Salutogenesis 2.0:
An examination of healthy ageing-in-place using a qualitative
application of the Sense of Coherence.

Sandra Walsh

Supervisor: Dr. Ronan Foley

Thesis submitted for the Degree of Ph.D.

Faculty of Social Sciences

Department of Geography

National University of Ireland, Maynooth

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Abstract

The aim of this thesis was to examine the theory of salutogenesis (Antonovsky, 1987; 1996), within the context of later life, and to consider the value of salutogenesis as an analytical perspective applicable to understanding older people's health and wellbeing as they age-in-place. This was done by applying the theory's analytical construct, the Sense of Coherence (SOC), qualitatively and using its three components comprehensibility, manageability and meaningfulness, to make sense of data gathered from life review interviews. These interviews were conducted with a sample of 'healthy' and active older people, aged 75 years and older, living independently in the East and South-East of Ireland. The results and analysis presented demonstrate the potential value of the qualitative application of the SOC, and additionally suggest that qualitative methods are underutilised in salutogenic research. Furthermore, using qualitative approaches to explore the SOC provides additional scope to incorporate context and place as central positions of analysis, thereby opening up the theory of salutogenesis more fully to health geographers. The results of this research contribute to the geographies of health and ageing literature by providing a detailed exploration of the theory of salutogenesis as a framework that can contribute to the geographer's understanding of the health-place relationship. The thesis also contributes to the salutogenic literature by examining the SOC through the lens of relational geographies of health and ageing. What emerges is a complementary dialogue and flow of ideas between diverse perspectives on health and wellbeing in later life.

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Chapter 1

Introduction

The aim of this thesis is to examine the theory of salutogenesis (Antonovsky, 1987; 1996), within the context of later life, and to consider the value of salutogenesis as an analytical perspective applicable to understanding older people's health and wellbeing as they age-in-place. Salutogenic theory requires the researcher to consider health and wellbeing as an outcome of the individual's interaction with their environment, for the older person ageing-in-place this is significant. The salutogenic question asks what creates health, as opposed to what causes illness (Antonovsky, 1987; 1996). In answering this important, but complex question, both the researcher and audience are required to consider health in its broadest definitional sense; that is to look beyond the physiological expressions of health and illness to consider mental, social and spiritual health as equally important dimensions.

To address the salutogenic question this thesis has adopted a trans-disciplinary approach. While the central objective is to inform health geography, and in particular develop understandings of the health-place relationship specific to the older person, much of the theoretical material used escapes disciplinary boundaries, to re-draw knowledge instead into thematic boundaries. In doing so the result is a 'hybrid knowledge that combines features and themes that are not usually assembled on the same epistemological plane' (Stenner and Taylor, 2008: 431). This trans-disciplinary approach is necessary in research fields such as health and ageing studies because when the wealth of knowledge from across a range of disciplines is brought together it provides a rich foundation from which to develop a thesis. The disciplines of Geography, Sociology, Public Health, Health Promotion, Gerontology, Psychology, Psychiatry, Biology, Medicine, and Philosophy have all informed this research. The attraction to other disciplines demonstrated in this body of work is in keeping with recent traditions in Geography of demonstrating theoretical porosity, extroversion, or even magpie behaviour, in terms of its attraction and openness to embracing theories and methodologies from elsewhere (Kearns and Moon, 2002).

Like most research projects, the development of this one was not linear, but rather it took several twists and turns. The original research questions for the project were concerned with the role of the community and voluntary (C&V) sector in supporting an ageing population, in particular the role of this sector in supporting older people to age-in-place healthily. But it was established that before the role of this sector could be examined, more

fundamental questions needed to be answered. By way of introducing this thesis and its objectives the original motivations for conducting this research are outlined in this chapter.

Motivation 1: Healthy ageing-in-place

In recent decades there has been much discussion within Ireland, and indeed elsewhere, on the emerging role of the C&V sector in supporting an increasingly challenged welfare system (Department of Health and Children, 2001; Department of Health, 1994; Department of the Taoiseach, 2006; Department of Health, 2013a; Department of Health, 2013b). Since the 1990's there has been a push by the Irish Government to modernise the legal and policy framework of the C&V sector in Ireland, and to set about establishing a more formal relationship with it (Acheson and Harvey, 2008). The publication of the *White Paper on a Framework for Supporting Voluntary Activity and for Developing the Relationship between the State and the Community and Voluntary Sector* in 2000, marked the movement towards enhancing the working relationship between the C&V sector and the government to ensure that the sector's resources can be used effectively in meeting the needs of the State. Developing this relationship involved including the sector more formally in the democratic process and giving them a political voice. This required recognising the contribution made by the C&V sector to Irish society. The White Paper was also concerned with putting in place a formal relationship between the State and the C&V sector and to address issues such as accountability and compliance in partnership working. For a critical perspective on the activities of the C&V sector and their role in supporting the welfare system, the relevant health geography literature on the voluntary turn in the health and social sciences was consulted, such as for example Skinner and Power (2011), Fyfe and Milligan (2003), Milligan (2007), Kearns (1998) and Wolch (2006). Supplementary readings from the public health and health promotion research literature that looked at the role of the C&V sector in supporting health development also influenced the direction of this research immensely. In particular the literature on asset-based approaches to community health development (Morgan and Ziglio, 2007; Hancock, 2007; Kickbusch, 2007) provided an initial introduction to salutogenic thinking, while the influence of Paulo Freire's emancipatory thinking on qualitative research methodologies and the importance of dialogue at the grassroots level to inform decision making (Ledwith, 2010), also informed the early stages of the research design.

Parallel to policy and disciplinary discourses on the C&V sector's role in society, there was, and still is, a lot of discussion about supporting older people to age-in-place, and the promotion of healthy ageing (*Care of the Aged Report*, 1968; *The Years Ahead – A Policy for the Elderly*, 1988; *Adding Years to Life and Life to Years: A Health Promotion Strategy for Older People*, 1998; *Care for Older People*, 2006; *National Positive Ageing Strategy*, 2013). 'Ageing-in-place' discussions quite often focus on the deficits of the older person, their needs, their inabilities, and dependence, and thus the older person in the community is often framed as problematic (Pierce, 2008). In asking how older people can be supported to remain living in their community, the focus is usually on providing functional support to those that need it, a worthwhile goal of course, but one that only provides a partial, pathogenically orientated, picture. The pathogenic orientation fails to look beyond the problems to consider what already exists at the individual and community level that can be enhanced to support people to age-in-place. To develop further our understandings of ageing-in-place it is worthwhile to introduce the salutogenic orientation by asking what moves older people towards health? In trying to answer the salutogenic question, in the context of ageing-in-place, health is defined in its broadest holistic sense, and requires the researcher to look beyond objective measures of older people's physical and mental health and decline, to incorporate questions on the subjective nature of ageing, and to consider health as something that is grounded in the social and spiritual life of the older person. It is about asking what gives life its value. For example the arthritic and diabetic 80-year-old man might have a busy social life with close friends and confidants, as well as a rich spiritual life, all of which supports his mental health. The pathogenic orientation would focus here on the man's illnesses, the salutogenic orientation would however acknowledge the need to palliate the symptoms of chronic ill health while at the same time promote and enhance the other health domains.

This idea of looking beyond physical health to promote wellbeing more broadly is not a new idea. Indeed it has been an objective of health promotion policy and healthy ageing policies for quite some time. For example the most recent strategy in Ireland on ageing and health, *The National Positive Ageing Strategy* (Department of Health, 2013b) identifies having purpose in life, and living a life of value to the older person, as key factors in determining health and wellbeing. This marks a shift in policy discourse from a dominant political economy perspective on ageing that emphasises the role of socio-economic structures in determining the experience of ageing. The problem with focusing too much on

the socio-economic structures in policies on older people is that this perspective does not fully recognise the role of agency in shaping the life worlds of older people (Blaikie, 1999; Katz, 1996; Hazan, 1994). Accounting for the subjective nature of ageing is recognised as a key challenge for policy makers (O'Loughlin, 2005).

The contribution made by the salutogenic orientation lies in the analytical potential of its related construct, the Sense of Coherence (SOC). The SOC refers to how an individual sees their world and their place in it, how they negotiate the environments of their daily life by giving meaning to their life world, and how the individual is motivated to draw on the internal and external resources that are available to them to make life manageable and goals attainable (Antonovsky, 1987; 1996). Salutogenic theory attempts to explain how and why a range of resources, some of which are provided by the C&V sector and are identified as 'community assets' (Morgan and Ziglio, 2007), can enhance health and wellbeing, and this explanation is to be found using the components of the SOC. The SOC is put forward as a health promoting resource that strengthens resilience (Eriksson and Lindstrom, 2006).

Of significance to the health geographer interested in healthy ageing-in-place the SOC is chiefly concerned with the relationship between the individual's internal environment and the external environment in which they are located physically, socially, culturally, economically, politically, and mentally. As an analytical concept it focuses on the relational intersection, or the space where emotions are generated (Hubbard, 2005). The external environment is recognised in this thesis, and within the policy context, as a setting that can potentially be enhanced by wider structures, such as the activities of the C&V sector. The C&V sector is considered not as a service provider working in partnership with the welfare state, but rather as a key agent with access to, and the ability to enhance the health promoting assets of a community (Morgan and Ziglio, 2007). An objective of this research is to use the salutogenic orientation, and the analytical construct of the SOC, to expand understanding of the person-place-health triangulation by looking at the lived experience of the older person as they age-in-place. In doing so the theoretical basis of geographical gerontology is supplemented and current theoretical perspectives on the health-place relationship are extended using the SOC as a tool to explain how the individual's relationship with place writes and re-writes itself onto the body, and subsequently dictates health and wellbeing. By applying the salutogenic orientation and the SOC in examining the health-place relationship, a new angle is presented to inform the literature on the voluntary turn.

So what about the voluntary sector, why is that significant here? Salutogenic theory was put forward by Antonovsky (1996) as a theory to guide health promotion, and the community and voluntary sector is currently recognised at the national and international level as key agents in creating supportive environments for health and wellbeing at the local level. This posits that supportive environments for health are environments where people live, work and play, and that provide access to resources for health, and opportunities for empowerment (Nutbeam, 1986). Antonovsky (1996) argued that health promotion was at risk of stagnation because it was too focused on <u>downstream</u> interventions i.e. curing those already ill, and intervening where people were already at considerable risk. This was according to him too late, because such approaches were not about promoting health but actually about preventing health getting any worse. He argued that to promote health the focus should be <u>upstream</u>, asking what creates health, or to draw on wellbeing theory, asking what makes a good life. This requires looking at the fundamental aspects of human nature that prevent people from a downward spiral of ill health, and Antonvosky (1987) identified the three components of the SOC that are key to maintaining or promoting health. These components are discussed in detail in Chapter Three.

Brief overview of Salutogenesis and the Sense of Coherence

The salutogenic orientation explores the factors that promote health and wellbeing, rather than those that cause illness. Salutogenic theory was first introduced by Aaron Antonovsky (1979) to explain people's ability to cope during adversity, by drawing on their internal and external resources to maintain their health and wellbeing. He later proposed that salutogenic theory could inform health promotion policy and practice, and would provide a valuable perspective that complements the pathogenic orientation's focus on the causes of ill health.

The process of salutogenesis i.e. the movement of people towards positive health and away from ill health can be understood using the Sense of Coherence (SOC).

The analytical construct, the Sense of Coherence, is used to explain people's ability to cope. It refers to an individual's enduring and dynamic feeling of confidence that:
(1) Any stressor presented to them, whether derived from their internal or external environment, is 'structured, predictable and explicable' (comprehensive).
(2) The necessary resources are available and can be accessed from within themselves, or from their external environment (manageable).
(3) Any challenges that arise are worthy of investment and engagement, and make sense on an emotional level (meaningful) (Antonovsky, 1987: 19).

According to salutogenic theory people move towards ill health when the Sense of Coherence is undermined. The Sense of Coherence is undermined when the world is experienced as a chaotic, unpredictable and overwhelming place. It is undermined when the necessary resources are not available to overcome adversity. The Sense of Coherence is also undermined when the individual cannot find meaning in the challenges that they are confronted with, and are thus not compelled to act.

The three SOC components, comprehensibility, manageability and meaningfulness, are not mutually exclusive, but are interdependent. The formation of the components depends on a 'solid capacity to judge reality' (Antonovsky, 1987: 17). The SOC components thus require the individual to position themselves relationally in space and time.

The formation of the Sense of Coherence according to Antonovsky (1987) occur within the bounded crucial spheres of life, identified as 'one's inner feelings, one's immediate interpersonal relations, one's major activity and existential issues'. What goes on inside these boundaries determines the strength of the SOC (Antonovsky, 1987: 23).

Box 1.1. Brief overview of salutogenesis and the Sense of Coherence

Within the pathogenic orientation the contribution made by the C&V sector to community health is predominantly one of intervention, care and palliation of those already sick, or at risk. Alternatively the role of the C&V sector within the salutogenic orientation is to buffer people against adversity by providing them with the necessary resources to cope, but also to create a vibrant, rich and fulfilling environment in which people thrive mentally, socially, emotionally and spiritually, as well as physically. This can be achieved by harnessing the resources or assets of the community that are most accessible through the C&V sector. It is the individuals interaction with such environments that shapes their SOC, and from this their health and wellbeing (Antonovsky, 1987). One of the problems, however, is that we need a deeper understanding of what the SOC looks like qualitatively, in the experiential sense, before the theory of salutogenesis can be used to guide health promotion as an operational concept. As a result before the C&V sector can be examined through the lens of the SOC, as a concept that can be applied in a practical sense, (the initial objective of this research) a more concrete understanding of the SOC components as something that is experienced and lived is needed before it can be located in practice. An objective of this research is to qualitatively examine the SOC among older people who are ageing-in-place, and unpack Antonovsky's theory to inform the practice of the C&V sector involved in supporting older people to age-in-place, and to provide an additional perspective to ageing policy design.

While the original motivation of the research was to contribute to the growing body of literature on the C&V sector in health geography, the direction it has taken and its subsequent outputs can still potentially inform asset-based community development, an important area of C&V sector activity. It can also potentially inform those health and ageing policies looking to establish upstream strategies that promote health and wellbeing in later life.

Motivation 2: Mind over matter: mental health and the chronic disease burden
The second motivation for looking at the causes of health derives from an interest in the role of social, psychological and behavioural factors in shaping health and illness. The SOC is used to determine an individual's ability to cope when faced with adversity. The individual with a high SOC is said to cope better when faced with adversity than the individual with a low SOC. This is because the person with a high Sense of Coherence does not regard their environment as threatening or debilitating, and supposedly uses the resources available to

them to maintain or promote their health and wellbeing, and to surmount the challenges they face (Antonovsky, 1987). Stress, depression and anxiety disorders are identified as leading causes of ill health, whether directly through their physiological impact on the cardiovascular system, or indirectly by shaping people's relationship with food and alcohol, or drug abuse. Having a high SOC is negatively correlated with depression and anxiety (Haukkala *et al.,* 2013; Schnyder *et al.,* 2000). This is significant because the World Health Organisation identifies mental illness as directly or indirectly influencing six of the ten main causes of chronic disease and according to population health projections it is expected that incidences of chronic diseases will increase by approximately 40% in the coming decades (Balanda *et al.,* 2010). Much of the research conducted on the association between the SOC and chronic illness has found a relationship between a high SOC and reduced risk of ill health. For example some studies on the SOC and chronic conditions have found that having a high SOC is associated with a reduced risk of stroke (Surtees *et al.,* 2007), cancer (Poppius *et al.,* 2006) and diabetes (Kouvonan *et al.,* 2008). Given these findings it would seem worthwhile to consider the SOC as a predictor of illness and as a focal point for health promotion policy and practice. However before this can be done the SOC and its components require further interrogation and expansion.

While chronic illness affects people across the life course, the greatest concentration is found among older people. For this reason any research that is concerned with the ageing process or healthy ageing, will need to consider the wider context of morbidity and mortality, and the processes that underpin trends in population health (Bowling, 2007). Ageing is a process of continuity, unfolding as a continuum of life events and experiences (Atchley, 1999), and so the individual's biography is a vital part of their health outcomes in later life (Ben-Shlomo and Kuh, 2002).

But the question arises, how do we account for these experiences and their impact on health and wellbeing, and make sense of health outcomes? Salutogenic theory and the Sense of Coherence provide a useful framework for recognising health and wellbeing as an ongoing process of health gains and decline, where experiences of place and context become embodied (Morgan and Ziglio, 2007). This embodiment is the individual's phenomenological response to their environment, because the individual's SOC is believed to be the result of an accumulation of life experiences that determines how the individual sees the world and their place in it, and this greatly impacts on their mental health and subsequently physical health (Lindstrom and Eriksson, 2010). According to salutogenic

theory the SOC increases across the life course (Antonovsky, 1987), and is found to be stronger among older people than younger people (Nillson *et al.,* 2010).

The SOC provides a valuable tool to explore health and its processes, while its emphasis on place, setting and lifeworld means that it is a promising analytical lens for the health geographer. The SOC as a quantitative measure does not provide sufficient scope for understanding the relationship between health, wellbeing, and place, but when its components are explored qualitatively relational processes emerge more clearly. Consequently, a key objective of this research is to apply the SOC qualitatively by taking its three components and applying these to an analysis of life review interviews conducted with a sample of older people aged over 75 years, who are ageing-in-place, and are active, independent, and in good health. Taking these results and analysis, together with research conducted in other fields such as epidemiology, gerontology and public health a body of evidence emerges that suggests the potential contribution the SOC could make in explaining health in later life holistically.

Another objective of the research is to situate the SOC theoretically within a relational geography of age perspective. This involves taking a range of disparate literature on health and its influences and bringing it together using the salutogenic theory and the SOC as a macro theoretical framing to make sense of health as a holistic concept. What emerges is a discussion on the extent to which the individual's cognitive processes and their relational perception of themselves influence their health and wellbeing. Because the SOC is strongly indicative of mental and physical health, the connection between the two is teased out throughout the thesis. Questions are also raised about who is responsible for wellbeing, rather than health, especially given the strongly subjective nature of wellbeing. The relational geographies of age perspective is discussed in detail and with reference to the empirical material in the results chapters.

Motivation 3: Wellbeing, resilience, and quality of life

Public health during the 20th century was driven by advancements in medicine and technology, sanitary reforms and the eradication of infectious diseases. Public health throughout the developed world during the 21st century will be concerned with the influences of the social and political context on wellbeing and quality of life, in particular questions of social investment and sustainability (Kickbusch, 2012). This shift in focus is a result of the progress made leading up to the epidemiological transition in eradicating

infectious diseases as the major cause of death and the emergence of degenerative diseases. The emergence of degenerative diseases has also intensified problems of health inequality in the developed world, where we see pronounced differences in life expectancy depending on socio-economic status (Marmot, 2005; 2013).

Wellbeing has become one of the main conceptual priorities within the health research community in recent year. It is the basis of the WHO's definition of health, and subsequently has attracted a lot of attention from policymakers, who appear to be gradually introducing the notion of wellbeing to replace welfare on the policy agenda. The conceptual shift from welfare to wellbeing replaces an economic focus on outcomes to a process of developing a 'fully rounded humanity' (Gough, McGregor and Camfield, 2007: 3). This application of wellbeing in social and public policies requires that the types of relationships and contexts that contribute to wellbeing are provided for in policy directives. It also requires policy to look at the positive aspects of humanity and develop these to promote ontological security rather than meeting traditional, narrowly defined and often basic needs (Taylor, 2011). The inclusion of wellbeing in policy discourses requires policymakers to consider 'social value' such as personal relationships, and the importance of trust and participation, as opposed to economic values of consumption (Jordan, 2008).

Despite the apparent societal relevance of wellbeing it remains an elusive idea that is difficult to define and difficult to measure. Nevertheless, the matching relationships observed between wellbeing and quality of life and physical health indicators, and measurements of the SOC for the same indicators suggest that the SOC might provide some additional insight on how the concept of wellbeing can be refined. To establish the link between wellbeing, as a conceptual idea, and the SOC it needs to be made clearer what exactly is being measured and why these components are significant to health. For the health geographer interested in the concept of wellbeing, and its relationship with place (Fleuret and Atkinson, 2007; MacKian, 2009) the SOC does provide a valuable analytical contribution. Wellbeing, like the SOC, is subjective in nature. In applying the SOC and its components qualitatively to analyse ageing-in-place it is possible to utilise it to examine the key aspects of daily life that contribute to wellbeing.

A focus on wellbeing, and a move away from welfare, might distract from the need to provide populations with basic material conditions. It also reinforces notions of self-help and individual responsibility (Edwards and Imrie, 2008). The notion of resilience is used in policy discourses to denote wellbeing (Friedli, 2009). Resilience is about advocating coping

mechanisms among the marginalised and deprived so that they can do their best in an adverse context (Schoon and Bynner, 2003), through a 'process of harnessing biological, psychosocial, structural and cultural resources to sustain wellbeing' (Panter-Brick and Leckman, 2013: 333). However, political agendas that push for building community resilience risk making societal problems about the failure of the citizenry rather than the structural inequalities that result from an unequal distribution of power. This requires us to question at what point interventions should be made at the societal scale rather than the individual scale, and vice versa (Canavan, 2008). While there is certainly some real value in promoting the wellbeing and resilience of individuals and communities it requires parallel shifts to redistribute power, wealth and access to resources, and attention to the impacts of national economic policies (Seccomb, 2002). A policy focus on building resilience must not be to the detriment of social progress and the achievement of a just and equal society. Interventions to promote resilience must also be sensitive to cultural differences and the social environment if they are to have a meaningful impact (Ungar, Ghazinour and Richter, 2013).

A tendency to look to the individual as a key agent in shaping their health and wellbeing is also present in the application of the salutogenic orientation to asset-based community development. Without a balanced focus that takes into account the problems and needs of a community together with their skills, assets and capacity, progress in developing disadvantaged communities might be stunted. Indeed a central critique of salutogenic theory put forward in this thesis is that Antonovsky appears to be a proponent of the stoic philosophical viewpoint whereby the conditions are not regarded as the problem, but rather the attitude of the individual about their conditions. It was his intention that salutogenic theory could inform the theoretical basis of health promotion, much of which is currently applied to policies on promoting wellbeing. The stoicism present in his original work is, however, contradictory to that of the views on promoting health proposed in the *Ottawa Charter* (WHO, 1986). In order to remedy this the application of salutogenic theory and the SOC in policy and practice must operate within a framework of empowerment. The SOC as outlined by Antonovsky does not incorporate the language of inequality or empowerment, perhaps because the social determinant of health model (Dahlgren and Whitehead, 1991) was not yet developed when Antonovsky (1979; 1987) was formulating his ideas. Yet in applying salutogenic theory using the asset-based model of community health development and promotion there is scope to address this shortcoming. Despite this the SOC is based on

an individualised notion of resilience and coping, and does require some development to take into account the more recent discourses of inequality. This thesis will pick apart Antonovsky's ideas to determine their compatibility with health promotion as a task grounded in collectivism as opposed to individualism. In doing so the application of salutogenic theory to health promotion practice and policy is re-evaluated.

Summary of thesis aim and objectives

The aim of this thesis is to examine the theory of salutogenesis as a framework that can contribute to the Geographer's understanding of the health-place relationship, specifically relating to older people as they age-in-place.

The objectives of this research are:

1. To use data from life review interviews to produce a qualitative description of the Sense of Coherence components;

2. To explore these components using a relational geographical framework, with an emphasis on the role of place in shaping these components.

3. And through a close reading of salutogenic theory, consider the value of salutogenic theory in developing a more nuanced evidence base for policy on ageing-in-place.

Thesis Structure

This thesis is divided into 10 chapters. The first chapter has provided a brief introduction of the topics that are addressed in the thesis, and it has indicated the aim and objectives of the research. Chapter Two presents Ireland's demographic and epidemiological context. This sets the scene for a consideration of policies on ageing and health. Chapter Three presents the models of health and ageing that have influenced policy, practice and research methodology thus shaping understandings of what health is, and what it means to age healthily.

Chapter Four provides a detailed overview of salutogenic theory, the components of the SOC, and its relevance to health geography, while chapter five in turn presents a critique of salutogenic theory and the SOC.

Chapter Six describes the methodology and methods employed in carrying out this research. It provides a discussion on the reasons why a qualitative method, specifically the life review, was employed in this research. It also presents a critical reflection on the

challenges of using the method, and experiences of the fieldwork using extracts from the reflective diary.

Chapter Seven is the first of the empirical chapters. It presents detailed extracts from the life review interviews and examines the data using the relational geographies of age framework, eudaimonic wellbeing, motivation and continuity theory, and situates the discussion within the salutogenic framework. Chapter Eight presents empirical data on friendships and close personal relationships in later life, and explores their relevance for health and wellbeing using the SOC, and the concept of belonging. Chapter Nine presents empirical data on the role of spirituality in promoting older people's health, specifically in helping them to cope with changes in later life. Again this is done using the SOC as the analytical framework.

Chapter Ten is the final chapter and presents a concluding discussion that addresses the value of the SOC in understanding ageing-and-place and health in later life, its analytical potential for health geography, reflection on the method, and suggestions for future directions for geographical research on the SOC.

Chapter 2

Ireland's Health Care and Epidemiological Context

Today's middle-aged adults are the ageing population that demographers and policy makers are concerned about. In order to prepare for older people's health in the future it is necessary to consider the health of the current adult population more broadly because it will be a very good indication of the future needs of older people, particularly if they are to age-in-place independently. This requires the health researcher to look downstream to see what is happening in terms of morbidity and mortality, while it is also necessary to look at the extent of population growth, population ageing, life expectancy and healthy life expectancy. This chapter presents Ireland's demographic and epidemiological characteristics, to contextualise where a salutogenic orientation might fit, following a brief overview of Ireland's welfare provisioning for older people.

