36	M	95	Widower	3
37	M	99	Married	3

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