The Irish Health Care Context

The care of older people in Ireland involves a mixed economy of welfare, consisting of supports delivered by the statuary and voluntary sector, in addition to the family and an informal support network. Working together these sectors direct their efforts towards achieving the goals set out in the *National Positive Ageing Strategy* and the *Healthy Ireland Policy*.

Statutory Supports

The Health Service Executive (HSE) is the statutory body responsible for the provision of health and social care services in Ireland. Through the HSE there are a range of services provided for older people, to meet their care needs and to promote their health, to prevent the progression of illness and to support their independence. In addition to direct health and social care service provision there are a number of schemes and benefits available to older people to make services and supports accessible and affordable.

Access to Health Care

Access to free primary care and hospital services through the medical card scheme is means tested for everyone in Ireland. For those over 70 years old means testing was reintroduced in 2009 following the recession. Those who qualify for a medical card have free access to their GP, hospital care, some dental services, and only pay a nominal fee for prescribed

medication. Despite holding medical cards however many older people still opt to purchase private health insurance because it provides them with quicker access to consultants and treatment, and they can essentially jump the queue ahead of those using the public system (O'Shea and Connolly, 2012). People, both young and old, who are unable to buy private health insurance often experience longer waiting times for health care. While the government are planning a universal health insurance system for the future, the health system is currently struggling to meet demands, with the health budget cut by more than €2 billion since 2009 (Thomas and Burke, 2012).

Home Care Packages

The HSE is also responsible for the delivery of Home Care Packages, which are made up of a range of services that support older people, and those with a certain degree of disability, to live and to be cared for in their own homes. The Home Care Package includes a set number of 'home help' hours where a care assistant carries out duties that the older person is unable to do, such as for example personal care, meal preparation, cleaning, grocery shopping and errands. The Home Care Package also includes a nursing service, therapies, such as occupational therapy, and access to day care services at a health care facility. The Home Care Package is free, but access is determined by dependency level, measured by the individual's ability to carry out activities of daily living (ADL), existing support and a physical examination by a health care professional (HSE, no date: A).

Nursing Home Support – Fair Deal Scheme

Social care in the community has always been fragmented in Ireland. In recent years, since the recession, austerity measures has meant that carers allowance, home help hours and day services have been cut. Even though it is a policy objective that older people should be supported to live in their own homes for as long as possible there is no statutory entitlement to community care services. However residential institutional care does have a statutory basis since 2009 when the Nursing Home Support Scheme (NHSS), also referred to as the 'Fair Deal' Scheme was introduced, leading inadvertently to the prioritisation of long-term residential care (Connolly, 2015). Indeed while the Irish health care system has been working on a shrinking health budget funding to support institutional care actually increased following the introduction of the Fair Deal Scheme (Thomas and Burke, 2012)

Under the Nursing Home Support Scheme (NHSS) the HSE is responsible for providing financial assistance for older people who need long-term residential nursing care. The Fair Deal Scheme assesses the individual's financial capacity to pay, including their assets such as their property, and subsequently the individual and the State share the cost of the residential care (HSE, no date: B). When the necessary supports are not available to allow the older person to live in their own homes affordable residential care becomes the most appropriate choice.

Other Statutory Supports

In addition to health and social care services there are several statutory supports available to older people to sustain a good of quality of life while ageing-in-place. For people over the age of 80 they receive an increase in their pension payments, and for older people living alone they are entitled to a supplementary payment on their Irish social welfare pension. For those aged over 70, regardless of who is living with them they are entitled to a Household Benefits Package, which includes an energy allowance (for gas or electricity) as well as a free TV license. People over the age of 66 are entitled to a Free Travel Pass that can be used on all public transport and with some private rural transport operators. The National Fuel Scheme is available to those who are unable to cover the cost of heating their homes. This is means tested. In addition, the Better Energy Warmer Homes Scheme offers low-income households attic insulation and draught proofing. While older people living in rural areas can also receive a grant under the Housing Aid for Older People Scheme to improve their homes if they are below basic standards. The Mobility Grant addresses older people's mobility issues in the home, and provides ramps and stair-lifts. The State also provides cost waivers on refuse and water charges. These schemes are all designed to support older people to remain living comfortably in their own homes (www.citizensinformation.ie).

Community and Voluntary Sector Supports

While the State has consistently made efforts to provide for the health and wellbeing of older people in Ireland, the supply of Statutory services and supports has often fallen short of the demand. In response to these shortcomings the community and voluntary (C&V) sector has played a significant role in supporting older people to age-in-place in Ireland. The C&V sector has been active in campaigning and advocating on behalf of older people, in

organising activities and delivering services to enhance the quality of life of older people, in promoting healthy ageing, and in supporting lifelong learning.

Of particular importance are informal carers who play a crucial role in supporting dependent people to live at home. In Ireland informal carers provide approximately 3.7 million hours of care every week, involving more than 160,000 people (2006 Census figures). The provision of unpaid care to people with high dependency saves the Irish State an estimated €2.5 billion per year (The Carers Association, 2009). Care, and support for the carer, is also provided by specialist charity organisations such as for example the Alzheimer's Society of Ireland, and the Irish Cancer Society.

The C&V sector has played a key role in promoting older people's quality of life as they age-in-place. Befriending services, Meals-on-Wheels, recreational groups and active ageing groups are just a few examples of community and voluntary led activities available to older people in Ireland. Such supports would be considered 'upstream' (Antonovsky, 1996) in that they attempt to promote or maintain the health and quality of life of older people as they age-in-place. A major challenge to the future realisation of ageing-in-place policies in Ireland is the new, although inadvertent, prioritisation of residential care for older people. The second major challenge is the chronic disease burden. Both suggest that meeting the health and social care needs of older people living in their communities will be a significant problem because the health care budget is directed downstream towards the care of those already sick. The distribution of health care budgets is a moral dilemma and is discussed in detail in Chapter Four.

Population projections

Ireland's population has grown steadily over the last five decades. Between the 2006 and 2011 Census the Irish population increased by 8.2%. Over the last twenty years the population has increased by 30.1%, representing an absolute population increase of just over one million people. Since 1961 the proportion of people aged 65 years and older has increased by 70%. Between 2006 and 2011 the population over 65 years increased by 14.4%, and now constitutes 11.6% of the total population. Notably the greatest increase (17.5%) was in the number of males aged 65 years and older, while the number of women aged 65 years and older increased by 12% (CSO, 2012).

The difference in life expectancy between men and women has meant that many older women live alone. For example in 2011, 3 in every 4 persons aged 85 or older and living alone were female (CSO, 2012). According to the Slán survey older people (aged 65 years and older) living alone are at the greatest risk of having insufficient social support (NCAOP, 2004).

It is projected that by 2041 there will be approximately 1.4 million people aged 65 years and older in Ireland, constituting approximately 22% of the total population (CSO, 2012). Since the beginning of the last decade Ireland's life expectancy has increased more than any other EU country, increasing from one year less to one year longer than the EU average. This trend is the result of decreasing mortality rates from major diseases, particularly within the older age groups.
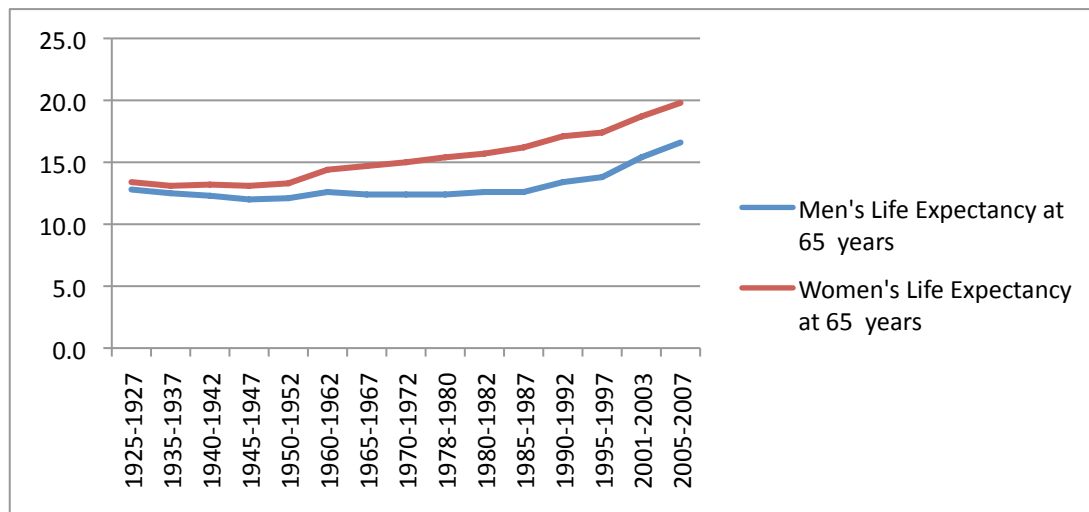
Graph 2.1 Irish men and women's life expectancy at 65 years (CSO, 2012)

2012	Life expectancy	Healthy life years
Female		
EU-27	21.1	9
Ireland	21.1	11.1
Male		
EU-27	17.4	9
Ireland	18	11.1

Table 2.1 Life expectancy and healthy life expectancy in Ireland and EU in 2012 (EuroStat, 2013).
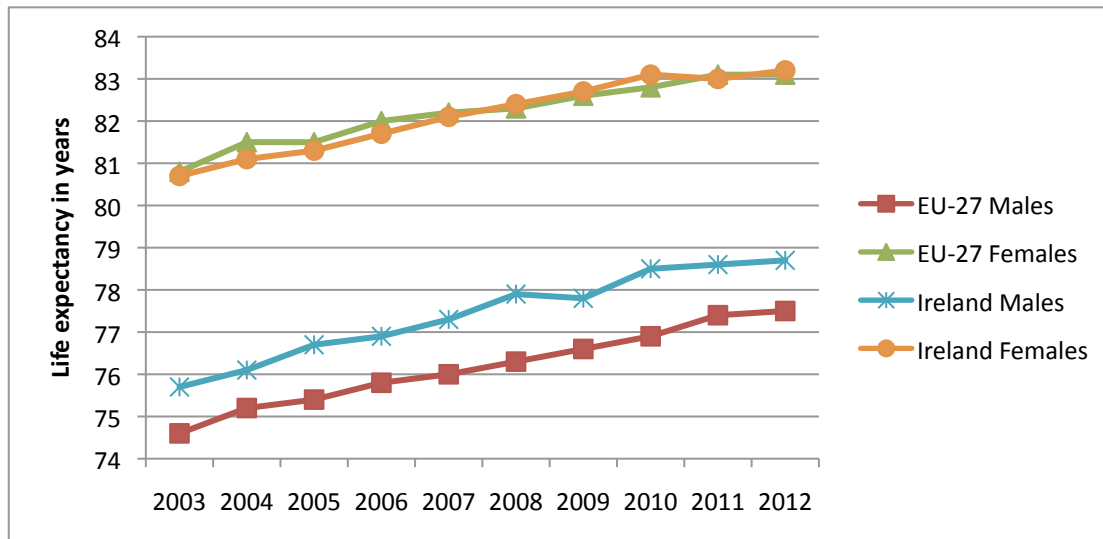
Graph 2.2 Life Expectancy at birth for Ireland and EU27 by gender, 2003-2012 (CSO, 2013)

According to Eurostat (2013) figures for the EU-27[1] the average life expectancy for women at 65 is 21 years, and for men 17.4 years, while healthy life expectancy for women at 65 years of age is 8.8 years, and for men of the same age 8.7 years. Ireland's 65 year olds have a better healthy life expectancy than many of their peers in the EU-27 (see table 2.1). For both men and women at 65 years of age it is 11.1 healthy years, which is considerably better than the EU-27 average of 9 years. Life expectancy for both men and women in Ireland has improved continuously over the last 50 years (see graph 2.1). The Irish male population at 65 years in 1950 had a life expectancy of 12 years. By 2005 this had increased to over 16 years. Of note Ireland's male life expectancy has been continuously higher than the EU average during the past decade (see graph 2.2). The Irish female population at 65 years in 1950 had a remaining life expectancy of 13 years, and this increased to just under 20 years by 2005. Thus, women's life expectancy has had a greater improvement than men's over the same time period. Even over a shorter time period life expectancy has improved in Ireland. Life expectancy for men has increased by approximately two years between 2004 and 2010, and for women over the same period by approximately one year. This suggests that the gender differences in terms of life expectancy may be narrowing. Healthy life expectancy has also improved between 2004 and 2010. In 2004, men at 65 years had an estimated healthy life expectancy of 8.5 years. By 2010 this had increased to 11 years. Similarly

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[1] EU27 refers to the members of the European Union until 30th June 2013

women at 65 years had a healthy life expectancy of almost 10 years, and by 2010 this had increased to 11 years. As with life expectancy males have had a more significant improvement in healthy life expectancy in comparison to women of the same age and over the same time period. Ireland has also exceeded the EU average for healthy life expectancy. In terms of comparative healthy life expectancy on an international scale, Ireland is reasonably well situated, ranked at 7th place for healthy life expectancy across OECD countries for 2009 (EuroStat, 2013).

There is a difference in both life expectancy and healthy life expectancy between Ireland and the EU-27 (see table 2.2). Despite Ireland having a younger population dynamic it appears that when mortality is standardised to take age structures into account, Ireland's mortality rates from the main cause of death, circulatory system diseases, in 2008 were 16.5% lower than the EU average. Mortality from all forms of cancer has remained 5.5% higher than the EU-27 average (DoH, 2011). According to the Department of Health (DoH, 2011) there has been a considerable improvement in the mortality rate for both circulatory system diseases and cancer in Ireland. Between 2000 and 2009 mortality rates for circulatory system diseases fell by almost 40%, and deaths from cancer decreased by 11%.

Dependency ratios[2] are an indication of society's ability to support its older population. Old age dependency ratios calculated on recent census figures provide an indication of population dynamics that are comparable internationally. According to Eurostat figures Ireland has the lowest old age dependency ratio within the EU-27, with a ratio of 16.8:100. That is for every 100 economically active people in Ireland there are 17 (presumably economically inactive) older people. This compares favourably with the EU average (see Table 2.2) and countries such as Germany, where the old age dependency ratio is 31.4:100, and Italy with a ratio of 30.8:100 (Eurostat, 2013). It is also important to note that Ireland has the highest fertility rate of the EU27 (CSO, 2013).

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[2] Dependency ratios are an arbitrary measurement. This is because they are based on an estimated number of economically active people. Projecting the old age dependency ratio is problematic, and it has been argued that projected age dependency ratios offer little more than a loose indicator of future population dynamics (Connell and Pringle, 2004).

	EU27	Ireland
% Pop. Over 65 in 2010	17	11.5
% Pop. Over 80 in 2010	4.6	2.8
Projected % Pop. Over 65 in 2060	29.5	22
Old Age Dependency Ratio % in 2010/11	25.9	16.8
Projected Old Age Dependency Ratio in 2060	52.6	36.6
Birth Rate /1000 Pop.	:	16.1
Death Rate /1000 pop.	:	6.34
Fertility Rate (2012)	1.5	2.01

Table 2.2 EU27 and Ireland demographic comparisons (CSO, 2013).

The extent of the chronic disease burden in Ireland

The World Health Organisation (Busse *et al*., 2010) identified the five main causes of death in Europe as: diabetes, cardiovascular disease, cancer, chronic respiratory diseases and mental disorders. The main causes of these diseases identified by the WHO are predominantly lifestyle and behaviour related: high blood pressure, smoking, excessive alcohol consumption, high blood cholesterol, overweight and obesity, unhealthy diet, and a sedentary lifestyle. These five chronic diseases are responsible for an estimated 86% of all deaths in Europe (Busse *et al*., 2010). They have also been identified as the biggest challenges for Ireland's health care system. According to the Health Status Report (HSE, 2008) over one third of the Irish population have a chronic illness, with the rates of chronic illness increasing with age. In 2006 there were over 1,250,000 hospital admissions requiring acute treatment for a chronic health conditions, the majority of which were older people (over 65 years). According to the Health Service Executive's (HSE) financial estimates 70% of all health care spending goes on chronic disease management, and 80% of all General Practitioner consultations are to deal with chronic disease. This section will outline the main chronic diseases affecting middle aged and older Irish people: diabetes, cardiovascular disease, cancer, chronic respiratory disease, and mental disorders (HSE, 2008).

<u>Diabetes</u>

It is estimated that 160,000 people in Ireland are living with diabetes and the Institute of Public Health Ireland projects a 62% increase in the prevalence of diabetes by 2020, representing a projected absolute number of approximately 233,000 people living with the disease (Balanda, Barron and Fahy, 2010). Within the EU context Ireland has a lower prevalence rate than the EU27 average (see graph 2.3). However, it is estimated that there are almost 71,000 undiagnosed diabetes cases in Ireland (IDF, 2013). Because of the large number of undiagnosed cases it is very difficult to provide an accurate estimation of its prevalence. Even though there is a shortfall in the available data on diabetes in Ireland, epidemiologists can look to BMI and obesity prevalence as an indicator of risk and/or prevalence of diabetes in a given population (Bays, Chapman and Grandy, 2007). Figures for the national average BMI are increasing thus indicating increasing diabetes risk (see graph 2.4).

According to Diabetes Action Ireland, diabetes is the single biggest cause of amputation, stroke, blindness and kidney failure in Ireland (HSE, 2011; www.diabetes.ie, www.irishhealth.ie). Figures for diabetes-related blindness equates with one person going blind every day from the disease. Another complication associated with diabetes is the loss of limbs. According to HSE statistics there were 781 diabetes-related lower limb amputations in Ireland between 2010 and 2011. This is an increase of 20% on the figures for 2008 to 2009 (McDonagh, 2012). Blindness and amputations associated with complications from diabetes are the result of failure to manage the disease appropriately. Diabetes is a downstream problem for the health care system, and so the focus on diabetes management is on the provision of adequate screening services that are designed to prevent the deterioration of the condition of those already living with the disease (Nam *et al*., 2011). Within the international context Ireland compares favourably having one of the lowest diabetes related death rates among the EU27. However, Ireland has not experienced a significant reduction in Diabetes related deaths based on the standardised death rates for 2000 and 2010 (Eurostat, 2013).
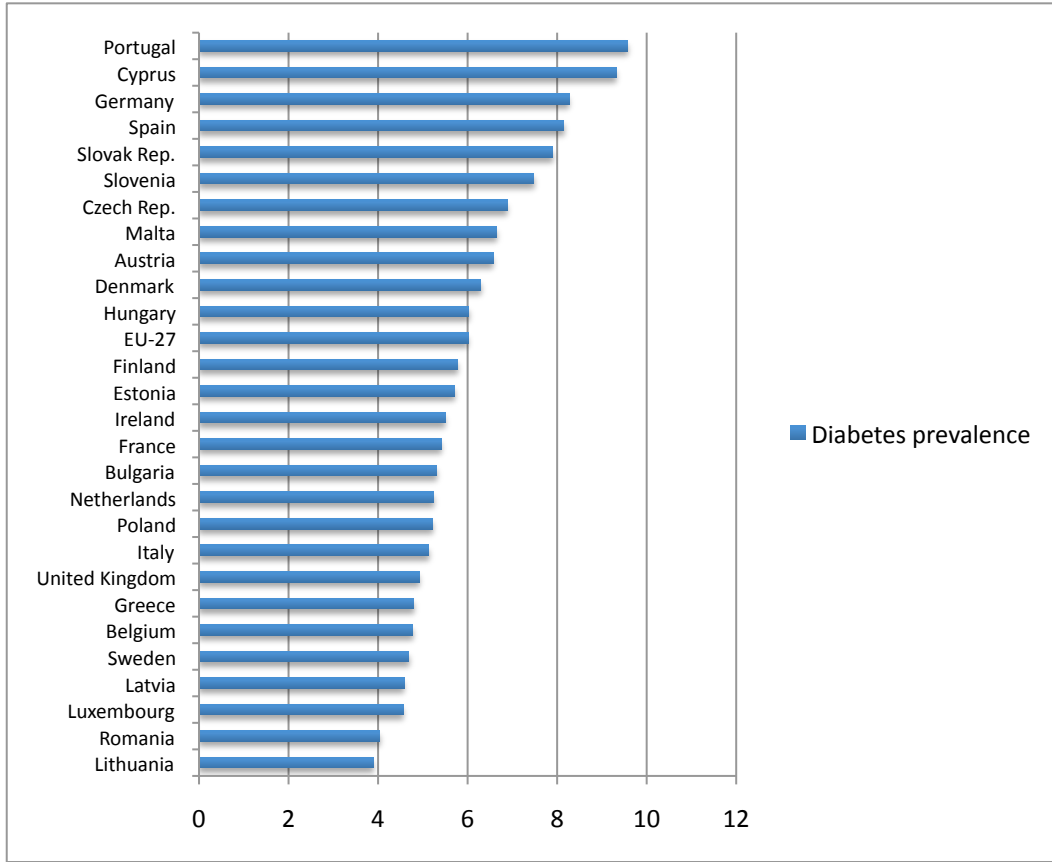
Graph 2.3 Prevalence estimates of diabetes mellitus among adults aged 20-79 years in the EU27 in 2014 (or nearest year available) (IDF, 2015).
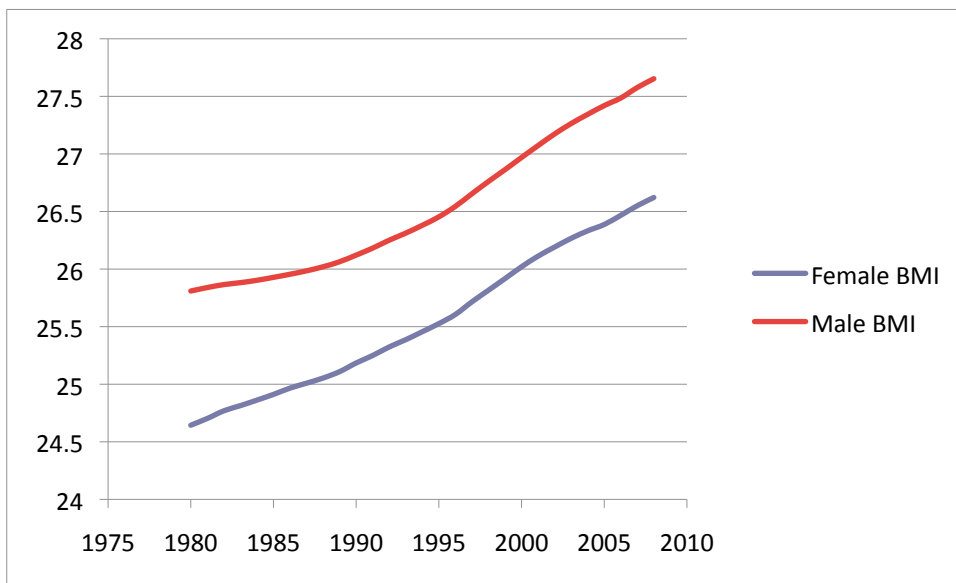
Graph 2.4 Average Irish Body Mass Index (BMI) for males and females (Gapmider, 2015)

Cardiovascular disease

Coronary heart disease is the leading cause of death in Ireland, accounting for 22.8% of all deaths, with an additional 100,000 people living with heart failure and 10,000 cases of stroke occurring annually. That is the equivalent to one stroke every hour. On average 100 people die every week from a sudden cardiac arrest (www.irishheartfoundation.ie). However, since the 1970s deaths from cardiovascular disease are falling, although this decline is at the present time very unstable due to the emerging health issue of obesity. Within the EU context Ireland's stroke mortality rate (see graph 2.5) and ischemic heart disease mortality rate (see graph 2.6) in 2011 was less than the EU average.
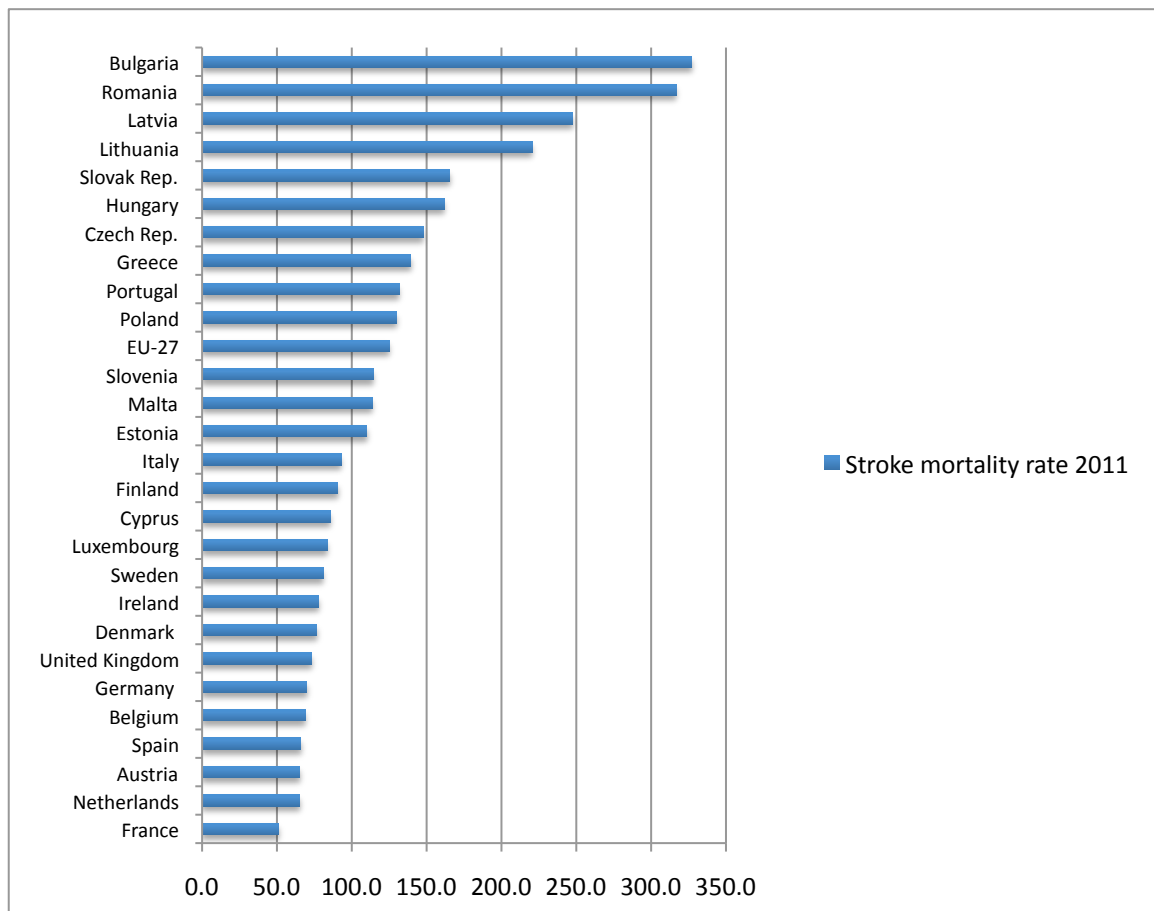
Graph 2.5 Stroke mortality rate age standardised /100,000 pop. for EU27 in 2011 (OECD, 2014).
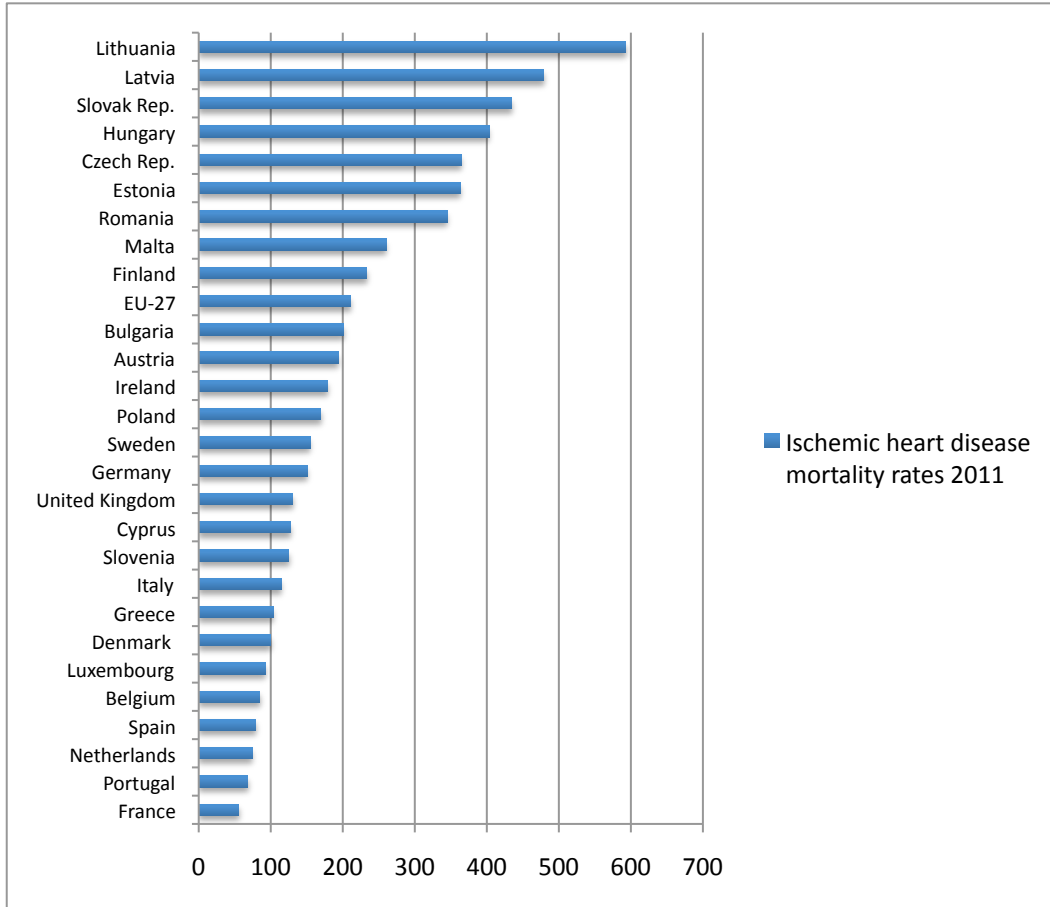
Graph 2.6 Ischemic heart disease mortality rate age standardised /100,000 pop. for EU27 in 2011 (OECD, 2014)

The Irish Heart Foundation has expressed concern that the current trend in obesity may result in the reversal of the progress made so far in cardiovascular related mortality, and they are also concerned that the State is not doing enough to address the obesity epidemic. According to recent figures 38% of the adult population in Ireland is overweight, while 23% are obese (DoH, 2010). Given these trends in overweight and obesity, it is estimated that the population affected by coronary heart disease will increase by 31% (IPH, 2012a), and the numbers affected by hypertension is expected to increase by 28% (IPH, 2012b). Body Mass Index, cholesterol levels and hypertension are bigger problems among the low-income social classes (Balanda *et al*., 2010; Madden, 2010). With relation to the EU27 Ireland has made the most progress in terms of reducing the number of death from ischemic heart disease between 2000 and 2010 (Eurostat, 2013).

On average 29,745 cancer cases were registered in Ireland each year between 2007 and 2009, representing a 12% increase for the previous 3-year period (2004 – 2006) (HSE, 2008). Based on current figures of incidences of cancer in Ireland the cumulative lifetime risk for cancer diagnosis is 1 in 3 for Irish men, and 1 in 4 for Irish women (HSE, 2008). Within the EU27 context Ireland has one of the highest incidence rates of cancer. In 2012 for example it had the 4th highest cancer incidence rate of the EU27 (see graph 2.7), and in 2012 the eight highest cancer mortality rate (see graph 2.8).
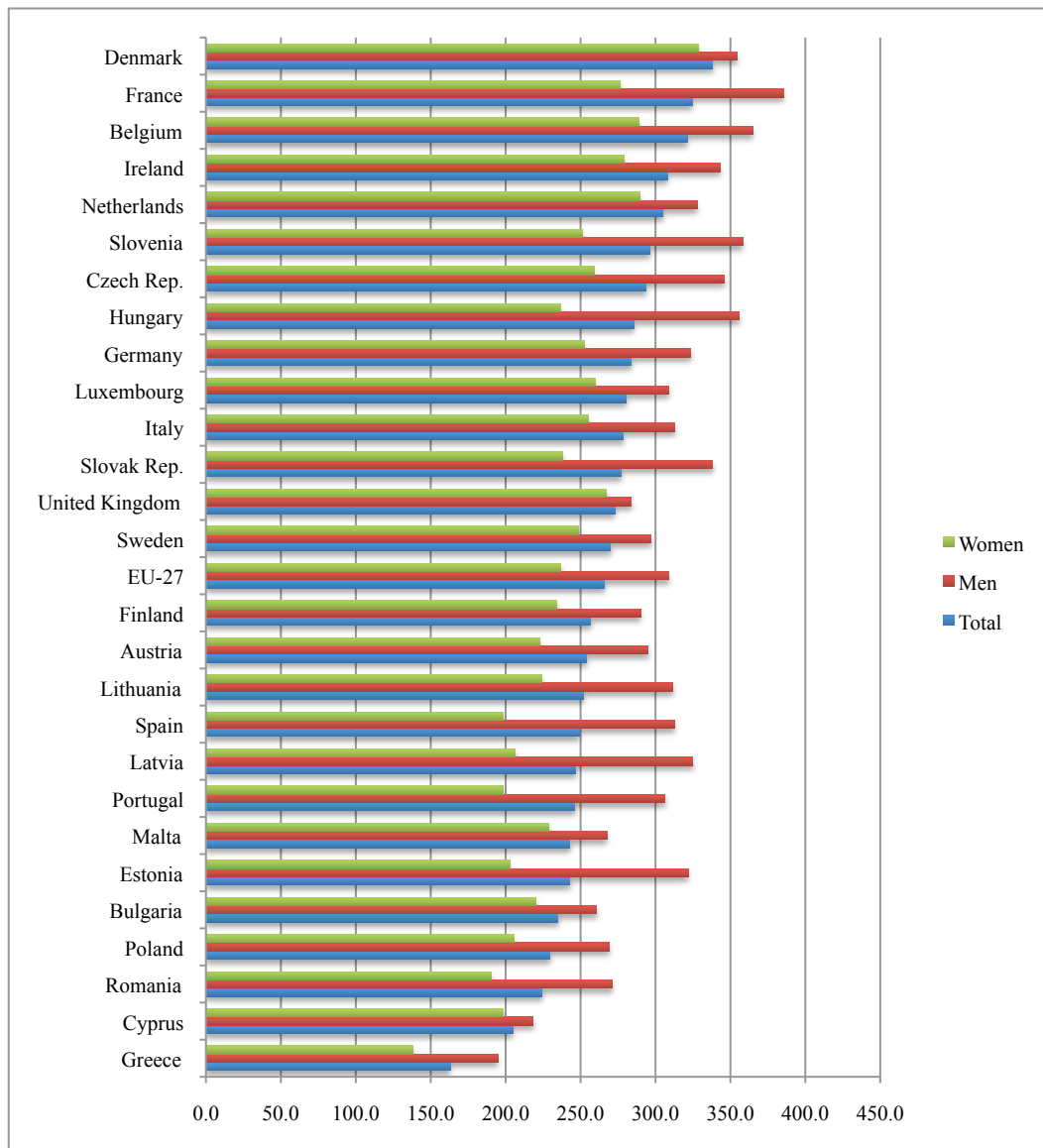
Graph 2.7. EU27 Cancer incidence rates (age-standardized for all types) Male and Female 2012 (OECD, 2014)

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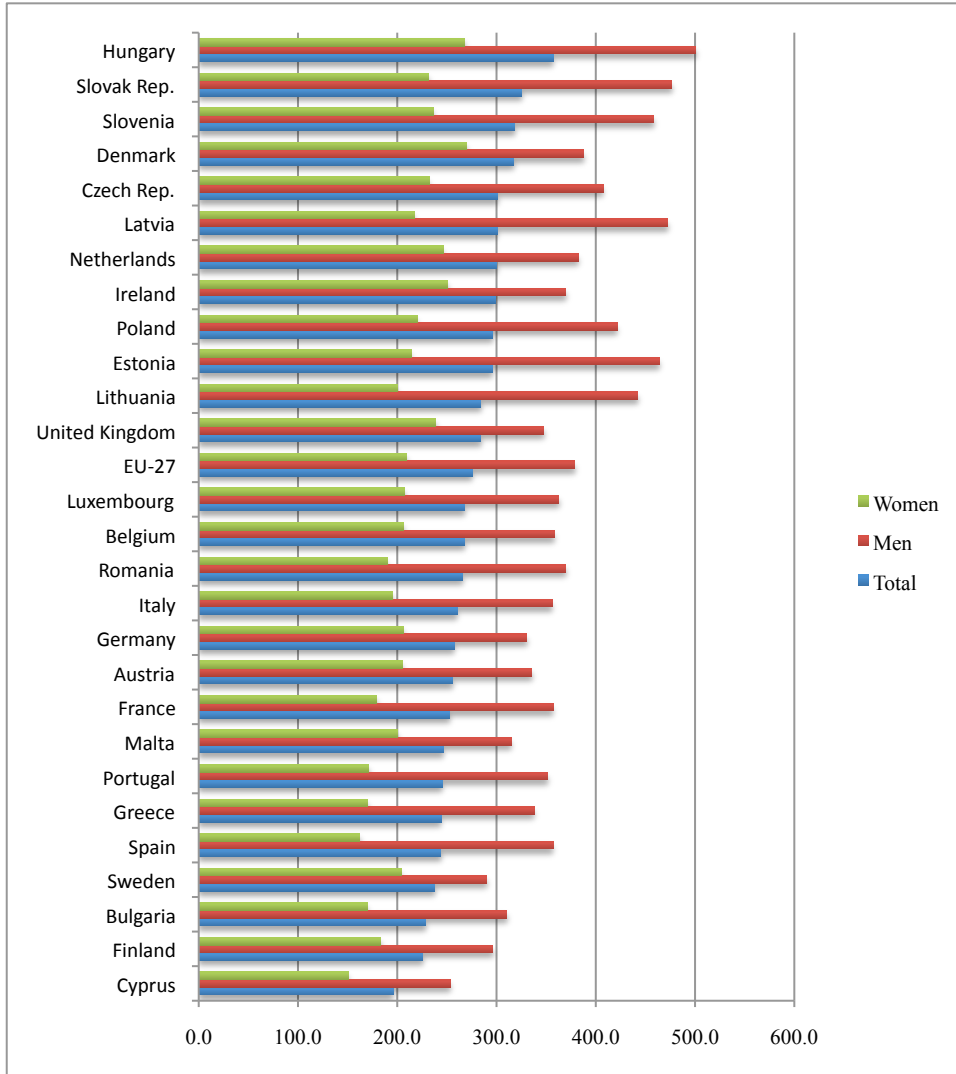
Graph 2.8. EU27 Cancer mortality rates (age-standardized for all types) male and female 2011 (OECD, 2014)

In comparison to the EU27 Ireland is doing poorly in reducing the incidences of cancer. For women cancer incidence rates in Ireland are the second highest rate in Europe, and for men the incidence rates are the fourth highest (HSE, 2008).

Lung Cancer

Since the 1980s deaths from lung cancer among men have been decreasing (see graph 2.9), although it is currently the most common cause of cancer in Ireland (HSE, 2008). Lung cancer accounts for the most cancer related deaths among Irish men (see graph 2.9), and the second most cancer related deaths among Irish women after breast cancer (see graph 2.10)

Within the EU27 Ireland had the 6th highest lung cancer mortality rate in 2011 (see graph 2.11), and Ireland had the 8th highest smoking rate for adults over 15 years in 2012 (see graph 2.12), a significant determinant of lung health.
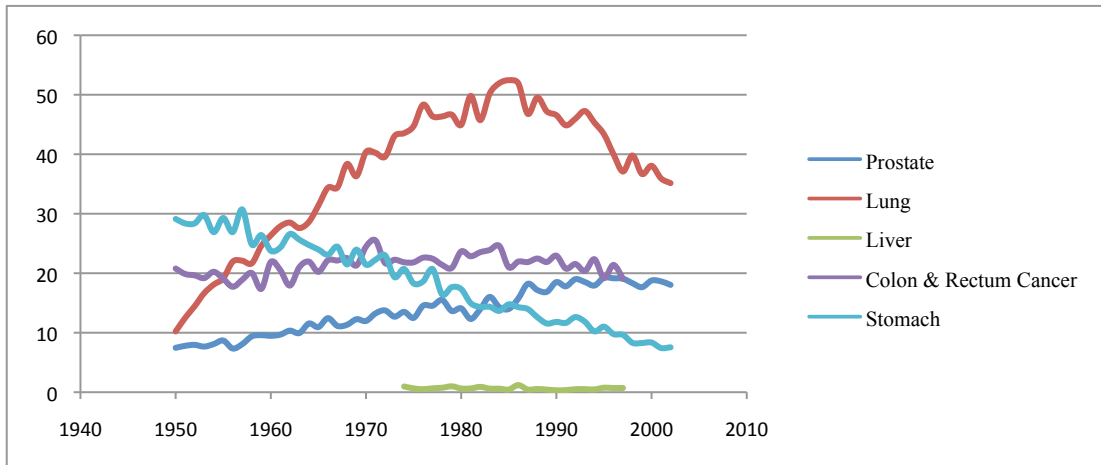
Graph 2.9. Cancer mortality rate /100,000 age standardised for Irish males. Source: Gapminder
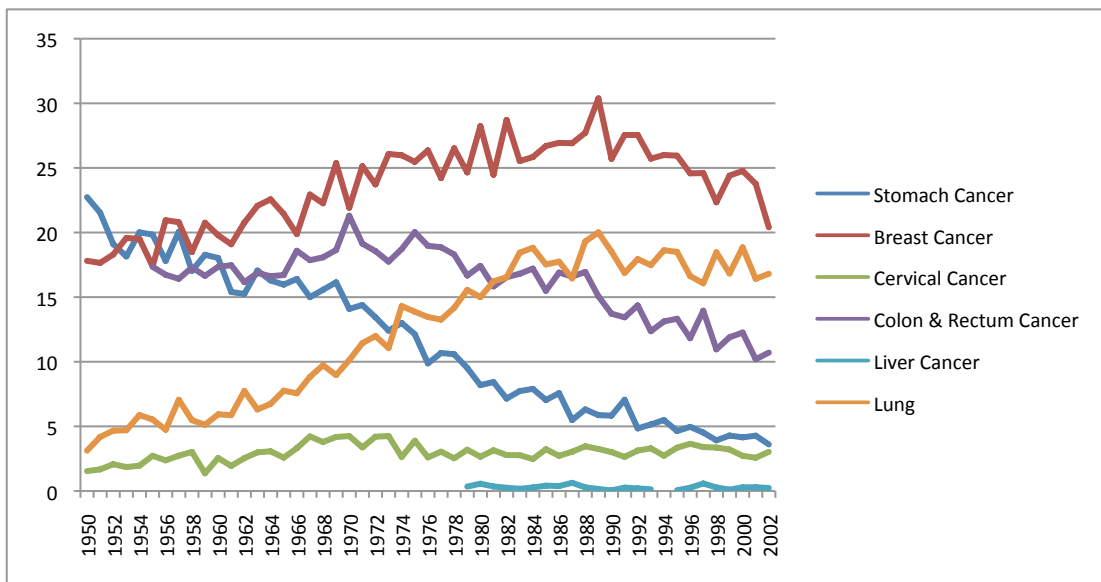
Graph 2.10. Cancer mortality rate /100,000 age standardised for Irish females. Source: Gapminder
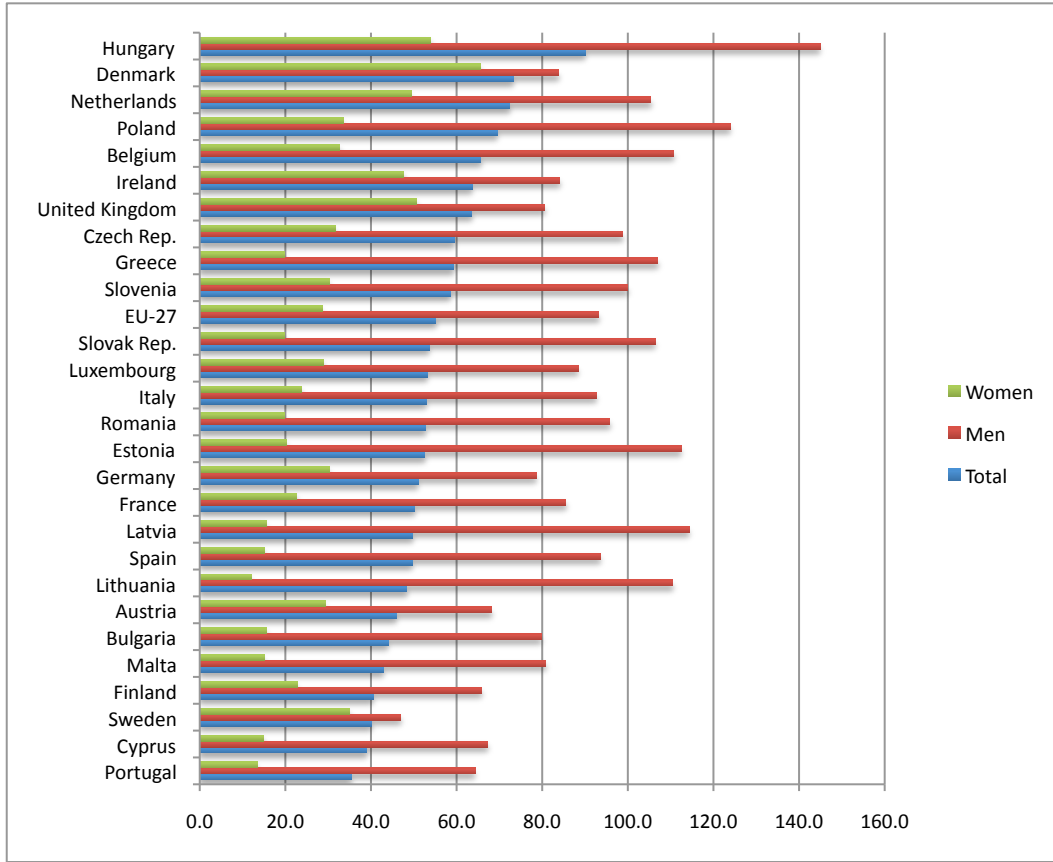
Graph 2.11. EU27 Lung cancer mortality rates (age-standardized) male and female 2011 (OECD, 2014)
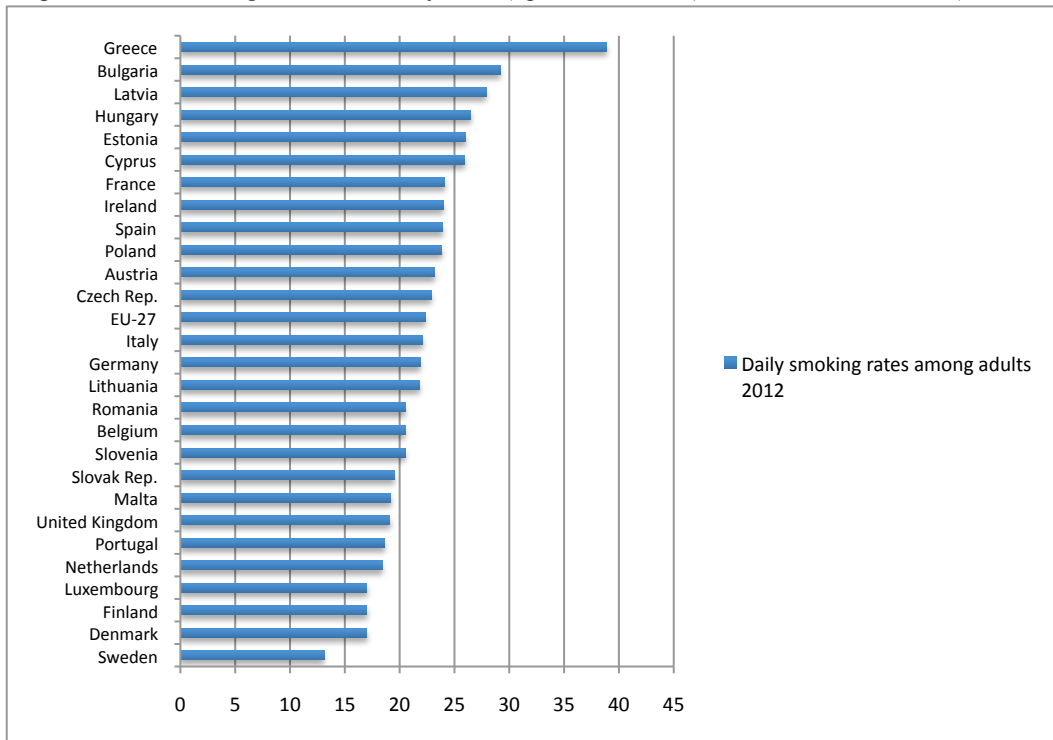
Graph 2.12 Daily smoking rates among EU27 adults in 2012 (OECD, 2014)

Breast Cancer in Women

For women lung cancer is more common than breast cancer, with a 6% difference in the incidence rate (HSE, 2008), although breast cancer has a higher mortality rate and is the leading cause of cancer related deaths among women (see graph 2.10). Breast cancer survival rates after 5 years of diagnosis have increased in Ireland significantly, however Ireland's 5-year survival rate remains behind the EU average. Despite improving breast cancer prognosis in Ireland, Ireland still has a higher breast cancer mortality rate than the EU average (OECD, 2014) (see table 2.3).

Years	1997-2002	2007-2012
Ireland	72.9	80.5
EU25 (avail.)	77.2	82.9

Table 2.3 5-year survival rate for women with breast cancer in Ireland and the EU (OECD, 2014).

Access to Mammography screening in Ireland, which is used to detect breast cancer, was above the EU average in 2012 (see graph 2.13), however between 2002 and 2012 the percentage of women accessing Mammography screening in Ireland reduced from 76.3% in 2002 to 72.2% in 2012 (OECD, 2014).

In terms of screening, incidence and mortality rates of breast cancer it is difficult to discern a pattern between the three (see graph 2.13). Take for example Belgium and Ireland, Belgium has a much higher incidence rate of breast cancer (111.9) compared to Ireland (92.3), but Belgium has the same screening rate as Ireland (73%) and similar mortality rates (Belgium: 41.3 and Ireland: 41.8). Bulgaria on the other hand has significantly less access to screening (21.9%), a lower incidence rate (58.5) and yet still a lower breast cancer mortality rate (38.3). These statistics indicate that there is something else determining breast cancer mortality rates than access to screening (see graph 2.13).

There have been a number of advances in cancer treatment and screening in Ireland over the last decade. For example surgical level activity has increased considerably for lung cancer (by 25%), colorectal cancer (by 24%) breast cancer (by 31%) and prostate cancer (by 717%). In the case of prostate cancer the exponential increase in surgery may be to some extent accounted for by the increase in PSA testing. Radiotherapy services have been expanded in Dublin, Cork and Galway, thus making radiotherapy accessible to more cancer patients.
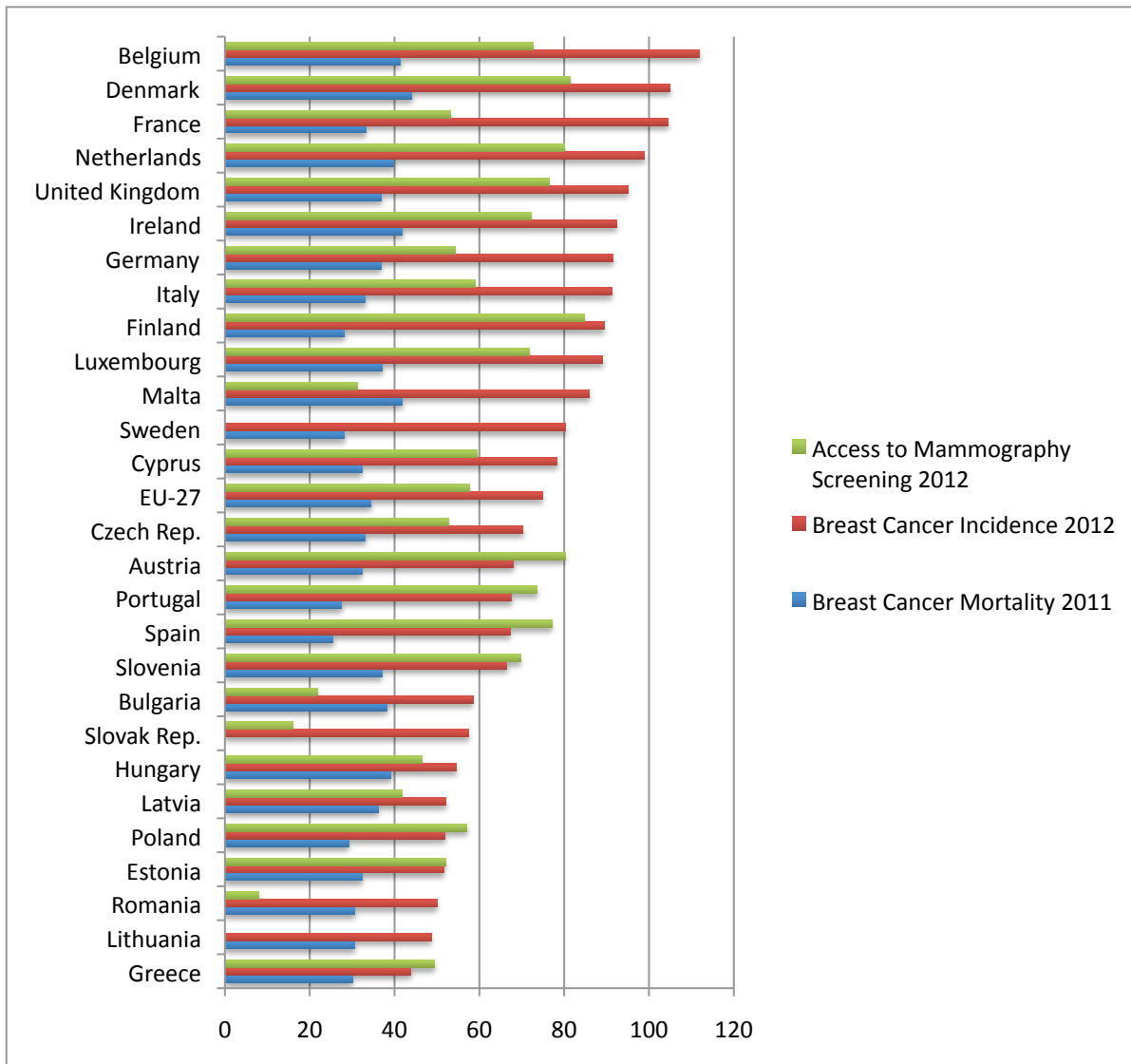
Graph 2.13 Breast cancer incidence rates and access to mammography screening among women aged 50 to 69 years in 2012 (or nearest years), and breast cancer age-standardised mortality data 2011 (or nearest years) using available data for EU countries (OECD, 2014).

It should be noted however that even though cancer is a disease predominantly associated with older people, the older cancer patient is less likely to undergo intensive treatment. One study on cancer treatment in older people found that cancer patients between the ages of 60 and 69 years were less likely to receive treatment for oesophageal cancer than patients under 60 years of age (HSE, 2008).

There is much discussion on the relationship between socioeconomic position and cancer incidence. A number of significant relationships emerge when cancer incidence rates for Ireland and the UK are examined with relation to disadvantage and affluence.

Populations in deprived areas experience incidence rates of cancers in the larynx, lip, mouth, pharynx and lung three times higher than affluent areas. This corresponds with higher rates of smoking and alcohol consumption among less affluent populations (Quinn, *et al.*, 2005). In addition to higher cancer incidence rates in low socio-economic areas, treatment and survival rates are also lower for both men and women. For example, cancer mortality rates for men in lower socioeconomic groups are 110% higher than for more affluent men (HSE, 2008). An inverse relationship between cancer incidence and social affluence is found in the cases of skin cancer (Deady *et al.*, 2014), female breast cancer (Larsen *et al.*, 2011; Klassen and Smith, 2011), and prostate cancer (Etzioni *et al.*, 2002), with higher incidence rates of these cancers occurring in more affluent populations.

Chronic respiratory disease[3]

In 2004, 21% of all deaths were caused by respiratory diseases in Ireland (this includes lung cancer already discussed), and while cardiovascular related mortality is decreasing, deaths from chronic respiratory diseases are increasing. Within the European context Ireland has the second highest death rate from respiratory disease with mortality rates twice that of the EU average. Respiratory illnesses are the most common problem presented in the GP surgery, the third most common reason for acute hospital admission, and require the greatest demand for prescription drug treatment than any other organ treatment (Brennan, McCormack and O'Connor, 2008). It is estimated that patients suffering from chronic obstructive lung disease and pneumonia occupy 143,771 hospital beds each year. In 2006 chronic respiratory diseases cost the Irish health system €437.1 million (Brennan, McCormack and O'Connor, 2008).

The influenza vaccination is one measure taken to reduce the number of acute respiratory infections, and is recommended for older people or those with a weakened immune system. Ireland has an above average vaccination rate for older people in the context of the EU countries (see graph 2.14), although the percentage of people aged 65 years and older receiving the vaccination decreased from 62.2% in 2003 to 56.9% in 2012.

It has been found that social inequality in Ireland is associated with the highest proportion of deaths from respiratory diseases than any other organ system. Deaths from

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[3] Figures given for respiratory diseases are concerned with pneumonia, cancers of the nasal cavities, larynx, pleura, trachea, bronchus, and lungs, tuberculosis, acute respiratory infections, congenital anomalies, pneumoconiosis, and foreign bodies in the respiratory system.

respiratory diseases among the lowest socio-economic classes are 200% higher than death rates for the affluent class, likewise circulatory diseases are 120% higher and for all cancers, 100% higher. Social inequality in terms of health outcomes is thus very well exemplified by rates of respiratory diseases across the social classes (Brennan, McCormack and O'Connor, 2008).
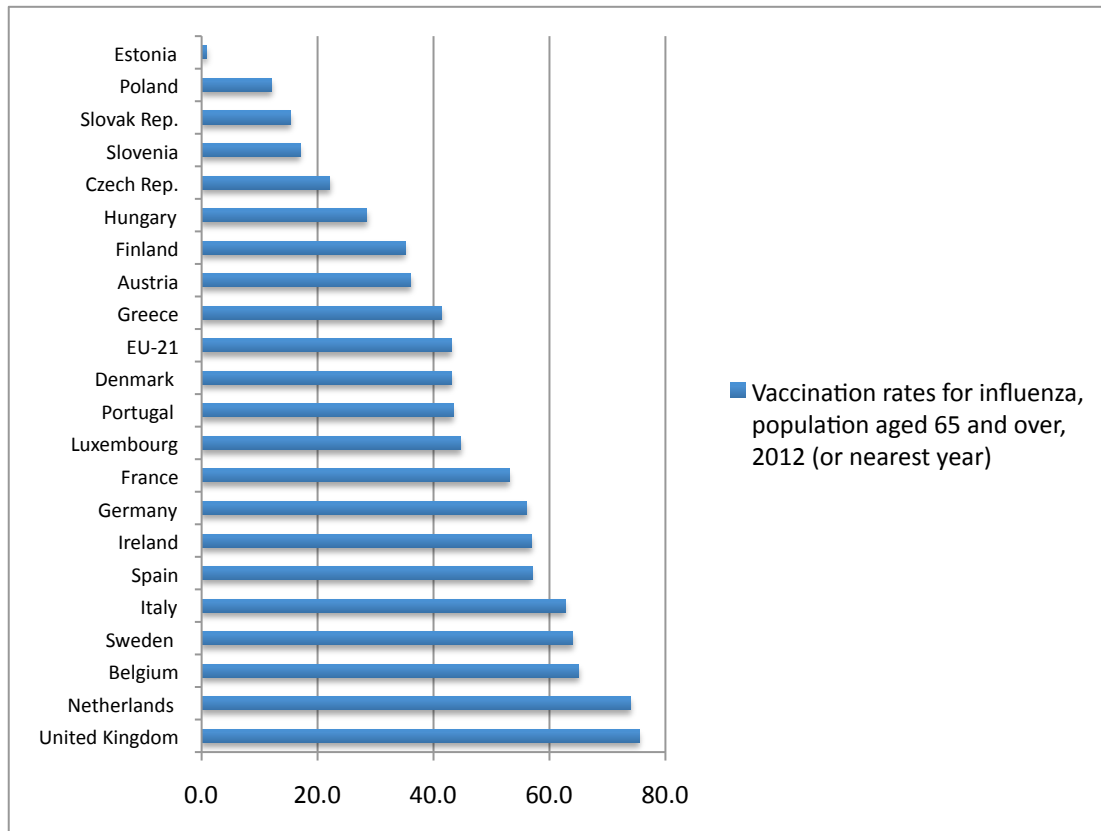
Graph 2.14 Vaccination rates for influenza for the population aged over 65 years in 2012 (OECD, 2014).

Psychological disorders

The HSE identified nine mental health disorders of significance in Ireland, these are: suicide, alcoholism, depression, drug dependence, stress, Alzheimer's disease, nervous breakdown, schizophrenia, and bi-polar disorder (HSE, 2007). According to a study undertaken by the Health Research Board's Mental Health Unit in early 2006, of every 100,000 people in Ireland approximately 14,000 have experienced a self-reported mental health problem at some point during the previous 12 months (HSE, 2008). According to CSO figures for 2011 the total number of suicides registered in Ireland was 525, which was a rate of 11.4 suicides per 100,000 population representing a 7% increase on the rate for the previous year. 84% of suicide cases were male (CSO, 2012b). In 2011, 12,216 cases of

deliberate self-harm presented at A&E departments in Ireland, involving 9,834 individuals. The age-standardised rate of individual presentations of deliberate self-harm in 2011 was 215 per 100,000 population representing a 4% decrease on 2010, and significantly this marked a change in the increasing rates of self-harm that occurred during the previous four year period (National Suicide Research Foundation, 2012). Within a wider temporal context Ireland has experienced a significant increase in the rate of suicide since the 1970s (see graph 2.15). Within the EU context Ireland's suicide mortality rate is lower than the EU average (OEDC, 2014).
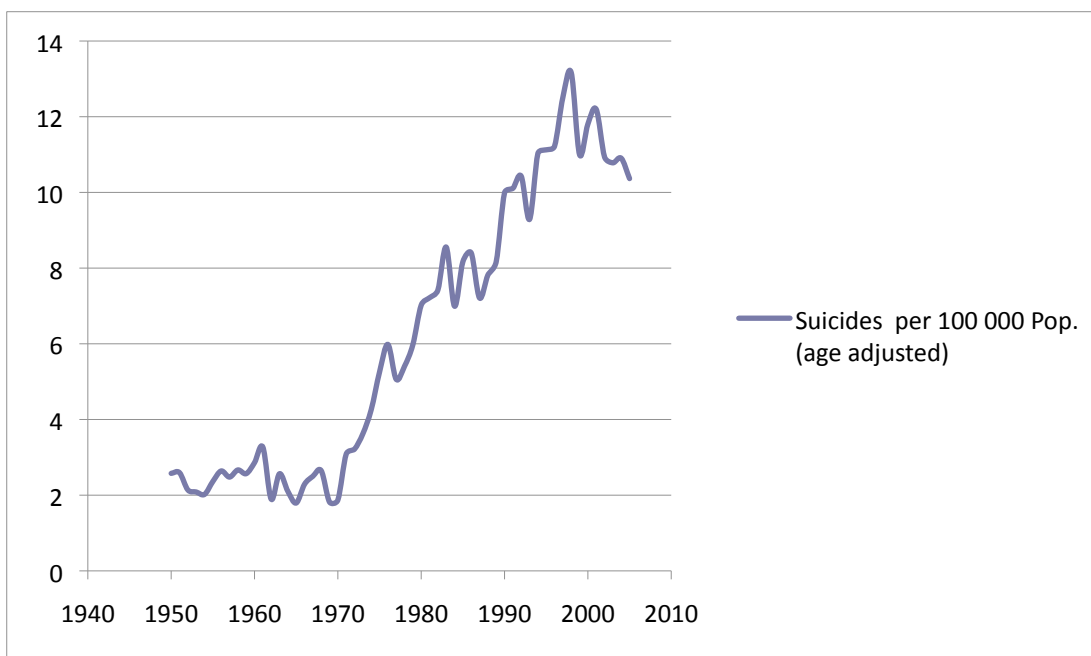
Graph 2.15 Ireland's suicide rate age adjusted per 100,000 population (Gapminder, 2015).

Although it is difficult to calculate rates of depression in a given population, the use of prescription drugs provides an arbitrary estimate. In Ireland the number of prescriptions wrote by GPs for anti-depressant medication over the last number of years have increased. According to a study conducted by the National Advisory Committee on Drugs (NCAD) 14% of adults in 2010/2011 reported having used prescribed drugs to treat depression, anxiety and insomnia (NACD and PHIRB, 2012). This was an increase of 4% since the same study was conducted in 2007. In 2010 there were 900,000 GMS prescriptions written for benzodiazepines (PCRS Data, 2005-2010). The increased prescription of antidepressant medication in Ireland is not uncommon. Among EU countries it is estimated using available

data that antidepressant consumption has more than doubled between 2000 and 2012 (OECD, 2014).

Alzheimer's disease and dementia related conditions affects 38,000 people in Ireland. These figures may reach as many as 58,000 people by 2021 due to the increasing numbers of people living to old-old age (over 75 years). As the Graph 2.16 demonstrates dementia is a significant problem in the much older age groups. Given the anticipated increase in the proportion of older people in Ireland in the coming decades, dementia requires a rapid policy response to address its epidemic potential (O'Shea, 2007). Within the EU context Ireland's dementia prevalence rate (6.2%) in people over the age of 60 was lower than the EU average (7%) for 2012.
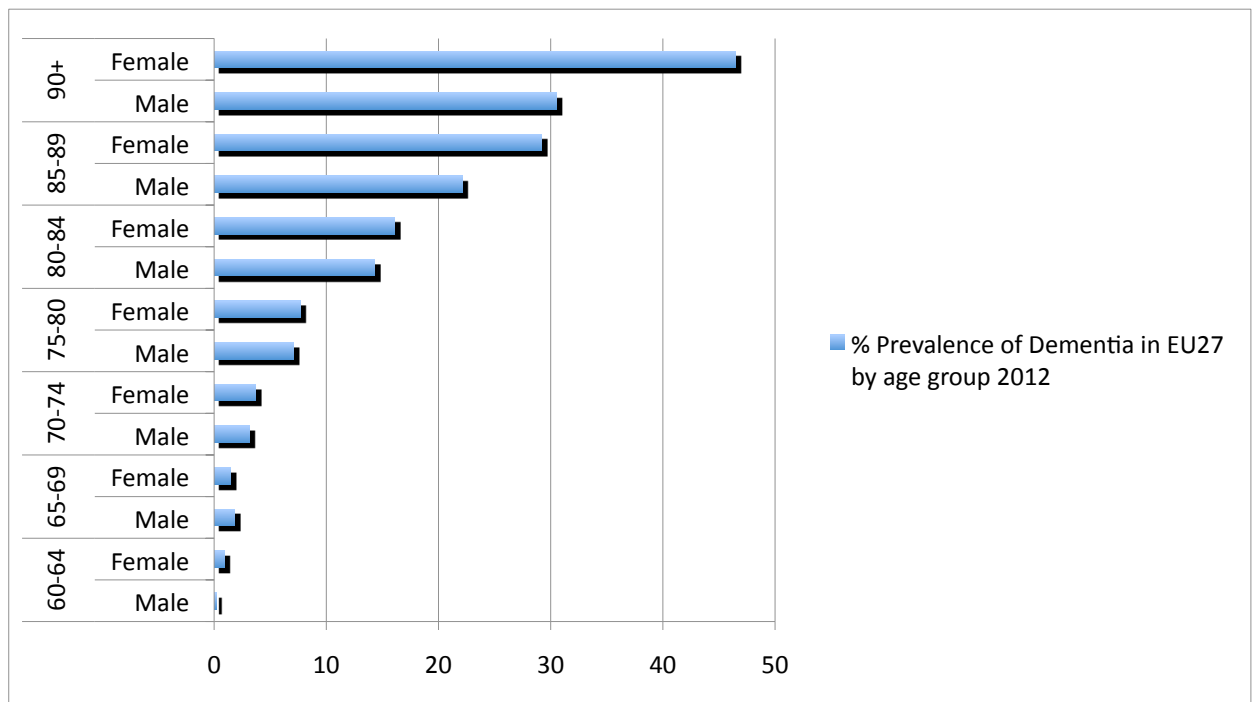
Graph 2.16 Prevalence of dementia in the EU27 by age group in 2012.

Taking the standardised death rate across the EU27 for six chronic illnesses: malignant neoplasm, cerebrovascular disease, diabetes mellitus, chronic lower respiratory disease, ischemic heart disease and chronic liver disease, it is possible to locate Ireland's progress in terms of its chronic disease burden more broadly. In 2009 Ireland scored well, but with room for improvement, when compared with the EU27. According to the figures for 1999 and 2009 and examining the difference in the death rates between these 10 years, Ireland is

one of the five EU27 countries to demonstrate the most significant reduction in the SDR for these six chronic illnesses. When compared to the EU27 Ireland has still a significant way to go to reduce its chronic disease burden and position itself at the top of the EU27 for mortality outcomes (Eurostat, 2013). However, in considering the temporal trends Ireland has demonstrated the most improvement in terms of its SDR across a range of chronic diseases – particularly for cancer and ischemic heart disease. This can to some extent account for the increase in the country's life expectancy since the turn of the century.

Morbidity: Ireland and the EU27

The figures discussed so far predominantly relate to mortality, which is just one measure of population health, yet tell us nothing about the number of people currently living with chronic disease. Again using Eurostat (2013) and census figures it is possible to shed some light on morbidity both nationally and internationally. According to Eurostat (2013) chronic morbidity rates for Ireland are comparatively lower than the EU-27. In 2009 for example 24.7% of Irish males were living with a chronic illness, compared to the EU27 average of 29%. The comparative difference for Irish females was even more positive, with 26.7% of Irish females reported as living with a chronic illness or condition, whereas the EU-27 average for this group was 33.3%. Similarly, rates of limitation in activity due to ill health are comparatively lower for Ireland than the EU-27.

Mortality rates are a very objective measure of health and may reveal little about how people experience their lives with relation to health and illness. Self-perceived health is thus an important measure of health. As already discussed Ireland is comparatively well placed with relation to healthy life expectancy, and mortality rates, with gradual improvements made annually. According to figures released by Eurostat (2013) self-perceived health is much higher in Ireland than in any other EU-27 country. For example, 45% of all males in Ireland rate their health as very good, for the EU-27 countries this figure is considerably lower at 25.4%. The relationship is similar for negative self-perceptions of health, for example 17.2% of Irish females across all age groups rate their health negatively, whereas for the EU-27 the figure is 34.7% (Eurostat, 2013).

In 2011 the Irish census included a question that addressed the subjective health status of the population, asking 'How is your health in general?' The choice of response was 'very good', 'good', 'fair', 'bad', or 'very bad'. The results as expected found that

subjective health decreased with advancing age for example 60% of the 40-44 age category perceived their health to be very good, while this reduced to only 30% of the 65-69 cohort.

Overview

In order to inform the theoretical basis of health promotion policy it is necessary to consider the context within which such policies are located. Policy makers have been concerned for some time about the impact population ageing will have on the social and economic infrastructure. Of particular concern is the ability to provide adequate health care to those living into old age with chronic diseases (Wagner *et al*., 2001). Studies have found, however, that population ageing is not a significant factor driving health expenditure as initially assumed (Fogel, 2009; Reinhardt, 2003). Using the available evidence on Ireland's population structure, as well as morbidity and mortality trends, this chapter has provided an evidence base from which a less pessimistic view of population health and ageing can be found. Much of the data discussed here has demonstrated significant improvements in terms of both life expectancy and healthy life expectancy for both men and women in Ireland. In comparison to the other European countries, in terms of its dependency ratios, life expectancy, and trends in the chronic disease burden, Ireland in a good position to put in place interventions to promote population health upstream in preparation for future demographic changes. Firstly the proportion of older people in Ireland, while growing, is still relatively small. Secondly the country has experienced a baby boom over the past number of years, a phenomenon quite unique in the Western world today. And thirdly, the chronic disease burden has improved. In addition, the Active Ageing Index ranks Ireland in 3rd place out of the 27 EU States in terms of its current and potential ability for people to continue to contribute socially, economically and culturally, as they grow older, i.e. to age actively (Zaidi *et al*., 2013). Thus, despite Ireland's recent economic recession the country has demonstrated a remarkable resilience and strength when placed relative to its EU neighbours. However, there are several concerns for population health emerging in recent decades, which might undo some of the gains in population health, namely cancers, type-2 diabetes, dementia and obesity.

Discussions on overall population health, such as the one presented in this chapter, where health is described in terms of objective measurements of morbidity and mortality, reveal little about health as a subjective experience. Treating health as a subjective, or lived, experience recognises its mental, social and spiritual dimensions, as well as physical

dimensions. In treating the older person as a purely physiological entity it is less likely that their strengths and qualities are given sufficient recognition, or that the quality of their mental, social, or spiritual health is considered. The importance of these 'softer' dimensions of health will be emphasised throughout this thesis, where the mental, social and spiritual components are recognised as prerequisites for overall positive health. The research evidence for this will be explored in detail later in the thesis, and will be used to explore and expand on Antonovsky's (1987) ideas about health and its origins.

Chapter 3

Geographies of health and healthy ageing: An exploration of the key concepts and models

The purpose of this chapter is to provide an account of models of health, and healthy ageing before moving on to look at the contribution made by Geographers and Environmental Gerontologists to ageing research, in particular to understanding ageing-in-place experientially.

Models of health and medicine

George Engel was one of the earliest thinkers to argue that medicine was in crisis. He responded to this crisis by establishing the bio-psychosocial model of medicine, which gained a lot of support from the research community (Engel, 1977). Engel's primary concern, and what he believed to be the cause of this crisis was the inability of the contemporary medical model to address non-somatic health issues. He argued that the medical and psychiatric institution was only concerned with the somatic parameters of illness, and thus physicians were not in the position to address psychosocial issues. As a result concern for psychosocial issues did not feature in their definition of, or practical approach to, disease. Engel argued that medical practitioners regarded the psychosocial model as falling within the theologian and philosopher's views on health and illness, and only focused on what they deemed to be 'real diseases' (Engel, 1977:129). Since Engel's writing in the 1970s there has been a considerable shift in the focus of health research with investigations into bio-psychosocial impacts on health commanding considerable attention in health research debates (Sidell, 1997). The potential of the bio-psychosocial model to explain disease processes has received considerable recognition, and has been applied to a diverse range of illnesses, for example renal disease (White and Grenyer, 1999), Crohn's disease (Bitton *et al*., 2008), alcoholism (Walde *et al*., 2002) and Alzheimer's disease (Ownsworth *et al*., 2006). The application of the bio-psychosocial model to improve health care systems has also been recognised (Frankel *et al*., 2003; Sperry, 2006). For the researcher interested in healthy ageing the bio-psychosocial perspective is vitally important in understanding what makes a 'healthy' later life. Findings from psychosomatic medical research will be referred to frequently in the results and discussions chapter of this thesis to develop the linkages between the SOC components and health and wellbeing.

The biomedical model

Under the biomedical model, health is viewed as the absence of disease, and functional fitness. It takes much of its philosophical grounding from positivism (Kriel, 2000) and as a result tends to be reductionist in its approach to understanding ill health (Regenmortel and Hull, 2002). The diagnosis and understanding of disease aetiology are explained using a biological framework, which implies that all diseases have organic origins, and originates in the body (Wade and Halligan, 2004). Furthermore, disease is considered to have a single origin or cause and once this cause is removed a return to health will follow. This however is not necessarily the case because when disease is taken out of the system there is no consideration for the 'health equilibrium', where disease and health are not dichotomies, but are indeed different ends of the same continuum, consisting of numerous dimensions beyond normal physiological functioning (Lindstrom and Eriksson, 2010). The focus on biomedicine is particularly problematic in thinking about health in later life, because the 'normal' healthy body of the younger person becomes bio-medically 'abnormal' with the physical degeneration and decline commonly associated with advancing age. The biomedical model's focus on the body as a de-contextualised and anonymous machine fails to recognise the individual who has a high degree of quality of life despite a high degree of disease. This is because it does not readily identify the factors that contribute to one's physical health by promoting social, mental and spiritual wellbeing. In recognising the limitations of the biomedical model the WHO expanded its definition of health in 1946, moving beyond health as just the absence of disease and normal physiological functioning, to incorporate physical, mental and social wellbeing as equally significant dimensions (WHO, 1946; Lindstrom and Eriksson, 2010). In terms of methodology and epistemologies the biomedical model is located in the positivist tradition, and thus 'lacks a metric for existential qualities' that often lead to illness such as grief or despair (Greenhalgh and Hurwitz, 1999: 50). The quantitative approach of biomedicine requires supplementary insight using qualitative research approaches that can provide insight on the contextualised mind-body relationship, where health can be examined as a phenomena occurring as part of the unfolding of story that makes up a person's life. Such narrative based approached reflects a growing interest in the particularity of individual cases and what is unknown (Charon and Wyer, 2008). This notion of the particularity of individual cases or the role of an unshared environment, as a 'gloomy prospect' in health research (Smith, 2011) is discussed further in Chapter Four.

The biomedical model of health and illness has been significant in the design of medical geography research. Medical Geographers have contributed to the biomedical model understanding of disease, for example in determining the order or spatial patterning of disease by looking for associations between disease patterns across space, using measurable and observable aetiological factors (Gatrell and Elliott, 2009). For Geographers drawing from the positivist tradition associated with the biomedical model to explain disease for example, location and spatial arrangement is crucial, while 'place' is only incidental (Gatrell and Elliott, 2009: 24). Working from a biomedical model medical geography provided only confirmation that place mattered but did not determine why it mattered (Kearns and Moon, 2002). Such findings posed new challenges to the Geographer to find out the extent to which place mattered, why it mattered and the way in which it mattered (Moon, 1995). Following the post-medical geography turn, many Geographers began to explore the importance of place with regard to health, disease and health care. New understandings of place and its relevance to health emerged, recognising place as an 'operational and living construct which 'mattered' as opposed to being a passive 'container' in which things were simply recorded (Kearns and Moon, 2002: 587). Recognising that place is something that can be experienced and lived required a shift in the methodological focus away from predominantly using the quantitative and reductive approaches of the positivist tradition, to qualitative methods associated with humanistic and phenomenological research. This qualitative turn in data collection opened up the potential for Geographers to address questions on the meaning of the places in which people live, work and play, experience illness and receive care. Subsequently this also required the Geographer to accept the expanded definition of health beyond the biomedical focus on disease, to consider the relationship between place and the other dimensions of health. The social model of health is therefore of great significance in the emergence of post-medical geographies (Kearns and Collins, 2012).

The social model of health

While the biomedical model of health dominated medicine for much of the 19th and well into the 20th century, there was a considerable shift in thinking about the origins of health and illness towards the end of the 20th century with the emergence of a social model of health. Health was no longer regarded as the remit of the medical profession, but was recognised as the responsibility of the wider sectors of society, and so a policy emphasis on

a 'whole system approach' emerged. The *Ottawa Charter* (WHO, 1986) is a good example of this. The social model of health acknowledges that health is a multi-dimensional concept that extends far beyond biological understandings of disease and illness, to incorporate the wider social, economic, and cultural context (Gore and Kothari, 2012). There are a number of models developed to explain the processes that impact on population health as a whole. The commonality between all such models is that they demonstrate the interconnectedness of the social, environmental and personal elements influencing health.

The two main social models of health are the social determinants of health model, developed by Dahlgren and Whitehead (1991) and the socio-ecological model developed by Labonte (1998). The salutogenic orientation fits most neatly into the socio-ecological model because it is primarily concerned with the experiential site of person-place interaction, and focuses on how one's view of life is formed at the person-place intersection, where they are exposed to risk conditions. Under the socio-ecological model the health behaviours and attitudes of individuals are given more attention. These behaviours are understood in terms of the individual's interaction with their structural environments. However, all scales of analysis are incorporated from the interpersonal to the societal level. Political and ecological decisions, as well as structural forces are viewed as responsible for health and can lead to the unequal distribution of resources resulting in comparative inequality. Exposure to risk conditions increases the likelihood of poor health outcomes, for example, a stressful work environment. A combination of risk factors and risk conditions will increase the likelihood of developing physiological conditions because of lifestyle choices. For example, substance abuse and physical inactivity can be understood as the individual's response to the risk conditions and risk factors they are exposed to. The presence of risk factors, either individual or societal, will intensify the impact of risk conditions Labonte (1998).

The social model of health emerged alongside the new public health, both resulting in an important alliance between the social scientists and the public health research community. Of significance to the Geographer was the emphasis put on scale and setting by the new public health approach. Importantly the *Ottawa Charter* (WHO, 1986), which was the first attempt to reformulate the 1946 expanded definition of health into a strategy for action to promote health, identified the 'inextricable links between people and their environment' (WHO, 1986) in shaping health and wellbeing. Sensitivity to the effects of place on health was described in the *Ottawa Charter* (WHO, 1986: 4) as follows:

'Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members' (WHO, 1986: 4).

The *Ottawa Charter's* view of health relocates the concept of health by situating it beyond the health sector in the everyday spaces of the home and community. In establishing the importance of place or context, health promotion as a field of study is opened up considerably to the perspectives of the health Geographer, while public health accommodates the potential contribution of health geography in developing understandings of contextualised health outcomes. The value of pursuing a humanist-inspired understanding of place in examining the effects of place on health is apparent, because the actions of learning, working, playing and loving are grounded in experiential and meaningful interactions with place. Thus the emergence of the new public health as marked by the publication of the *Ottawa Charter* (WHO, 1986) was according to Moon (1995) an exciting development for the Geographer interested in health and health care research because of the strong spatial component, and sensitivity to the effects of place on health. Before the social model of health took hold medicine was the ally of medical Geographers, however the trans-disciplinary approach of the social model of health opened up geography research on health and illness to a smorgasbord of theoretical perspectives and approaches. Further to this, the health turn and the adoption of constructs such as place, identity and wellbeing acted to distance the Geographer from medicine and bring them closer to their parent discipline through new found theoretical interests (Kearns and Collins, 2012).

In keeping with the tradition of health geography's evolving and wide ranging approaches to the study of health and illness, this thesis introduces yet another philosophical take to health geography, the qualitative application of the Sense of Coherence. The emerging application of health as a multidimensional concept, the growing relevance of wellbeing and positive health, 'place' as a worthwhile focus for study, and the acceptance of qualitative methods, has provided the scope to explore the health-place relationship using the salutogenic orientation.

Towards a new definition of health and wellbeing

> *There is no health. Physicians say that we,*
> *At best, enjoy but a neutrality,*
> *And can there be worse sickness than to know*
> *That we are never well, nor can be so.*
> John Donne

Defining a phenomenon such as health is a difficult and complex task because it requires a triangulation between the reality, the concept and the definition, and this triangulation is itself situated in a multidimensional space of concepts, definitions and entities. '[C]ore meaning, operational characteristics, boundaries, exclusion conditions and relations with other concepts' are also important in determining definition (Ustun and Jakob, 2005: 802). The way in which health is defined has important implications for health policy. This is because it raises several important questions for policy makers, for example: which is more important, health gain as survival years, or as social participation and functioning? What counts as recovery from illness? What are realistic health expectations? What are acceptable limitations to daily living? With relation to the social domain there are a number of questions to be addressed also. Who must fulfil the obligations for maintaining and promoting health? How should individuals be supported to manage life independently? Who is responsible for supporting participation in social networks and activities? How should subjectivity feature in health policy? These questions become all the more pertinent when buzzwords begin to emerge in policy discourses such as resilience, resources and lifestyle as found in *Healthy Ireland* (2013), Ireland's most recent strategy for promoting the population's health and wellbeing, because these terms are heavily loaded with the notion of responsibility, and in addition the policy goal of achieving complete physical social and mental wellbeing across populations.

Such policy angles began to emerge strongly after the drawing up of the *Ottawa Charter* in 1986. Importantly the *Ottawa Charter* (WHO, 1986) defined health promotion, which would become a central objective of health policy strategies at national scales, including Ireland (Health Service Executive, 2011). The *Ottawa Charter* (WHO, 1986) defines health promotion as follows:

> *'Health promotion is the process of enabling people to increase control over,*
> *and to improve, their health. To reach a state of complete physical mental and*
> *social wellbeing, an individual or group must be able to identify and to realize*

aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing.' (WHO, 1986: 1).

The definition of health promotion presented in the *Ottawa Charter* (1986) makes a number of assumptions, particularly about the agency of individuals to control their health, and the potential of achieving completeness in terms of a multidimensional wellbeing. In this brief definition alone there are a number of theoretical issues. In order to effectively apply policy strategies such as the actions set out in the *Ottawa Charter* (WHO, 1986), a thorough understanding of the policy's elements is required. At the most basic level it is necessary to question the assumptions of policy directives such as the *Ottawa Charter* (WHO, 1986), in order to devise the most appropriate strategies for addressing population health. These questions include asking how health should be defined, how wellbeing should be defined, what is the relationship between health and wellbeing, and based on these definitions, how can they be pursued both efficiently and effectively across various scales from the macro national scale to the micro scale of the situated and lived life. Later in this chapter parallel questions on defining healthy ageing will be explored as an equally complex theoretical issue for policies focused on health and wellbeing in later life.

In 1946 the World Health Organisation adopted a holistic definition of health as

'a state of complete physical, mental and social wellbeing and not merely the absence of disease and infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political beliefs, economic or social condition' (WHO, 1946: 1).

Before the WHO's holistic definition of health was published, Canguilhem (1943; 1991) argued that there was no such thing as a normal health status, and that health should not be defined statistically or mechanistically. Rather, health should be understood as the individual's ability to adapt to their environment because health is determined by circumstances. Both the animate and inanimate environment, as well as physical and social life dimensions may influence health. Canguilhem's (1943; 1991) view of health was a liberating one. His argument that health might be understood through adaptability is potentially valuable considering the range of forces that are influencing health today. Huber

et al. (2011) also argued that the 1946 definition of health is no longer adequate because of the rise in the number of chronic diseases, and that it has now become necessary to formulate a new definition. As an alternative perspective on what it means to be healthy, and similar to Canguilhem's (1943; 1991), Huber *et al.* (2011) suggest that the ability to adapt and self-manage, when confronted with social, physical, and emotional challenges provides a more appropriate definition of health. In the face of ageing demographic structures and the rate of chronic illnesses, the 1946 definition is arguably counterproductive because the notion of 'complete' physical, mental and social wellbeing is unachievable, and would define almost everyone as unhealthy most of the time.

On a conceptual level, health described as something that is both psychological and social suggests the relevance of life experiences, and so its conceptualisation appears to be more closely related to happiness than health (Saracci, 1997), again an existential and philosophical issue. A conceptualisation of health that resembles happiness leads to another dilemma about responsibility, that of health as a human right. While it is possible to argue that health as the absence of disease is a universal human right, as described recently in *Health 2020* (WHO, 2011: 11), it is less convincing to argue that happiness is also a human right, because happiness cannot be imposed on another individual (Saracci, 1997).[4]

Saracci (1997) provides four cautions against the WHO's holistic definition of health. Firstly, unhappiness can be regarded as a health problem requiring biomedical interventions. Secondly, the pursuit of happiness is unlimited in its scope, and so the demand for health services will also be unlimited. Thirdly, a prescriptive view of happiness may result, which undermines personal autonomy, and points towards a totalitarian regime where someone else decides what will make an individual happy. And finally a State led pursuit for happiness might subtract resources from providing essential acute and chronic health care services, and achieving equity in health care. One additional caution can be added here. The spiritual dimension of health, which was included as the fourth dimension of the WHO's definition in the 1980s (Mahler, 1987, cited in Lindstrom and Eriksson, 2010), would be particularly problematic to incorporate into health policy especially in countries such as Ireland where there has been a progressive uncoupling of the State and the

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[4] Governments are becoming increasingly interested in measure happiness Bhutan has led the way by introducing a Gross National Happiness Index in 2010 (Ura, 2012), and the UK government followed with a programme to measure wellbeing, or how its electorate 'are doing' (Self, Thomas and Randall, 2012).

Catholic Church in recent decades. Indeed, one area that was, and still is, exceptionally problematic is that very relationship between health, (organised) religion and national health policy. Tellingly when the British Office for National Statistics, led by David Cameron in 2010, set out to measure and define wellbeing the expert committee consisted of social scientists and economists and did not include any philosophers, priests or artists. The report noted that spirituality was an important aspect of their wellbeing, despite this spirituality or religion was not recognised in the formulation of wellbeing (Evans, 2012). And yet, as will be examined in Chapter Eight, experiences of spirituality and its practices can be subjectively significant to health, even when objectively measured and observed.

Saracci (1997) offers a solution suggesting that health could be regarded not as a completeness of the four dimensions outlined by the WHO, but rather as 'a condition of wellbeing free of disease or infirmity and a basic universal human right'. This he suggests requires appropriate and measureable indicators of mortality, morbidity and quality of life that remove ambiguity. Perhaps what he was arguing for was a return to the very original conceptualisation of health as merely the absence of physical illness, and that at the national level the eradication of illness and suffering would be sufficient to address the 'condition' of health, while at the same time provide the conditions that promote mental, social and spiritual wellbeing. Ideally, in achieving equality across a population the result should be a harmonising of society, where individuals were '*able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment'* (WHO, 1986: 1). Ideally, within a harmonious society people believe that they are valued, can reach their potential, and that their desires are attainable in society (Han, 2008). While this is a very ideological perspective of very complex issue, evidence does suggest that achieving equality within a society has a positive impact on the dimensions of health (Wilkinson and Pickett, 2009). Feelings of control might be easier to achieve in an equal society where an individual feels that they can realize their aspirations, satisfy their needs and cope with uncertainty. Achieving these basic conditions can still be done using the five actions[5] set out in the *Ottawa Charter* (WHO, 1986). The only difference is 'health' conceptually remains truly within the remit of the health care services, and other dimensions of wellbeing are located

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[5] The five actions of the Ottawa Charter are as follows: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, re-orientating health care services towards disease prevention and health promotion.

across a range of domains, and perhaps some are even outside the responsibility of the State once it has provided the necessary conditions to close the gap on inequality.

The concept of wellbeing cannot be overlooked either. Its use in the WHO's definition of health seems to suggest that it is the holistic result of satisfying physical, mental, social and spiritual needs. However, wellbeing itself has a considerable theoretical and philosophical history, and an exploration of its development adds to the complexity of that multidimensional space between the triangulation of reality, concept and definition where abstraction takes place. Wellbeing can be traced back to the Greek philosophy of having a good life, eudaimonia, which can be translated as happiness, or flourishing. Importantly, eudaimonia is not about achieving positive emotions such as happiness, but it is instead a value-laden and an intrinsically moral concept of doing the right thing for the right reasons. So when policies begin to talk about wellbeing and attempts are made to provide a proven model of a good life, wellbeing (flourishing or happiness whichever word is used to denote it) may become quite coercive (Pigliucci, 2012). For research such as this, that attempts to provide an empirical and theoretical angle to inform the evidence base for policies concerned with health and wellbeing in later life, moving from the tentative conclusions of empirical research to what a good life ought to be according to ethics and politics may result in a rigid dogma instructing people on how they must think, feel and live (Evans, 2012). The vision of wellbeing in Ireland, as outlined in *Healthy Ireland* (2013) is one that involves every level of society:

> *'A Healthy Ireland, where everyone can enjoy physical and mental health and wellbeing to their fullest potential, where wellbeing is valued and supported at every level of society and is everyone's responsibility'* (Department of Health, 2013: 6).

Not only does the responsibility for wellbeing involve every level of society but also wellbeing appears to be something decidedly different from physical and mental health. When every level of society is responsible for population wellbeing there will be numerous perspectives on what wellbeing is and how it should be promoted.

Instructions on leading a good life might be particularly devoid of reality and the experiential dimension depending on the methodology and epistemological standpoints applied in gathering the empirical data. Measuring eudaimonia or happiness (Linley *et al.*, 2009) can at best provide a crude indication of how people feel about their lives (for

example 1 is very content, 10 is very discontent), but it certainly cannot provide any detail on how an individual experiences and understands their place in the world. Measuring one's appraisal of their life cannot provide an evidence base that indicates how they engage with or conduct their life, or interact with the people around them, or actually live. When the particularity of aspects of daily life are examined in terms of thinking, feeling and living, as will be presented in the empirical chapters, the distance between writing policies on living a good life, and retrospective thoughts about living a good life becomes apparent. Further to this, the timing at which someone assesses eudaimonia is important. For the philosopher, approaching the end of life is a good time to start assessing life's worth. This is because the pursuance of eudaimonia requires taking time to reflect on the motivations that guide one's life (Pigliucci, 2012).

For health Geographers wishing to broaden their theoretical and methodological scope beyond the traditional and somewhat emotionally barren concerns of medicine, the concept of wellbeing has provided them with considerable leverage in terms of gathering empirical data. Of importance is the emergence of emotional geography, which attempts to understand emotions in terms of their 'socio-*spatial* mediation and articulation' (Davidson, *et al.*, 2007: 3, author's emphasis), and how the emotional experience of place can contribute to feelings of wellbeing, and also how the complex layering of social structure, history, nature and the built environment can act to either enhance or erode wellbeing (Kearns and Collins, 2012). Wellbeing research has opened up the possibility of exploring the subjectivities of experiencing place relationally for Geographers (Tan, 2013; Duff, 2012; Burke, *et al.*, 2013). The relational self in geography is important in untangling the significance of place for wellbeing. Relational geographies of the self view the self as an entity that emerges through relations with other people and events. These interrelations can have both positive and negative outcomes, on health and wellbeing for example, and these relations can be improved so as to have positive outcomes. In terms of time and space relational geographies are not fixed, but rather such relations can consist of ongoing friendships experienced in the present, as well as relationships with others across time and space using the faculties of memory and imagination. Of significance to wellbeing and Sense of Coherence research (as will become apparent via the empirical data later) is that the relational perspective in geography considers people's emotional life to be shaped by the wider relational context, and an ecological conception of place, that includes the human, non-human and the inanimate (Conradson, 2005; 2007).

The conceptualisation of health in this research

Gregg and O'Hara (2007) provided a set of values and principles that can be applied in defining health in health promotion. These values and principles are informed by holistic, ecological and salutogenic perspectives on health and wellbeing. These values and perspectives form the basic framework for this research. This framework is summarised as follows: Health is regarded as something that is lived, experienced and dynamic involving a whole-person approach that includes the mind, body and spirit. Epistemologically, knowledge about health is collectively constructed based on subjective experiences and understandings of those experiences, thus there are multiple truths rather than one single objective truth. Understanding health requires the researcher to acknowledge that people exist and experience their health across a range of scales from the micro-scale of the individual, to family, to community, up to the abstract scale of the population or societal level. This multi-scalar view of people's lives, the ecological perspective, focuses not on the individual parts of the scalar system, but attempts to understand how the whole system is connected and interrelated. Health is not just about the presence or absence of illness, or risk, but also considers aspects of wellbeing that promote health, as a subjective and holistic experience, and addresses the quality of life of those experiencing illness. Thus it provides scope for those who are physically ill to experience wellbeing and a good quality of life.

Conventionally health is considered an end in itself, however the holistic and salutogenic understanding of health considers health to be a resource or condition required in order to live a purposeful, meaningful and enjoyable life. When people are empowered and provided with the basic conditions of having their needs met, and social equality, they make healthful choices. Thus it is within the capacity of the family and community to promote healthy behaviours within the right conditions i.e. having access to the necessary resources, education, and opportunities to participate. Any good strategy that promotes health is about enabling and empowering individuals and groups to take control of their health. Such activities are participative and egalitarian in nature, and attempt to re-distribute power and avoid hierarchies of knowledge. Marginalised, vulnerable and disadvantaged groups are prioritised, and groups identified are seen as allies in a collaborative working process. They are acknowledged as experts on their lives, and because the needs of these groups are not always the most obvious or visible they are given the opportunity to voice their experiences and provide insight on the reality of their lived experience. Providing

opportunities to have the voices of communities, such as older people, heard is fundamental to collaborative working (Gregg and O'Hara, 2007).

Health in later life: The problem with ageing concepts and developing policy

It is difficult to develop ageing policies that commit to healthy ageing or active ageing models because they contain discourses, and thus confusion, regarding the nature of these concepts (Bowling, 2007). Several attempts have been made to understand positive health for older people, and these have led to a multiplicity of conceptualisations: successful ageing (Rowe and Kahn, 1997); active ageing (WHO, 2002) productive ageing (Kerschner, and Pegues, 1998); positive ageing (Bowling, 1993); and healthy ageing (Stewart and King, 1994; Kendig *et al.* 2001; Hermanova, 1995; US Dept. Health and Human Services, 2000). Irish national policy on ageing uses the broad conceptual idea of 'positive ageing' (National Positive Ageing Strategy, 2013). Each one of these conceptual ideas differs, and these differences will determine the direction of ageing policies. Fundamental to these conceptual ideas on ageing is the desire to remain active in social roles and activities that enhance feelings of wellbeing in later life (Bowling, 2008). Atchely's (1999) theory of continuity has been important in developing these concepts. Continuity theory focuses on the ability of older people to carry forward their values, activities and relationships into later life that promote their wellbeing. Importantly, what is carried forward into later life is meaningful to the individual, and this meaning is grounded in their biography and sense of self. According to Bowling (2008) theories of ageing do not pay enough attention to the distribution of power and resources, and the effects of inequality on the dynamics of ageing.

As a basis for informing policy on ageing, and to inform research on positive health outcomes in later life, a consensus should exist on how ageing is to be defined and measured in terms of its characteristics. What emerges from the literature is the multidimensional nature of ageing concepts, and a particular emphasis on the older person's capacity to function well, and adapt to the environment when confronted with the environmental challenges of the ageing body in terms of physical, mental and social wellbeing (Peel, Bartlett and McClure's, 2004). However, healthy ageing is not determined by achieving longevity and avoiding chronic illness alone, but is a much wider experience, as would be expected given the expanded definition of health discussed in the previous section. For example healthy ageing has been described and conceptualised as a life long process, with optimal conditions for positive health outcomes, including the preservation of health, the

promotion of physical, social and mental wellness, promoting and sustaining quality of life, supporting independence, and aiding people through life-course transitions (Health Canada, 2001). This is an all-encompassing definition, but notably it does not include the fourth dimension of health, spirituality, which has been identified as the forgotten dimension of healthy ageing despite its significance in the research literature (Dhar, Chaturvedi and Nandan, 2011).

While an abstract understanding of healthy ageing identifies its processes, the concept must also be considered as an empirical issue with measureable outcomes. It is here that some confusion exists, particularly in matching the definitional understandings of positive health in later life with empirical research that has been carried out. Knowing what to measure and subsequently developing policies that are centred on positive concepts of health, has proved difficult, because a biomedical and deficit model has been most widely applied. Research on the physical health and functional capacity of older people to inform definitions of ageing are quite plentiful (Vaillant and Mukamal, 2001; Burke, Arnold and Bild, 2001; Lamb and Meyers 1999; Leveille *et al.*, 1999; Reed, Foley and White, 1998; Baltes and Lang, 1997; Strawbridge *et al.*, 1996). The application of such pathological models in research cannot however provide adequate empirical data to inform discussions on healthy ageing because looking at objective illness cannot tell us about the characteristics or processes of ageing, or the experiences of ageing with illness (Grunding and Bowling, 1999). Continuing to describe healthy ageing in terms of functional capacity compounds the conceptual problem of defining successful ageing in a capitalist (threat-focused) world, where one's ability to age 'successfully' is determined by their ability to remain economically and socially productive, and independent (Bowling, 1993; Kendig *et al.* 2001). Fries' (1980) compression of morbidity model presents a pathogenically orientated understanding of successful ageing, whereby the ideal way to grow old is to remain functioning and independent for as long as possible, and to eventually die as the result of an acute illness. The notion of the older person as a burden to their family and to society can become tangled up very easily in discourses of functional capacity, and this does not recognise sufficiently the contribution made by older people to family and community life, or society more generally. According to Strawbridge (2000:14) older people experiencing health problems tend to feel they have not aged successfully – '[p]eople should never be told that they failed ageing because they had arthritis' (Strawbridge, 2000:14).

The pathogenic perspective does not sufficiently consider the older person who is ageing well despite suffering from chronic ill health, functional impairments or disabilities (Bowling and Diepp, 2005). Instead investigations into positive health concepts need to examine the 'symptoms' of wellness, and in the case of healthy ageing as a positive health concept '[i]nterest in healthy ageing requires researchers to shift their outcome measurements to focus on those persons who are ageing well' (Peel, Bartlett and McClure, 2004: 115). Given the WHO's definition of health, healthy ageing is not simply the opposite to ageing with disease, disability, or reduced functioning; other aspects must also be recognised, and the focus may need to expand beyond the concept of health, to consider the concept of wellbeing. The ageing body is complex, and thus it is not likely to be fully understood using physical reductionism as the analytical lens (Reed, Stanley and Clarke, 2004). There is also an assumption that healthy ageing is a 'measureable outcome' that can be empirically validated. (Peel, Bartlett and McClure, 2004).

In terms of policy development, without conceptual boundaries defining what 'healthy ageing' is, current health and social policy has had to assume the existence of a defined condition of healthy ageing, and such assumptions make it unlikely that healthy ageing policies can be implemented with success. Ireland's *National Positive Ageing Strategy* (DoH, 2013b) for example applies a very broad conceptualisation of positive ageing. Policy and research defines healthy ageing in positive terms, however, research on ageing and the empirical evidence from which the concept derives focuses predominantly on negative health conditions, morbidity, disability, and functional decline. Thus research design should provide scope for examining factors that influence health, but might not be readily identified as health promoting, primarily because of their subjective and experiential nature, such as having a sense of purpose, willpower, and other attitudinal characteristics (Bryant *et al.,* 2001). Making space for the subjective experience in ageing research is important, and this again requires researchers to look beyond the biomedical model, because according to Featherstone and Hepworth (1991) it acts to mask the subjective experience of the body as something that is both lived and experienced. Further to this the application of the biomedical does not provide scope for exploring the range of quality of life resources that promote health, such as relationships with family and friends, emotional wellbeing, the home environment, quality of relationships with neighbours and wider community life.

While the pathological model does not provide enough scope to ask questions relating to the wider dimensions of health in later life, the salutogenic orientation may

provide an appropriate, perhaps even a progressive, supplementary theoretical approach to the study of healthy ageing, allowing scope to explore its heterogeneous nature. This is because the salutogenic orientation opens up ageing research to examine the significance of the wider dimensions of health to the life of the older person, such as social participation (Garfein, 1995), being autonomous or self-determining in daily life (Bryant *et al.,* 2001; Ford, 2001), and subjective wellbeing (Day, 1993). Additionally when the salutogenic model is applied to existing perspectives on the lived experience of place and context in late life, as developed by Geographers and Environmental Gerontologists, the wider dimensions of health and wellbeing begin to emerge. The following section draws on the existing body of geographical gerontology research, and grounds the previous discussion on health in the policy and practical concept of ageing-in-place.

Geographical Gerontology

Geographers' interest in ageing research has encapsulated the theoretical and methodological developments and diversity in the discipline over time. Early research on ageing and older people carried out by Geographers reflected the traditions of the discipline of the time. Warnes (1981) for example set the agenda for Geographers in contributing to ageing studies suggesting that the focus of the Geographer's research on older people should look to the spatial aspects of older populations, in terms of their movement, location and the distribution of, demand for, and access to, the necessary services to support them to live in their communities. Rowles (1986) later suggested that for researchers to contribute meaningfully to the gerontology literature they should focus on the older person's relationship with their environment across various scales. Of significance he argued was the importance of place, and that through a meaningful engagement with the concept of place further contributions to understanding older people's lives could be made. Harper and Laws (1995) echoed Rowles' (1986) argument for the importance of place, suggesting that geographical gerontology should pay attention to emerging theoretical and methodological perspectives following the cultural turn in human geography and should progress alongside the discipline. Following the trends of the cultural turn and adoption of critical social theory, by applying a life course perspective, incorporating a gendered dimension into their research, and being reflexive, Geographers would move away from a paradigm dominated by positivistic spatial interpretations (Andrews and Phillips, 2005). Following Harper and Laws' (1995) proposition for the future of geography research on ageing and older people,

the theoretical and methodological scope of geographical gerontology has expanded greatly (Andrews, *et al*., 2007). In more recent years Geographers have engaged with three areas of ageing research 1) spatial trends in population ageing; 2) health, healthcare and care-giving and 3) the various settings and environments of ageing (Skinner, Cloutier and Andrews, 2014). This review of geographical gerontology will focus primarily on the insights from Geographers on the latter two areas, and will be supplemented by insights from environmental gerontology.

For the Geographer interested in the unfolding of the older person's life in place they pay attention to the interconnected nature of these lives and how the lived experience reflects the rhythms and histories of place. Indeed, the geographies of the older person's life world pays attention to the role of the older person in establishing those rhythms, and as a character in that place's history, whether place refers to the micro-geographies of the home, or the more extended geographies of the neighbourhood or community, right up to the national scale (Rowles, 2003). For the Geographer the life course unfolds within a context of time and events, and within place. The lived experience is strongly influenced by this context, to the point that each stage of life can be viewed as a social and spatial construct. Life is regarded as something that is 'created in the social environment by institutions, traditions, and the general expectations of families and communities' (Fincher, 2009: 207). In the experiential sense, place begins to take on a special meaning and has strong emotional attachment when it is explored with relation to the lived experience (Rowles, 2003). Through both memory and attachment place becomes infused with emotion, both negative and positive, and is established as having a certain degree of significance in the context of the life course. According to Andrews and Phillips (2005) place attachment plays an important role in facilitating wellbeing.

Geographers began to pay attention to the lived experience of individuals in the 1970's with the emergence of phenomenological Geography. The introduction of phenomenology, as the 'description and interpretation of the human experience' (Seamon, 2000), to Human Geography opened up the discipline to a range of methods and research questions. Within the phenomenological tradition of research the everyday and the ordinary is given significance, nothing is taken for granted. According to Seamon (1979) we live transparent lives, where the day-to-day just happens, especially when we are in good health, it is only when we experience illness or disability that the 'taken for granted' emerges as significant. The phenomenological approach to uncovering the life world opens up the lived

experience to make the seemingly insignificant significant, consequently phenomenology lends itself very well to the salutogenic question of what creates health, by both paying attention to the ordinary, and also by examining the ongoing processes at the person-place interface.

For the Geographer interested in the experiences of ageing, the home as an experiential site, and as a concept, is a good place to begin to explore the Geographer's contribution to ageing research.

Home as place

Tuan (1977) provides the Geographer interested in ageing and older people's experience of place, with valuable insight on place as a felt and experienced entity. Ageing-in-place is inherently a spatial concept, and it demands that the basic components of the lived world are not taken for granted, but rather that the complex nature of human experiences of space and place is examined with consideration for the consequences of living life in 'place'. Living life in 'place', as ageing-in-place implies, requires place to be recognised as centres of felt value, to which people respond in complicated ways and attach meaning (Tuan, 1977: 4). Throughout this thesis the Sense of Coherence is applied to understanding what it means to live life in place, and the implications for health and wellbeing.

Home is central to the concept of ageing-in-place and refers in a policy and practical sense to the home environment situated within wider community life as a site of long-term care, where the required care can be delivered both formally and informally (Dyck *et al*., 2005). As a policy strategy ageing-in-place prevents the need for institutional care (Bookman, 2008). To the older person the idea of 'home' is often however a much more loaded term. Home is a location that is known intimately. It is a site of deep emotional experience, attachment and identity. It is what Relph refers to as a place of 'existential insidedness' (Relph, 1976). When home is threatened, for example when ill health requires a necessary relocation into residential care, the true importance of home to the lifeworld emerges (Relph, 1976). Home is also a site for knowing and constructing subjective reality, and for remembering and feeling close to previously known realities. As an experiential space home can reflect the passage of time, acting as a focal point in the cycle of life – first home, marriage, births, raising a family, and deaths (Tuan, 1977). In its physical capacity, and its permanence, home as place has an enduring quality that the body lacks in its biological weakness, which might explain to some extent one's attachment to home as they

approach their latter years of life (Tuan, 1977: 140). Rowles (1983) found that attachment to place was stronger among the old-old, those over 75 years, than the more mobile younger-old. The environment can come to represent life itself for the older person because of its endurance, thereby embodying the person's life course and in reflecting their personhood (Rubenstein, 1989). Sense of time can thus affect one's sense of place, and looking back in time through memories of place may provide the older person with an acquired sense of self and identity (Tuan, 1977: 186). Through a lasting relationship with place, in terms of its permanence and longevity, the older person can identify with something more than 'what the thin present defines' (Tuan, 1977: 186), i.e. the frail, ageing or mortal body. According to Rowles (1978; 1983) having intense feelings for certain spaces arising from social, physical and autobiographical 'insidedness' potentially provides the individual with a means to maintain identity during change. Social connectedness, or the feeling of being part of a community and having good social relationships for instance, might be an indicator of potential access to support during times of change for older people (Rowles, 2003).

In environmental gerontology the relational or reflexive self and place have an important relationship. According to environmental gerontology meaning is assigned to place by projecting the self onto a given place or environment. In addition there is also a counter-projection of the self where the self is contained in a given environment and can be counter-projected back onto the person. This is particularly important if or when notions of the self become weakened in later life (Rubinstein and de Medeiros, 2005: 49). Place can remind the older person of who they are, where they have come from and to what they belong. Likewise, the relational geographies of age perspective presented by Hopkins and Pain (2007) recognises that older people are embedded in the environments of their home and their community, and they exist within a wide network of people at different scales. From this embeddedness they act as co-creators of their world (Cummins *et al*., 2007; Skinner, Cloutier and Andrews, 2014). Cutchin's (1997a) concept of 'place integration' incorporates the individual's sense of self and place with a commitment to overcome the challenges of everyday life in that given place to become 'at home' there. Cutchin (1997b) also provides a detailed exploration of what the self is, and the constancy and the pervasiveness of the self in every experience. He identifies the self as a 'intersubjective entity', where the self exists as an independent and creative being, but one that is also shaped by the 'values, rules and actions of the community and social group to which it belongs' (Cutchin, 2007b: 1662). The self is the personal, or inward, and social, or outward,

consciousness 'bound into a coherent identity and personality' (Cutchin, 2007b: 1662). Furthermore the self is 'place-based because interactions are centred in the communities of our locales' (Cutchin, 2007b: 1663). Several other Geographers have similarly identified the close relationship between space, time and identity (Massey, 1994; Pile and Thrift, 1995). Explaining the intricacies of this relationship, and ultimately the consequence of this relationship for health and wellbeing, is an important concern for the health Geographer. The Sense of Coherence, as will become evident when it is examined in detail in the following chapter, provides insight on the affective and thought processes that exist at the self-place interface, or during place integration as described by Cutchin (1997a). Potentially the components of the SOC can provide a richer conceptual basis on which to build insight of the notions of historical, social and emergent selves as presented by Cutchin (1997a). However, in its current state the SOC lacks qualitative insight to add to the Geographer and Gerontologist's discussions on the person-place relationship, or even self-place relationship. This thesis, as already stated, examines the SOC qualitatively, thus establishing a new dialogue between Geography, Gerontology and Salutogenic theory. The relational geography of age perspective, which begins this discussion, is reviewed in detail, and is used to examine and explore the empirical data in Chapter 7.

Casey (2001: 684) claims that place cannot exist without the self, and the self cannot exist without place. In order to understand the intense bond between people and place some Geographers have employed the concept of 'affect' (Duff, 2010; Anderson, 2009; Anderson, 2006; Thrift, 2004). Of importance to the Geographer particularly is the role that place has in the constitution of affect as it arises from encounters between bodies in place, and between bodies and place (Thrift, 2004). Affect is not emotion, but rather it refers to an individual's dispositional orientation (Duff, 2010), and is an observational expression of emotion. Affect is powerful in that it can influence the constitute power of bodies (Duff, 2010). The concept of affect is much like the Sense of Coherence in that the SOC appears to have a similar power. Indeed the application of the SOC to an empirical investigation, as will be done in this thesis, could potentially act as a means to measure and capture 'affect' at the interface between person and place, but only once it's components are more clearly defined in a lived or experiential sense. As will become obvious throughout the thesis the SOC lends itself very well to framing the affective power of the person-place relationship through an investigation of the lived experience. Not only this but the SOC can also take

geographical thought one step further to connect and explain the health and wellbeing impacts of the affective power of place.

We experience place by being 'affected' by it (Duff, 2010: 881), when we experience place or are affected by place such places are referred to as 'thick places' because they contribute to personal enrichment, they have meaning, and enhance one's sense of belonging. Home might thus be described as a thick place. Thick places are said to have an affective pull. 'Thin places' on the other hand do not hold any intense feelings of belonging or meaning, and do not contribute to personal enrichment (Duff, 2010). The diverging ontology of thick and thin places, or meaningful or meaningless places, are arguably dependent on dispositional orientation (both affect and the SOC are described as dispositional orientations), therefore it is important to keep in mind that a meaningful connection with place might be subject to the willingness of the individual to find meaning or connection, and how this degree of willingness plays out. The significance of the dispositional orientation will emerge later in the thesis.

The notion of home as both a physical location and a psychological concept most often suggests warmth, security and a haven for escaping to. On the other hand, home can also become a site of inequitable relations, psychological tensions and violence therefore the concept of home is often complex and sometimes contradictory (Bowlby *et al*., 1997: 343). Home symbolises notions of the 'family', child rearing, and the life course trajectories of family members, where home is most commonly understood and viewed as a gendered space. This symbolising of home using the nuclear family relationship as its basis (headed by a heterosexual couple) is problematic because it marginalises alternative living arrangements and alternative family units that are now commonplace (Bowlby *et al*., 1997). The emotional texture of home can also be determined by the feelings we have towards the people there, or indeed the 'felt' presence of deceased loved ones. And while these feelings can be very intense they are not always positive, nor are the relationships always the nurturing kind associated with a comfortable home environment. In the most extreme cases, situations of domestic abuse and elder abuse are examples of intensely negative emotional experiences that arise in the intimacy of the home environment.

While home is idealised as the most appropriate place to grow old in tensions can and do arise for older people there, such as problems posed by the physical condition of the home (Wood, 2005), conflict regarding the provision of care (Lowenstein, 2009), mobility issues (Metz, 2000), the walkability of neighbourhoods (Wood *et al*., 2008), the quality of

the neighbourhood environment (Scharf and De Jong Gierveld, 2008), and social exclusion and loneliness (Victor *et al.*, 2009). For some older people their ability to remain living at home is spatially contingent because access to the necessary supports and resources varies considerably from place to place (Andrews and Phillips, 2005).

Home as a site of caring

The changing spatiality of care-giving has attracted the attention of health geographers in particular to the role of the caregiver (Parr, 2003; Wiles, 2003), both paid and informal, in supporting older people (Milligan, 2010) and those with disabilities (Gleeson and Kearns, 2001) to live in the community rather than in an institutional setting.

The shift in the spatial focus of care from institutional care, or the deinstitutionalisation of care, to community based alternatives, such as day care and domiciliary care, puts an increasing emphasis on the use of the 'homespace' as the 'preferred location of health and social services' (Milligan, 2000: 49). Home as a location of care can however become contested and reconstructed physically, socially and symbolically when it becomes a site for regular long-term health care (Dyck *et al*., 2005). According to Tuan (1977: 138)

> *'[i]n sickness adults also know frailty and dependency. A sick person, secure in the familiarity of his home and comforted by the presence of those he loves, appreciates the full meaning of nurture. Intimate places are places of nurture where fundamental needs are heeded and cared for without fuss.'*

To be 'cared for without fuss' at home is often, but not always, the reality of ageing-in-place. The relocation of older people's care to the home environment poses significant challenges, because the home as a site of care brings the public and private into tension (Milligan, 2009: 67). This is because the reality of providing care intensively in the home results in a changing of its spaces and their uses. When the home is opened up to care providers, most often strangers, the boundaries that define and separate the private and personal space of the home are dismantled (Milligan, 2009). Additionally, where a once private living room is used as a site for both informal and formal care provisioning for example there is an apparent 'institutionalisation' of that private space occurring (Milligan, 2000: 55). While the use of the spaces of the home might change depending on who is the caregiver, for some people dependent on others to meet their care needs this

'institutionalisation' of the homespace is a necessity to preserve their dignity. For the person receiving care in their home there is a challenge posed to existing relationships with family and other potential caregivers that could perhaps be avoided with the employment of a stranger to provide intimate care (Twigg, 2000).

Twigg (2000) highlighted the significance of the mundane spaces of home in the provision of intimate care. She argues that it is by paying attention to the fine texture of the ordinary that we can gain insight on the multiple meanings of being cared for at home, including, but not limited to, the importance of maintaining one's identity and appearance of bodily integrity within the home environment, as well as the home as a reflection of wider society. In her research on the body and intimate care, specifically bathing and washing, Twigg (2000) found that older and disabled people generally preferred intimate tasks to be carried out by a stranger in a defined care-giving relationship, rather than by a known family member or friend. This was to maintain existing relationships usually acted out in the home, and to prevent the formation of a new identity as someone unable to manage their bodily functions. In this way the negativities of the body are hidden and taken care of by the caregiver thereby hiding the realities of ageing and disability. Both Milligan (2009) and Twigg's (2000) discussions suggest that to be cared for at home 'without fuss', as Tuan describes, is a complex and multilayered process that exists within a wider context of political, ideological and subjective discourses on who should provide the necessary care for older people (Milligan, 2006).

According to Dyck *et al*. (2005: 173) home as a 'caregiving space' is embedded in 'policies and practices constructed at a scale beyond home' and within a 'climate of extensive cost-cutting measures'. While the statutory sector and families have made a considerable effort to provide older people with adequate care so that they can remain living at home, there is a need for policy-makers and practitioners to pay attention to the role of friends and neighbours in supporting older people to remain living at home, and not to take informal caregivers for granted (Nocon and Pearson, 2000). According to Nocon and Pearson's (2000) study there are many friends and neighbours engaged in very intense care-giving for older people living at home, however there is some difficulty in formalising a care-giving relationship between friends and/or neighbours. This is because there is a 'fuzzy boundary between neighbourliness and friendship on the one hand, and 'care' on the other' (Nocon and Pearson, 2000: 364). While such caring relationships are difficult to formalise

there is a considerable move towards formalising the care giving structures of the community and voluntary sector, this will be discussed in the next section.

Changes to the structure of family means that relying on informal care giving to support older people to age-in-place in the future might be more precarious than it was in the past. While relatives have been the main source of informal support for older people living at home the increasing participation of women in paid employment, the dispersal of families around the globe, increasing rates of divorce and separation, people choosing to have fewer children and later in life means that people are now more likely to end up living alone and without family support in later life. Further to this the foundations of close knit and mutually supporting neighbourhoods are undermined in recent years by the availability of private transport, housing and employment patterns which means that people's social networks tend not to be confined to a small area (Nocon and Pearson, 2000). In an effort to understand older people's experiences of ageing-in-place and the 'care' they receive it is important to locate them outside of the home and within a wider community or neighbourhood setting.

Community and Voluntarism

Home as a concept is elastic in nature. Conceptually it can stretch from the micro-geographies of the household out into the neighbourhood. It can incorporate community, or parish, and can stretch all the way up to the national scale so that a given country can equally be referred to as 'home'. The home itself exists within a larger context, and this context contributes to both the meaning and the experience of home. Within the lifespan place attachment includes bonds with the broader community and its members as well as to the place itself (Rowles and Ravdal, 2002). Relatedly, Thomas and Blanchard (2009) suggest the practical and conceptual approach of 'ageing-in-community' as an alternative to ageing-in-place, which emphasises the importance of social relationships over place.

Community is a broader symbolic identity to which people feel a sense of belonging, and to which they can situate themselves relationally inside a collective. However, communities and neighbourhoods are always in a process of becoming, and so an important aspect of place attachment that includes social bonds is the ability of individuals, both old and young, to adapt to changes over the life cycle – that is the person's lifecycle and the lifecycle of the community or neighbourhood also (Norris-Baker and Scheidt, 2005: 281). Such changes include the composition of the neighbourhood, its character or

atmosphere and its physical environment. For older people who are long-time residents of an area they may have a particularly strong attachment to or bond with the community, having spent many years establishing their identity, and gaining an autobiographical affinity with the community (Rowles and Ravdal, 2002). For some older people however they might never have felt an affinity with the local community because of discrimination, marginalisation or social exclusion experienced earlier in life. Age-friendly and local development policies are working towards incorporating both younger and older people firmly into the social fabric in an effort to promote social cohesion, inclusion and wellbeing across the lifecycle (Golant, 2014).

Relating to the social position of the older person within a wider community, Tuan (1977: 146) argues that 'life is lived, not as a pageant from which we stand aside and observe' but rather that we locate ourselves through place within a wider flow of life and activity. This is reflected in healthy ageing policies that encourage older people to stay active and engaged in family and community life, and encourage communities to provide opportunities for intergenerational relationships to form. For Milligan (2009) this is neoliberal policy trying to reinvigorate active citizenship and subsequently there is an expectation that the local community can and will act as a 'prop' to support (and include) it's older members (Milligan, 2009: 91). The reinvigorating of communities to embrace its older members and include them in social life comes in anticipation of a burdening ageing population, and also an acknowledgement of the importance of social relationships in promoting health and wellbeing. Encouraging communities to actively include older people also appears to be a measure taken against what Laws (1997) terms 'ageism of space', where older people are made invisible while youth remain visible. Ageism of space relates to age segregation which acts to undermine the notion that places are lived in and experienced as 'centres of felt value' (Tuan, 1977: 4) and thus through age segregation, for example institutionalisation, the organisation of space acts to impose an identity of dependence and/or otherness (Laws, 1997). This segregation of older people from the flow of activity resembles what Tuan describes as living life as if it is a pageant (Tuan, 1977: 146), by moving the older person away from the vibrancy of community life. For some older people just hearing and seeing life in the neighbourhood from their homes is enough to feel that they are part of or belong to that collective (Fobker and Grotz, 2006; Ewart and Luck, 2013).

Age segregation at the neighbourhood scale can indeed happen unintentionally. Within the immediate context of the neighbourhood it is often difficult for older people, particularly those with mobility issues confined indoors, to engage with their neighbours. Furthermore empty streets during the daytime means that older people's opportunities for encounters with their neighbours are limited. Because younger people tend to work away from home, and particularly now with more women in the labour market, there can be a lack of regular contact with neighbours, which is often necessary to establish the connections that potentially lead to informal social and instrumental support (Lager *et al*., 2015). For older people in rural or isolated areas opportunities for casual encounters with neighbours might be more difficult, as is the development and maintenance of a consistent support network. Neighbourhoods, rural or urban, are evidently not an isotropic surface because not everyone has equal access to social and instrumental supports. The difficulty here is further compounded by the restructuring of welfare societies and an increasing emphasis on the role of the community and voluntary sector in supporting older people to age-in-place (Skinner and Joseph, 2007).

There can be substantial gaps in the provision of services required to support older people to live in rural areas especially (Wenger, 2001), so rural communities often depend on the community and voluntary sector to make ageing-in-place possible (Hanlon *et al*., 2014; Joseph and Skinner, 2012; Skinner, 2008), or in some rural places family and friends are relied on to provide care informally (Cloutier-Fisher and Joseph, 2000). However, not all communities have a strong voluntary sector that actively respond to local needs (Hanlon and Halseth, 2005), for example Milligan's (2001) study of welfare provision for frail older people and voluntary group activity in Scotland demonstrates how local politics can determine the development of voluntary organisations, and explain their distribution between urban and rural areas. Despite the issues with spatial variation in voluntarism, the voluntary sector does deliver very valuable supports for older people. Other influences determining the spatiality of voluntarism include the availability and willingness of volunteers. For example, place attachment has been identified as a significant determinant of (older) people's willingness to volunteer, in particular having a strong sense of attachment to their community and locale, and ascribing significance to place and community in the formation of their identity (Fraser *et al*., 2009)

There are many voluntary and community led initiatives designed and delivered to enhance the quality of life, and to promote the health and wellbeing, of older people living

at home. While these supports are often functional, for example medical transport schemes to access health care in a rural area (Sherwood and Lewis, 2000), many specifically address the social or emotional needs of older people. One major issue affecting older people's quality of life is loneliness and social isolation, a challenge that is described in great detail in Chapter. 8 Social gerontologists recognise that non-family social interactions are important for the older person's subjective wellbeing, and in preventing feelings of isolation (Andrews *et al*., 2003). One example of community initiatives set up to attend to the social and emotional needs of older people are befriending services (Andrews *et al*., 2003). Befriending services attempt to alleviate loneliness and isolation by providing conversation and companionship, and acts as effective network-building interventions in an effort to maintain or promote older people's mental health. While friendships established through a befriending service are bound by a formal code of practice and a contract, meaningful bonds do often result and are effective in tackling loneliness (Andrews *et al*., 2003). Active retirement groups are another C&V sector response to older people's needs, and hold a very important role in supporting older people in Ireland to remain active and engaged in society, as well as keeping them 'present' in wider social and community life. They also have a strong political influence exercised by advocating for the needs and rights of older people. Additionally active retirement groups facilitate in the development of social cohesion and social capital, and importantly they position older people right at the heart of community life and society (Walsh and O'Shea, 2008). Returning to the role played by individual disposition or perception it must be noted that even if supports are made available to older people, such as for instance befriending services, the provision of such 'local opportunity structures' are not a predictor of social support, because the benefits are determined by whether or not the individual perceives that the opportunity structures are worth engaging with (Buffel *et al*., 2012).

Aspects of salutogenic theory are applied practically to a form of community development referred to as 'asset based community development', and refers to collective action undertaken by the community and voluntary sector to improve the quality of life and promote the health of communities and neighbourhoods by drawing out and building on their existing assets (Morgan and Ziglio, 2007). Again there is potential for dialogue between salutogenic theory and an established group of Geographers interested in the 'voluntary turn' and the health geographies of voluntarism. While salutogenic theory can potentially add significantly to the geographies of voluntarism, by providing a useful

framework for situating voluntarism conceptually and practically, the geographies of voluntarism provides very valuable insight on the contextual emergence of community development and voluntary activity, and its resulting spatiality.

A new disciplinary intersection: The SOC and Geographical Gerontology

Geographical research on ageing has tended in the past to explore the vulnerability of older people within a given context rather than their resilience (Andrews and Phillips, 2005), but more recently there is an emerging interest in the health promoting aspects of places, and how some places facilitate wellbeing and resilience (Cutchin, 2005; Wiles, 2005; Wiles *et al.*, 2009). This reflects developments in the wider discipline (Kearns and Moon, 2002), and it also provides an excellent inroad for salutogenic theory and an opportunity for Geographers to engage with the SOC. Through engaging with theories of resilience from outside the discipline geographical research on ageing should gain some ground and establish itself as an influential strand of the discipline, a problem noted twenty years ago by Harper and Laws (1995) and reaffirmed by Skinner, Cloutier and Andrews (2014) more recently. The sustained interest in the importance of place in the human experience of ageing (Cutchin, 2005; Milligan, 2009; Golant 2003) could be reinvigorated through the application of the SOC by establishing a new analytical perspective on the person-place relationship, and in addition lead to new methodological approaches and empirical enquiry.

An emerging focus on resilience marks a shift from a deficits-based model to a strengths-based one to examine later life. Resilience, defined as an individuals 'successful adaptation to adversity', has traditionally focused on children's experiences of growing up and becoming more resilient when faced with adversity (Reich, Zautra and Hall, 2012: 4), whereas older people have generally been regarded as a group that demonstrates less and less resilience with time (Fry and Keyes, 2010). One of the main reasons resilience has emerged as an important perspective on ageing is the increasing numbers of people living longer with chronic illness, thus requiring coping and adaptation skills (Huber, 2011). As described in Chapter Two, recent epidemiological trends for Ireland indicate that future trends in cancers, type-2 diabetes, dementia and obesity are posing a significant threat to population health, and especially the health of older people. Conceptualisations of ageing, such as successful ageing, are thus difficult to achieve across a population within this epidemiological context. The application of resilience to understand population ageing requires a holistic view of the older person, recognising the emotional (Elder and Colerick

Clipp, 2006), psychological (Ong, *et al.*, 2006), social (Bartley, 2006) and spiritual (Ramsey and Blieszner, 2013) dimensions of resilience in later life. Resilience is thus not a fixed personality trait but is a multidimensional and multilevel process (Whittington, 2014). Much of what is presented in this thesis builds on, and in fact compliments, Wiles' *et al.* (2012) research on resilience and older people by introducing salutogenic theory to this existing knowledge. Through their research Wiles *et al.* (2012) advocate for incorporating vulnerability into discussions on older people's resilience thus recognising that resilience can co-exist with vulnerability, so that even those with serious illness can be viewed as ageing well because resilience is multidimensional and treats the individual holistically. As Wiles (2011) pointed out recognising and living with vulnerability requires resilience and by recognising the co-existence of vulnerability and resilience the negative stereotypes of the aged body is challenged. The key contribution made by this thesis in developing this view further is the application of Antonovsky's health-ease-dis-ease continuum along which individuals move towards or away from the healthy pole depending on the balance of generalised resistance resources and generalised resistance deficits (Antonovsky, 1987). Referring back to Wiles *et al.* (2012), the level of resilience resulting from these resources and deficits, and the older individual's subsequent movement along the continuum, are dependent on the broader social and physical contexts in which the older person's life in embedded. The theory of salutogenesis and the analytical construct of the SOC lends itself very well to examining resilience as an outcome of the person-place relationship, although the SOC does emphasis the individual's disposition in determining resilience, it also recognises the role of context in both building resilience and undermining it. This once again compliments Wiles *et al.* (2012) because it provides an additional theoretical and analytical means to move towards a potentially clearer understanding of the cognitive processes that occur at the person-place interface where resilience appears to be either underpinned or undermined. Antonovsky's (1987) formulation of the SOC seems to advocate for the role of the individual's internal resources in determining their resilience, while Wiles *et al.* (2012) argues that it is only at a surface level that internal characteristics are determining resilience, and rather it is the wider context in which the individual is embedded that is determining resilience. In response this thesis unpacks these contradicting viewpoints using the SOC as the analytical focal point. In terms of research methodology Wiles *et al.* (2012) demonstrates the value of using a narrative or in-depth qualitative methodological approach to explore resilience in later life, in particular its value in

accessing the nuanced and complex interactions between individuals and their environments.

Geographical gerontology is a comfortable place to co-develop theories and concepts such as those around ageing and resilience, and to derive empirical knowledge on older people's relationships with space and place (Andrews *et al*., 2009). What has been presented so far of the geographical gerontology literature represents its broad remit. Evidently Geographers have made a considerable contribution to ageing research, yet despite this there is concern that theory is absent from geographical work on ageing, and in response to this there is a call for a 'distinct body of conceptual and theoretical knowledge' to take geographical gerontology to the next level and to inform existing empirical expertise (Andrews *et al*., 2009: 1653). The empirical and theoretical research presented in this thesis answers this call by bringing the theoretical and philosophical perspective of salutogenesis from health promotion as discussed earlier in this chapter and merging it with the theoretical inroads of Geography such as the 'relational geographies of age' approach which incorporates intergenerationality and the lifecourse (Hopkins and Pain, 2007), geographical perspectives on life transitions (Horschelmann, 2011), and the emotional geographies of belonging (Wright, 2014). Each of these theoretical perspectives on ageing are detailed in the results chapters alongside the empirical data, and form a basis for the thesis's empirical discussion.

Chapter 4

Developing a new paradigm of ageing research

Health, the 'River of Life' and health policy formation

Before examining the theory of salutogenesis as put forward by Antonovsky (1987), it is useful to outline the 'River of Life' metaphor as a guide to the health policy process, and to provide a visual representation of curative, preventative and promotive health policy models. Health promotion, as an emerging force tackling health issues, represents a major policy step forward from the concept of disease prevention. This is because it introduces and locates the idea of positive health in the policy process. Conceptually, health promotion is related to the WHO's definition of health. When we talk about health, we are not just talking solely in terms of the presence or absence of disease, we are also talking about, for example quality of life, wellbeing, life satisfaction and happiness, which are just some examples of positive concepts of health. Eriksson and Lindstrom (2008) developed and further expanded the 'River of Life' metaphor (see figure 4.1) first introduced by Antonovsky (1987). This thesis attempts to develop the metaphor even further by aligning it with the necessity to develop policies for healthy population ageing. The 'River of Life' metaphor locates positive concepts of health along a policy continuum, on which strategies for health can also be located.
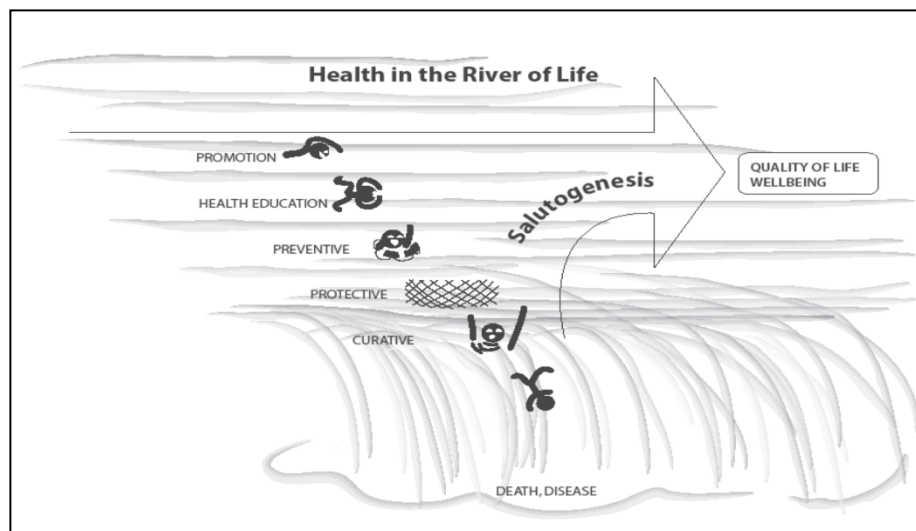
Figure 4.1 The River of Life (Eriksson and Lindstrom, 2008: 195)

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The downstream health policy focus on the River of Life

Policies located downstream on the River of Life are those relating to the disease care system, or the curative model of medicine. The disease care system is focused on meeting the care needs of those already ill. Such needs are addressed primarily using medical technology and treatment. Interventions further upstream, or offering support or interventions earlier on, are expected to prevent the need for such expensive curative measures which may not even restore health. Metaphorically, downstream health policies are devoted to those swimming in dangerous waters (individuals or groups at risk), or even drowning. Research that aims to inform the work of the disease care model are asking pathogenically orientated questions, such as questioning the treatment options, and the prognosis (Eriksson and Lindstrom, 2008).

The mid-stream health policy focus on the River of Life

The disease prevention system and its policies are located mid-stream on the River of Life, where the focus is on the causes of the disease in terms of both aetiology and the determinants of health. Disease prevention policies are about preventing the causes of disease, and intervening to limit risk of illness. To use the River of Life metaphor, the disease prevention system is asking 'who or what is pushing them into the river in the first place?' (Antonovsky, 1996: 12). Policy options for disease prevention are again pathogenically orientated, and are about limiting threats to health, whereby the focus is on the cause of illness, and the salutary efforts are concentrated on the characteristics of risk and responding to them (Eriksson and Lindstrom, 2008).

The up-stream health policy focus on the River of Life

Health promotion is yet another policy perspective, and it is located on the banks of the River of Life. The health promotion approach asks another very different question, and that is what creates health? It is here at this location on the River of Life, or under this policy perspective of health promotion that this research is located. Health promotion is a positive concept, and unlike downstream policy perspectives where the focus is on risk and illness, health promotion is concerned with both social and personal resources and capacities, and their positive influence on health (Eriksson and Lindstrom, 2008). The health promotion focus further compounds the notion that public health is 'everywhere and nowhere' (MacKian *et al*., 2003; Wylie, Griffiths and Hunter, 1999). The significance of this view of

public health is that health is opened up to a range of actors, and is no longer considered to be the 'sole preserve of medics' (MacKian *et al*., 2003: 220). There is a certain urgency to establish an understanding of health and its determinants when the sole responsibility for health is gradually being removed from the medical practitioners and clinical setting, to be instead dispersed across a range of actors, thereby blurring the boundaries of responsibility for health (Fyfe and Milligan, 2003; Milligan and Conradson, 2006).

Health outcomes - a new focus for geographers

Measurements of health outcomes have relied significantly on the difference in health status between population groups, or health inequalities (Mathar and Loncar, 2006). The reduction of gaps in health status between these groups, whether they are groups defined by their social class, ethnicity, gender or geography, is a central objective of public health today (Department of Health, 2013a). In order to address these health gaps research on the causes of inequality is crucial. Yet, while it is impossible to deny the importance and significance of efforts to understand patterns of ill health, for example the Whitehall studies (Marmot *et al*., 1991), and other studies on social inequalities, the social gradient and health (Marmot and Wilkinson, 2005; Wilkinson and Marmot, 2003; Wilkinson and Pickett, 2006), it should be noted that health outcomes are generally measured in terms of mortality and disease burden, with comparatively less attention paid to investigating the processes of positive health. Therefore, measures of population health are more often measures of population ill health. Relating this pathogenic focus on ill health to Eriksson and Lindstrom's (2008) *River of Life* research metaphor, and with it the evidence base, health outcomes are predominantly located downstream. As a result policy responses, or solutions, will also have a downstream, curative health system focus. For any real progress to be made in eliminating health disparities a new paradigm in health research that goes beyond the focus of meeting the health needs of a population using a curative health system will need to be utilised (Levine *et al.,* 2001). As the health system continues to be the anchor for public health, health promotion is merely a 'sleeping giant', which can only be woken if health promotion advocates embark on a strategy of transforming public and political opinion on the centrality of the health care system in contributing to overall health (Wise and Nutbeam, 2007: 26). Health promotion needs to affirm its identity to ensure that it is recognised as part of the new public health paradigm (Raeburn and Rootman, 1998). Until health promotion is sufficiently recognised and embraced it is unlikely that health inequalities will ever be fully

addressed, perhaps because health promotion research offers a revitalised evidence base for public health that may crucially further inform our understanding of health (Morgan and Ziglio, 2007). With this in mind, it has also been suggested that interdisciplinary research on health promotion has not yet reached its potential (Ridde, Guichard and Houeto, 2007).

The health geographer's role has been very important in conducting epidemiological examinations of health outcomes and health inequalities manifesting in many forms, such as societal and spatial patterning of mortality, age-standardised and cause specific mortality, life expectancy, healthy life expectancy, morbidity and disability. They have also made significant contributions to informing health care planning (Gattrel and Elliott, 2009). Health geographies engagement with positive health concepts has however been limited, yet Fleuret and Atkinson (2007) have identified wellbeing as a new arena for health geographers to engage with positive health as an increasingly important idea in contemporary health debates. Accepting the *River of Life* metaphor, marrying the salutogenic orientation with the health geographer's focus on the intrinsic relationship between health and place, and in addition the push for supportive environments (which in itself is a strongly geographic concept relating health to place) as outlined in the *Ottawa Charter* (WHO, 1986) it would appear that the health geographer's contribution to the field of health promotion has not yet been fully realised.

Perhaps, one of the main contributions made by this thesis to the development of health geography is its engagement with the salutogenic theory of health promotion, introducing the salutogenic orientation into geographic thought, and making a distinction between pathogenic and salutogenic health geography research. By making explicit the pathogenic-salutogenic dichotomy it becomes possible to locate the health geographer's research within the health policy process, thereby addressing the task of policy relevance, much debated within the discipline (Ward, 2005; Martin, 2001; Parr, 2004). Identifying the specific contribution health and medical geographers can provide in explaining patterns of health outcomes at the different stages of the *River of Life* is an important starting point. For example through an upstream phenomenological focus on the qualitative experiences of place using the analytical lens of the SOC, as is done in this research, one can bring a perspective to health research that is overlooked by other disciplines. As will become apparent in later chapters, the geographer's engagement with the salutogenic orientation provides them with a lens through which the space at the intersection between the individual and their environment can be analysed. By bringing new ideas into health geography in

order to understand social processes, space and place, new pathways between theory, policy and praxis might be established (Parr, 2004).

The theoretical intricacies of Antonovsky's salutogenic theory of health promotion
Before going any further it is perhaps best to elaborate on what exactly is meant by the salutogenic orientation. Aaron Antonovsky (1987) developed the theory of salutogenesis as a potentially suitable framework for health promotion practice and policy. Antonovsky's model of salutogenesis appeared at a time when there was growing disenchantment with the technological advancement of the medical care system (Antonovsky, 1987). There was concern expressed for the less humane focus on the organic pathology of disease. There was also a movement towards the notion of self care and personal responsibility, and in addition to this a growing awareness that health was socially determined, i.e. that social factors shape individual and community wellbeing. For Antonovsky all of these factors deserved considerable attention when thinking about the origins of health (Antonovsky, 1987: xiii).

The health-orientation position, like the traditional medical disease-orientated position, is based on the fundamental healthy-sick dichotomy. Those who take their influence from the health-orientation position would argue that resources should be allocated to keeping people healthy and preventing them from becoming sick. However, those who take their influence from the disease-orientated position focus on treating the sick, preventing death and chronic illness, and working towards health restoration. The former argue for the investment in health maintenance resources, while the latter would argue that it is inhumane to disregard the suffering of the sick. Antonovsky's response to this was the health ease/dis-ease continuum (Antonovsky, 1987: 3). We are all terminal cases he argued, but so long as we are still alive we still have some degree of health. So the salutogenic-orientation poses that the individual's condition is best considered as a location somewhere along this continuum. In arguing for a salutogenic focus, Antonovsky is questioning whether the clinician should be focusing on the disease or the 'story' of the person with the disease. He argues that in focusing on the pathology the clinician might miss some important etiological data. This idea of the 'story' comes from the medical concept of causality, and he draws from an analysis of this concept citing the story of an older man who is hospitalised for an advanced knee problem. The pathogenically orientated clinician would move through the standard symptom identification, diagnostics and suggestion of the appropriate therapy almost assuring re-hospitalisation of the patient.

However, a medical student attending the same patient might discover that he was recently widowed, had moved to a strange city, and lived on the fourth floor of an apartment with no lift. While his knee posed a very real and serious problem causing him to be hospitalised in the first place, the next time hospitalisation could result from malnutrition, pneumonia or a suicide attempt. Antonovsky argues following this example that the salutogenic approach would provide an understanding and knowledge of this man's life and living environment which is a prerequisite for his movement towards the healthy end of the continuum. He claims that to look at the person and not the patient a clinician can arrive at a more effective diagnosis (Antonovsky, 1987: 5).

Antonovsky also refers to what he calls the 'deviant case', which is ignored by the pathogenic orientation to the detriment of health research. As the scientist formulates hypotheses and carries out rigorous testing to establish the linkage between smoking and cancer for example, and causality is distinguished, a high-risk group is identified and the solutions devised. Yet only a part of the variance is ever really accounted for and rarely is the deviant case considered because the problem appears to be answered. In this scenario the pathogenicist is happy with the hypothesis confirmation, however the salutogenicist would look towards the deviant cases asking for example who are the smokers who don't get lung cancer and what protected them? (Antonovsky, 1987: 11). For the researcher interested in healthy older people, the salutogenecist would ask how an individual can reach 95 years old, overcome serious illness, and still live an active, independent and fulfilling life?

Antonovsky summarises what is meant by the salutogenic orientation. Fundamentally, this orientation identifies heterostasis, senescence and entropy as core characteristics of all living organisms (Antonovsky, 1987: 12). Heterostasis means the maintenance of physiological stability despite changing circumstances, predictable or unpredictable, using adaptation. Senescence is the process of ageing and entropy refers to disorder or randomness in a closed system i.e. the body.

There are six fundamental points to remember about the salutogenic orientation (Antonovsky, 1987: 12):

1. The orientation requires us to reject the dichotomous classification that distinguishes between healthy and diseased, instead the focus is on the individual's location on the multidimensional health ease/dis-ease continuum;

2. In rejecting this dichotomous classification the focus is not concentrated on the etiology of disease, but instead the focus widens to incorporate the individual's 'total story', which includes the illness;

3. Instead of asking what causes the illness the question is "What are the factors involved in at least maintaining one's location on the continuum or moving toward the healthy pole?" To answer this question we must look at coping resources;

4. Stressors, understood as a stimuli that causes a stress response, are viewed as potentially salutogenic and thus not always pathological, depending on the character of the stressor and the resolution;

5. The orientation urges a search for the things that cause negative entropy to understand and thus facilitate an individual's adaptation to their environment and their circumstance;

6. Deviant cases are always considered during an inquiry.

The salutogenic orientation requires that the data is looked at in a different way, that different questions are asked and also that alternative hypotheses are used. This does not however mean that the pathogenic orientation is abandoned, but rather that the two orientations are used to complement each other, and that there is a balanced allocation of research efforts working from both perspectives (Antonovsky, 1987: 13). In summary Antonovsky states that

> '[T]hinking salutogenically not only opens the way for, but compels us to devote our energies to the formulation and advance of a theory of coping' (Antonovsky, 1987: 13).

To understand how people remain healthy despite adverse conditions the focus can effectively shift from a pathogenically-dominant approach, focusing on morbidity and psychological burnout, to a salutogenic paradigm focusing instead on health and wellbeing, and how it is sustained in stressful conditions (Ablett and Jones, 2007). According to Rutter (1985: 608)

> 'the promotion of resilience does not lie in an avoidance of stress, but rather in encountering stress at a time and in a way that allows self-confidence and social competence to increase through mastery and appropriate responsibility'.

This notion of resilience is thus a process of personality construction. Antonovsky (1987) attempts to explain the relationship between health and resilience, using the analytical

construct of the Sense of Coherence, which works from the basis that the potential to create health exists when life is perceived as comprehensible, manageable, and meaningful. Antonovsky, through the salutogenic orientation, attempted the task of understanding how an individual chose to use, apply or interact with the range of resources available to them internally or externally to cope with adversity, and in doing so, to develop resilience, and in effect promote and enhance health. The SOC was proposed as a suitable tool for understanding the route to developing resilience. Antonovsky (1987: 19) defined the SOC as follows:

> *'The Sense of Coherence is a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that (1) the stimuli deriving from one's internal and external environments in the course of living are structured, predictable, and explicable; (2) the resources are available to one to meet the demands posed by these stimuli; and (3) these demands are challenges, worthy of investment and engagement'* (Antonovsky 1987: 19).

The SOC definition and formulation was the result of a research project conducted by Antonovsky on Jewish immigrants living in Israel during the 1970s and 1980s. In total 51 individuals were interviewed and the SOC was developed using the common characteristics of the participant group. Importantly all the participants chosen to take part in the research had experienced major trauma in their lives. The interviews were unstructured but were loosely framed on questioning how each of the participants viewed the unfolding of their lives. Examining the data generated from these interviews Antonovsky identified three common themes that he found to be relevant to the successful coping strategies of the participants. These themes later became the core components of the SOC. These were comprehensibility, manageability and meaningfulness. The individuals interviewed that had coped very well despite trauma demonstrated all three of these themes, and thus were deemed by Antonovsky to have a high SOC. The research found that a person with a strong SOC, that is an individual who viewed life as being manageable, meaningful and understandable, was also a person that

> *'seeks a balance between rules and strategies, between stored and potential information. There is confidence that sense can be made of the new information. There is little felt danger in seeing the world as a challenge and in being open to feedback'* (Antonovsky, 1987: 27).

Antonovsky (1987) indicated that the SOC was not sensitive to cultural boundaries, but was generalisable across populations. This was because the SOC dealt with fundamental characteristics of human nature. Indeed, the SOC has been examined across many cultural settings from Hong Kong (Shiu, 2004), to Finland (Bernebe, *et al.*, 2009), to South Africa (Van der Coiff and Rothmann, 2009) to examine individual's response to stressors.

The components of the SOC

Each of the three components of the SOC, comprehensibility, manageability and comprehension, necessitate a closer look. The *comprehensibility* component refers to the extent to which an individual can make cognitive sense of stimuli (illness, growing older, etc). In making sense of the stimuli the information is ordered, structured and clear, therefore explicable. A person that demonstrates a high level of comprehensibility will approach stimuli in the future with a degree of predictability, and so the environment appears to be controllable (Geyer, 1997). This requires a 'solid capacity to judge reality' as opposed to thinking 'things will work out' (Antonovsky, 1987: 17). The *manageability* component refers to an individual's perception of the resources they have at their disposal, and whether these are perceived to be adequate in meeting the demands of the stimuli, and help the individual to cope should they encounter such difficulty. The *meaningfulness* component is, importantly, the motivational element of the SOC. Meaningfulness is about the importance of being 'a participant in the process shaping one's destiny as well as one's daily experience' (Antonovsky, 1987: 18). There is both a cognitive and emotional aspect to meaningfulness. Events or traumas are considered challenges, and when someone with a high SOC is faced with such challenges they consider them 'worthy of emotional investment and commitment' (Antonovsky, 1987: 18). Meaningfulness may also be regarded as closely connected with, or related to, feelings of control. When life makes sense emotionally to an individual they will feel that challenges and adversity are worth investing energy in, and pose worthy challenges that require their commitment and engagement. Antonovsky claims that for the individual who can find meaning in life, challenges are welcomed, and feel less burdensome. To put this into perspective Antonovsky states that

> *'[t]his does not mean that someone high on meaningfulness is happy about the death of a loved one, the need to undergo a serious operation, or being fired. But when these unhappy experiences are imposed on such a person, he or she*

will willingly take up the challenge, will be determined to seek meaning in it,
and will do his or her best to overcome it with dignity' (Antonovsky, 1987: 18).

Likewise, the psychiatrist Victor Frankl argues for the important motivational role of meaningfulness. According to Frankl

'[m]an is ready and willing to shoulder any suffering as soon and as long as he
can see a meaning in it' (Frankl, 1967: 56).

Based on his experiences as a concentration camp prisoner during the Holocaust, Frankl observed that survival despite suffering was nothing to do with youth or physical strength, but was rather the result of the strength one derives from purpose and meaning in life and life experiences.

The Sense of Coherence is, as Antonovsky (1987: 22) puts it a 'generalized, long-lasting way of seeing the world and one's life in it' therefore the SOC is about the individual's subjective and objective views of the world they live in and the world they experience.

The SOC and creating a bounded and relational world

Antonovsky found that people set boundaries within their world and thus their SOC is determined by their experiences of this bounded world. What goes on outside this world, whether it is comprehensible, manageable or meaningful, does not matter. Therefore, by introducing the idea of a 'boundary' the application of the SOC components is limited to the experiences occurring within this boundary, and the SOC measurement is largely affected by experiences located within the parameters of this boundary. Emerging from this is the issue of identifying the spheres of life that have subjective importance for the individual and how such spheres determine the strength of the SOC. Drawing these boundaries is not however a simple task, because they are in constant flux, and are continuously negotiable. Antonovsky outlines four crucial spheres that are significant because of the amount of an individual's or even a community's energy that is bound up in them. The crucial spheres are identified as 'one's inner feelings, one's immediate interpersonal relations, one's major activity, and existential issues' (Antonovsky, 1987: 23). Existential issues include for example death, isolation, failures, and conflict. With regards to 'major activity' which can relate for example to one's job, finding meaning is not solely based on intrinsic satisfaction,

but meaning can also be found if the individual is persuaded that they are productive through this activity, such as sustaining their family's lifestyle or building towards a successful career. Importantly, these crucial spheres are strongly reflected in the empirical results presented later, and emerged naturally from the life review data.

Antonovsky also notes that the narrowing of boundaries does not mean that the real world is having no effect on an individual or that it does not influence their health. The structures of society have a very real influence on how bounded lives are experienced. Boundaries are flexible and can thus be redrawn, expanded and contracted by the individual, often to maintain their SOC, this is where the control element comes into practice. Being able to exert control within this bounded world is essential to the individual's feelings of security in the external environment and stability in their internal environment. Antonovsky gives the example of the retiree to demonstrate how an individual can alter their SOC following a significant life change. Following retirement the retiree can move beyond the paid work realm, and redraw their boundaries around a new sphere of community action and volunteer work (Antonovsky, 1987: 24). In doing so the SOC is determined by this new sphere and the influence of the paid work sphere begins to fade. The flexibility of boundaries is not clearly explained by salutogenic theory, and indeed the SOC questionnaire is confined to the four crucial spheres already discussed. There is thus opportunity to revisit this notion of flexible boundaries and perhaps add stronger place-based dimensions to them thereby drawing together the previously disparate works of salutogenesis and relational geographies.

The SOC as a generalised long lasting way of seeing the world, is based on earlier encounters with the world, albeit different spaces and places. To draw on Antonovsky's idea of the bounded world and link them to relational perspectives in geography, there is some scope for elaboration on what a bounded world means in terms of place, and this provides a new perspective on why place matters to health. Perhaps one of the contributions that can potentially be made here is to address a problem in health geography, that is the construction of places and people, or context and composition, as mutually exclusive (Macintyre *et al.*, 2002). According to salutogenic theory this is not the case, and likewise relational geographies regard context and composition as a false dualism because people and places are involved in a 'mutually reinforcing and mutually reciprocal relationship' (Cummins *et al.*, 2007: 1823). Geographers such as Massey (2005) describe space and place as unbounded, unstructured and connected, and this at first appears to be at odds with

Antonovsky's view that the individual experiences the world by looking outwards at it from inside a series of boundaries or crucial spheres, which have been drawn and negotiated according to the context. These boundaries are scalar, experiential and cognitive manifestations projected onto the world. They are also fluid and negotiable just like relational space and place, because the individual actively draws and re-draws the boundaries. Distance within Antonovsky's bounded spaces is defined by one's inner emotional life that is both a product of, and reaction to, the world. People thus experience place through these boundaries.

Generalised resistant resources and deficits
Although the focus is predominantly on coping resources the stressor variable must also be factored in. Stressors according to Antonovsky (1987: 28) are demands that have no readily available responses, and generate a state of tension. In creating this tension they act to weaken an individual's SOC. There are three types of stressors: chronic stressors, major life events and hassles encountered during daily life. All three stressors are bound to overlap but they are qualitatively different. Chronic stressors are ones that are enduring and permanent. The spectrum for such stresses is quite broad, and can include the individual's historical background, interpersonal relations, social role and even personality. Regardless of the stressor the same question applies: 'to what extent does it provide sets of life experiences characterised by being toward one or the other end of the continuum conducive to a strong or weak SOC?' (Antonovsky 1987: 29). Any of these three types of stressors are primary determinants of one's SOC, and are thus related to health and wellbeing. If they act to strengthen an individual's SOC they are labelled Generalised Resistance Resources (GRR) and if they weaken the SOC they are called Generalised Resistant Deficits (GRD) (Antonovsky 1987: 29). GRRs and GRDs are located within broader political, economical, social, and cultural structures and thus are subject to inequality. Having access to community resources will depend on the community's ability to provide them, and this will reflect the wider structural and social conditions. However, as will become apparent, Antonovsky was an advocate of stoicism, and argued in favour of the role of personal agency regardless of structural influences. In more recent applications of the salutogenic orientation, the assets-based approach to community health development, recognises the need for egalitarianism to promote individual and community health and in providing access

to the assets that people can use to take control of their health, their education and their future (Green and Haines, 2011).

Stressors are experienced in time and space and can vary greatly. Chronic stressors could be for example long-term illness such as living with schizophrenia or diabetes. Chronic stressors may also exist in the form of poverty, living in an environment marked by violence, disorder, political unrest, or power inequalities. Examples of major life events include a death in the family, divorce, a new child, or retirement. The event itself is not important, but the consequences are. If the event has negative consequences these become stressors that may impinge on health. According to Antonovsky the existing strength of the individual's SOC at the time of the event will determine if the outcomes will be neutral, noxious or salutary (Antonovsky 1987: 29). Daily life is the third of these stressor typologies. Antonovsky claims that these are insignificant because he does not see how such stressors can impact on the SOC. This may be questionable. There is however a small bit of slippage here between the three types of stressors. Chronic stress for example may be experienced on a daily basis, and therefore daily stressors experienced may be because of a more fundamental situation rather than having an accumulative effect. On the other hand infrequent daily hassles may indeed have no influence on the SOC at all.

The relationship between the SOC and health

Research on the SOC and its relationship with health, stress and coping has found a direct relationship between a high SOC score and positive health. It has been demonstrated that an individual with a strong SOC will likely have a positive health status, thus supporting Antonovsky's claims about the relationship. Soderhamn and Holmgren (2004) tested whether or not the SOC questionnaire was valid and original when applied to examining health and wellbeing among physically active older people in Sweden, and in explaining self-perceived health. The study concluded that is was both valid and reliable in explaining self-perceived health for this population group. Langeland *et al.* (2007) questioned whether the SOC could predict life satisfaction among a sample of the Norwegian mental health patients. They concluded that by improving an individual's SOC life satisfaction would also be improved. The research found the 'meaningful' component of the SOC to be the most influential in terms of life satisfaction. For the individuals studied, those with a higher SOC score were able to mobilise the health resources accessible to them when faced with a challenge. This appeared to improve their life satisfaction. This study thus supported the

theory of salutogenesis, and indicates that the SOC is a predictor of wellbeing and life satisfaction, and also Antonovsky's suggestion that the meaningful component is the most important health-determining factor.

Nesbitt and Heidrich (2000) evaluated the SOC model with relation to the quality of life of 137 older American women who were widowed, had very low incomes, and had several health problems. All of these characteristics are directly related to quality of life. The study found that regardless of the degree of stress the participants were experiencing, the higher the SOC score the more positive the appraisal of their quality of life. The study concluded that positive personality resources, interacting with the physical and social environment, had a protective role to play in terms of older women's quality of life. Nesbitt and Heidrich (2000) made several suggestions for clinical practice based on their research into the SOC. They suggested that encouraging women suffering from chronic illness to identify meaning in their lives was important to sustaining and enhancing their quality of life; that older people should be encouraged to recognise their strengths and capabilities so that their situation felt more manageable; that older people should be provided with enough information to understand their illnesses, and to help them self-manage so that they feel in control of their lives; and finally that older people should be provided with information about health services available to them and how to access them. Finally, the authors suggested that using the SOC as an organising framework lent credibility to health promotion interventions, and may inform additional strategies. Applying the SOC framework will also place health promotion practice into a theoretical framework, a source of concern for public health thinkers (Nesbitt and Heidrich, 2000).

Read *et al.* (2005) found that there is a relationship between the strength of an individual's SOC and good cognitive functioning, and physical activity, which are all positively related to physical and mental health, across a sample of Finnish men and women aged 65-69 years old. The research found that married men had a stronger SOC than unmarried men, however for married women the relationship between marital status and SOC was not significant. Overall the study established that there was a relationship between an individual's SOC and physical and mental health. They added that Antonovsky's theory of salutogenesis and the SOC provide an interesting perspective for gerontologists to consider yet the SOC with relation to older people had not been explored to any great extent. Hakanen, Feldt and Leskinen (2007) argued that while a relationship did appear to exist between the SOC and health, wellbeing and quality of life, more information needed to

be gathered on the formation of the SOC, in particular the potential role for strengthening the SOC in later life, and the role of resistant resources and life events in this process.

The assets-based approach to health development

Importantly, Antonovsky did not intend for the Sense of Coherence or the theory of salutogenesis to only be applied individualistically, or to be solely aimed at the individual. Rather his intention was for his theory and concepts to be further developed and applied on a greater scale, most importantly as a framework for designing and implementing health promotion practice, and framing the salutary question:

> *'What can be done in this 'community' – factory, geographic community, age or ethnic or gender group, chronic or even acute hospital population, those who suffer from a particular disability, etc. – to strengthen the sense of comprehensibility, manageability and meaningfulness of the persons that constitute it?'* (Antonovsky, 1996: 16)

The theory of salutogenesis has gained some momentum in recent years in public health under the alias of asset based community development (ABCD) where it has been applied to the neighbourhood scale or geographic community (Morgan and Ziglio, 2007). The development of the assets-based model represents a tug-of-war with traditional public health methods, a struggle that can be defined using Antonovsky's salutogenic-pathogenic dichotomy. The assets based approach works from a similar premise as salutogenic GRRs, the main difference between GRRs and assets is that ABCD include potential resources as well as existing ones that exist within the social and physical environment (Lezwijn *et al.,* 2011). Health itself is considered an asset within the ABCD salutogenic framework, and as a result of complex processes during which the individual interacts with their social and physical environment (Naaldenberg *et al.,* 2009).

The deficit model has been predominantly applied at the community level in public health practice; that is identifying the needs and problems of a population, and addressing these issues using professional resources, thereby encouraging dependency on a welfare system. The deficit model defines communities in terms of their problems. For an ageing community, defined using the deficit model, attention will be focused almost exclusively on health care needs and the demands on the economy. The asset based model contrasts significantly, in much the same way as pathogenesis contrasts with salutogenesis, because in

addition to identifying the challenges of a community, the asset model will also highlight its capacities and resources, and works with the protective and promotive 'health assets' that already exist in the community (Morgan and Ziglio, 2007). Health assets are defined as

> *'any factor (or resource), which enhances the ability of individuals, groups, communities, populations, social systems, and/or institutions to maintain and sustain health and wellbeing and to help to reduce health inequities. These assets can operate at the level of the individual, group, community and/or population as protective (or promoting) factors to buffer against life stresses'* (Morgan and Ziglio, 2007: 18).

The asset model attempts to demonstrate that the degree of dependency on a health and welfare system is exaggerated when the deficit model is applied because it fails to recognise its resources. Morgan and Ziglio (2007) argue that a deficit model informs many of the decisions made by policymakers, and the results are policies and practices that act to dis-empower populations/communities. They also argue that the asset-model is a 'more resourceful approach to tackling health inequities' because there is a felt need to redress the balance of the focus on the community in terms of its capabilities and resources, and its problems. Taking the asset and deficit approaches together the understanding of factors influencing health may be expanded. The assets model embraces the salutogenic notion of health creation and takes seriously the goals of participation and empowerment. In targeting a community to improve their health the application of a deficits model, which identifies and prioritises need, does little to promote the self-esteem of its members, and gives the community an identity that is characterised by dependency. When the health assets model is applied the positive attributes of the community and its members are identified from the outset. From the point of view of addressing inequalities in health, the health assets model accepts the use of a new set of indicators in assessing community-based approaches.

Morgan and Ziglio (2007) outline a list of health assets that can be promotive of health regardless of the level of disadvantage in a community. These health assets can be understood as scalar in nature because they exist across a range of scales. When applying the health assets approach in organising a health care system with an up-stream focus, planners will look to the resources available within and to the community and then act to maximise these assets. In applying the health assets model in community health development, for example in preparation for population ageing, there are a number of questions for planners to consider:

1. What are the external factors contributing to health and development?
2. What are the factors that make individuals and communities more resilient?
3. What helps us to fully experience life?
4. What contributes to overall levels of wellbeing?
5. What are the assets for health at the different stages of life?
6. How do these assets relate to health outcomes?
7. How do assets work in combination to lead to positive health outcomes?
8. What are the protective and health promoting resources that support health and wellbeing, and are these health resources available within the community?
9. How can policy act to build and sustain these resources?

Applying the health asset model also requires that the planners recognise the population as co-producers in health rather than a group dependant on a paternalistic system. The population/group must also be enabled and empowered in realising their potential to contribute to health development. Health assets are identifiable across the individual, community and institutional scales. Individual level assets, are for example social competence, commitment to learning, positive values, self-esteem and having a sense of purpose. Community level assets are supportive networks of family and friends, intergenerational solidarity, community cohesion, and religious tolerance. At the institutional level assets include; employment security, opportunities to participate in society and to contribute to society, safe housing conditions, political democracy and social justice, to name but a few (Morgan and Ziglio, 2007)

The presence of health assets in a community might explain why socio-economic disadvantage is not always correlated with health damaging behaviours (Marmot, 2007). In trying to explain such 'resilient places' it might be useful to consider the quality of human relationships, often conceptualised as social capital, and to consider the quality of public services. Exploring the community assets of 'resilient places' might go a long way in explaining why poverty is more damaging in some places than in others (Friedli, 2009). With the salutogenic approach the question is not about the problems of places but about the strengths of places and the people within them. The ABCD approach rejects the notion that people are passive victims of their circumstances. According to the methodological principles of the ABCD approach, in identifying the strengths of places or communities it is possible to move forward more readily in terms of social development and improving the

social conditions. This is because in acknowledging, and working with, what assets are already present within a group the emotional capital, confidence, and esteem of the people is promoted. The ABCD approach takes positive mental health seriously, and works to promote the emotional and cognitive capital of individuals and communities. This is because without emotional and cognitive capital the necessary requirements for community development, such as trust, networks of cooperation and social cohesion, cannot readily form.

It should be noted that one of the disconnections between salutogenic theory and the Sense of Coherence and its application to the ABCD model is the absence of ideas around autonomy and empowerment from Antonovsky's ideas. This may be because Antonovsky was writing at a time when such ideals of grassroots action and empowerment were newly emerging in discourses on public health, and indeed when his ideas were published, the *Ottawa Charter* (WHO, 1986) was just released.

The relationship between salutogenic theory, mental health and inequality

The Sense of Coherence has been strongly correlated with positive mental health and psychological resilience (Super *et al.*, 2014; Flensborg-Madsen, Ventegodt and Merrixk, 2005). Likewise, a strong relationship has been identified between inequality and mental health, and in turn yet another relationship has been identified between mental and physical health (Marmot and Wilkinson, 2005; Wilkinson and Marmot, 2003; Wilkinson and Pickett, 2006; Chiavegatto Filho *et al.*, 2013). It thus appears that the Sense of Coherence, resilience, inequality, and mental and physical health are all closely connected. Much of what has been discussed so far in this chapter on resilience, and having access to and utilising generalised resistance resources is reflected in the WHO's definition of mental health:

> *'Concepts of mental health include subjective wellbeing, perceived self-efficacy, autonomy, competence, intergenerational dependence and recognition of the ability to realize one's intellectual and emotional potential. It has also been defined as a state of wellbeing whereby individuals recognise their abilities, are able to cope with the normal stresses of life, work productively and fruitfully, and make a contribution to their communities'* (WHO, 2003: 7).

Given the emerging chronic disease burden as outlined in Chapter Two, it is worthwhile to consider the relationship between mental and physical health. In addition to this, it is

important to recognise that mental health can be directly influenced by social inequality. Indeed, mental health may be central to understanding the impact of inequalities on health, affecting an individual's ability to cope with relative and material disadvantage. Relative disadvantage is an interesting angle through which to consider the impact of social inequality, particularly if ill health effects are present despite all basic material needs being met. The impact of relative disadvantage on an individual may be explained by the behaviours adopted and lifestyle choices made to remedy the social injuries of inequality. These social injuries are subject to social status differentiation (Friedli, 2009), something that can perhaps be interpreted using the SOC construct.

The emotional and cognitive effects of social status differentiation seem to reveal a lot about the effects of inequality. The social and psychological dimensions of inequality might capture the missing mechanisms that link health outcomes to social conditions, and the determinants and outcomes of inequality. Within the resilience framework mental distress and some physical health outcomes are the result of the individual's response to inequality, social injustice and relative deprivation. It is suggested that responses to social status differentiation might result in the erosion of spiritual and intellectual resources that are fundamental to positive mental health and wellbeing. It is through psychosocial stress attacking the neuro-endocrine, cardiovascular and immune system functioning that the social determinants seem to impact on health. Not only is the biological response to stressful situations resulting from social inequalities impacting on the body directly, the body is also implicated in emotionally motivated survival strategies adopted in response to social status differentiation (Friedli, 2009). Survival strategies take the form of crime, or health damaging behaviours, for example the excessive consumption of alcohol or the use of drugs to numb the emotional response to social inequality and injustice (Friedli, 2009; Wilkinson and Pickett, 2010).

Often promoting healthy lifestyle choices is put forward as the key strategy for improving the chronic disease burden, however improving mental health might be a more fruitful strategy if we consider the relationship between mental and physical health. Take for example cardiovascular disease (CVD); the risk of developing CVD is strongly correlated with mental health, the highest rates of CVD being found among those experiencing mental ill health (Hare, *et al*., 2014). Patients with CVD and depression have poorer outcomes than non-depressed patients (Hare, *et al*., 2014). Further to this mental illness accounts for approximately 5% of premature mortality, but 30% of all morbidity and disability. With the

exception of CVD, no other condition accounts for more than 10% of the disease burden. However given that mental ill health is related to CVD risk, the contribution of poor mental health to the global burden of disease is perhaps understated (WHO, 2003). While poor mental health is associated with physical ill health, positive mental health is associated with good physical health (Stead *et al.*, 2007).

Within resilience theory, two routes to solving the problems of social inequality are identified. The first is to promote social justice and equality, and the second route is to promote the mental resilience of the population so that it can better respond to social inequality (Friedli, 2009). The latter route, promoting mental resilience, might find a solid theoretical grounding in Antonovsky's ideas, but this is not without its shortcomings. For instance the question of who is responsible for an individual's health is raised. Antonovsky's ideas while fruitful in their analytical potential, when applied practically and to policy, raise ethical issues around responsibility. The construct of the Sense of Coherence is based on Antonovsky's preoccupation with the deviant. The deviant is the individual who demonstrates strength and resilience in the face of adversity, the individual that overcomes obstacles to succeed and has surpassed peers. The focus on the deviant individual suggests that the inability of a person to demonstrate positive mental health is in someway a shortcoming of the person over and above the shortcomings of the unequal society that provides the context. If one person can overcome adversity why has his/her peer not done the same? The Sense of Coherence identifies the ability of individuals to cope with adversity as an innate personal strength that is to some degree separate from their context. Antonovsky seems to belong to a tradition of stoic philosophy with the view that if you cannot change your circumstances then change how you think about them. The SOC and salutogenic theory identifies positive mental health and resilience as one of the most important influences on health outcomes; it also feeds into a range of other life domains that are not unrelated to health, such as relationships, and earnings, for example. Promoting mental resilience will do little to directly improve structural issues of social injustice and inequality, however it might encourage people through developing their confidence to challenge their social, political and economic environment. In the next chapter a fuller interrogation of Antonovsky's fundamental beliefs is presented.

The theory of salutogenesis and the Sense of Coherence focus a great deal on the individual's beliefs and feelings about their place in the world, and argue that this is essential to their Sense of Coherence. In discussions on social inequality the idea of social

status has attracted a lot of attention (Marmot, 2004). Social status can be understood within the framework of the SOC as the relative positioning of the individual within their social world in accordance to objective and subjective measures of social standing i.e. education, income, gender, age, contribution to society. How an individual will react to their social world is strongly dictated by their social status or at least their perception of their social status. This is found to have an influence on both mental health and health related behaviour. This is because how a person thinks about their life and their position in the social hierarchy incorporates emotion (affectivity/feeling), cognition (perception, thinking, reasoning) social functioning (relations with others and society) and coherence (sense of meaning and purpose in life). In their work on social inequality Wilkinson and Pickett (2010) pay close attention to the role of social status and social hierarchy in determining health, wellbeing and quality of life.

Wilkinson and Pickett (2010) argue that the benefit of increasing affluence has reached its limit in the developed world; at a certain point in economic development the level of economic growth is no longer correlated with quality of life, health and wellbeing. Indeed economic growth, when linked to diverging trends in social status, appears to actually damage psychosocial health. This might be because the consumerism associated with advanced capitalist societies appears to promote anxiety, to undermine social solidarity, and further differentiate people according to their social status. An individual's position in the social hierarchy is determined by 3 axes of social stratification, which are material requisites, the psychosocial (having control over one's life), and political voice (the ability to participate in decisions). An individual's psychological resources, such as confidence, self-esteem and connectedness are embedded within the social structures, so the individual's position relative to others in both public and private spaces is important. Social position influences emotion, cognition and behaviour and so it is difficult to separate contextual effects from an individual's characteristics or attributes (Singh-Manoux and Marmot, 2005). The inability to separate the individual from their context in order to understand the determinants of health and wellbeing makes it very difficult to identify with accuracy the key areas on which to focus public policies and investments in social progress.

According to Singh-Manoux and Marmot (2005: 2129) socialisation has an important effect on health, whereby 'socialisation involves the inter- and intra- generational transfer of attitudes, beliefs and behaviours'. Further to this socialisation is defined by Singh-Manoux and Marmot (2005) as the process

'by which individuals become part of a group, involving processes that progressively confine their behavioural potentialities within an acceptable range and prepare them for the types of roles they will be expected to play later in life'(Singh-Manoux and Marmot, 2005: 2129).

The socialisation perspective is put forward to explain the powerful effect social class has on behavioural, social and psychological variables whereby

'health-related and psycho-social behaviours are never truly voluntary; they are products of, and embedded in structures of society… The unit of analysis is not the individual but the socio-cultural context that shapes the individual' (Singh-Manoux and Marmot 2005: 2130).

The processes of socialisation, intergenerational and intragenerational 'involve the harmonisation of an individual's attitudes and behaviour with that of their socio-cultural milieu' (Singh-Manoux and Marmot 2005: 2130). Subjective social status is the person's perception of their place in a wider socioeconomic structure, or their status relative to other people within a categorical context of social class defined in accordance to income, education and occupation. Reflecting on Antonovsky's SOC this seems to refer to the individual's comprehensibility, and the level of control they have over what happens within the bounded spheres of their lived world. Status is closely linked to a person's economic position within society. The results of the well-known Whitehall studies are extremely important in linking health outcomes with social hierarchy and identified a direct correlation between health and position within the socio-economic structure (Singh-Manoux, *et al*., 2003). The subjective social status perspective involves processes of social comparison grounded in wealth, wealth potential, financial security as well as control over decision-making. The harmonisation of individual's attitudes and behaviours in accordance with their milieu, that Singh-Manoux and Marmot (2005) talk about, could be reframed as a task involving the promotion of the individual's Sense of Coherence, whereby they develop a view of their place in the world that is ordered, manageable and meaningful.

Salutogenesis, the Sense of Coherence and ageing-in-place
The application of the theory of salutogenesis to reconceptualise health in later life has been developed by Lezwijn *et al.* (2011) and Sidell (1995; 2007). Sidell (2007) makes a strong case for the use of the salutogenic paradigm in ageing research and argues that the disease

focused orientation paints a bleak picture of health in later life. She suggests that the salutogenic approach is more useful, because it provides a holistic view of health, recognising the person in their entirety as a unique individual characterised by a collection of complex body processes, which sometimes cause illness. But in addition to this the holistic salutogenic view also recognises the individual as a thinking, emotional and creative individual, with both strengths and weaknesses. Holism recognises that it is possible to be healthy in spirit despite the presence of a physical illness or disability. In addition the salutogenic approach also provides a framing that addresses the health-place relationship, viewing health as the result of the conditions of daily life. According to Sidell (2007), disease in later life is not just the result of physical decline but also the result of the hostile forces encountered in the environment. Lezwijn *et al.* (2011) presented the Health Promotion 2.0 framework (H.P. 2.0), which draws on the theory of salutogenesis and the SOC construct, as a suitable framework to facilitate working with the principles of health promotion more broadly, and working specifically on promoting the health of older people. The H.P. 2.0 framework suggests that when implementing strategies for older people's health promotion, attention should be paid to the SOC components, resources for health, and how these are contextually interrelated. Thus the framework requires different kinds of research to be undertaken to inform health promotion activities. Such research needs to target the different stakeholders, and the results should build on the knowledge base and also indicate the methods required to strengthen and enhance the SOC for older people. In order to develop appropriate health promotion activities for older people, older people themselves must be involved. Methodologies need to prioritise older people's participation to uncover the motives and experiences of the salutogenic relationship. That is elaborating on the SOC components with relation to the social and physical environment. It is this suggestion of the need to elaborate on the SOC components, using the lived experiences of older people that this thesis is responding to. The methodological design of this thesis examines the SOC components present in the life review accounts of a sample of older people.

The salutogenic relationship can be regarded as an inherently geographical concept of health and place. The salutogenic relationship is about an individual's interaction with the resources for health that exist within their social and physical environments, and thus the health-place relationship is identified as paramount in health promotion (Lindstrom and Eriksson, 2005; Eriksson and Lindstrom, 2008; Lezwijn *et al.* 2011). The notion of a

salutogenic relationship is closely linked to the health promotion action area of developing supportive environments for health, because the resources available are directly involved in improving health, and in accordance with Antonovsky's thinking these resources influence the SOC. For example a positive resource for health is having any form of a relationship where there is a close bond, for example with a partner. Such relationships may be perceived as meaningful and therefore motivates the individual to face life's challenges (Ciairano *et al.,* 2008).

Salutogenesis, the SOC, resilience and health in later life

The application of resilience theories, including the salutogenic orientation and its SOC construct, to the study of ageing and health represents a significant contribution to the strengths perspective in critical gerontology research, a broad area of scholarship which calls for emancipatory social change including establishing positive ideals for later life (Moody, 1993). For gerontologists the introduction of resilience theories into the ageing research agenda marks a significant step forward because they provide a new positive perspective on later life, where

> *'in contrast to the focus on adversities, deficits and pathologies, so common in gerontology scholarship, resilience theory draws from the strengths perspective, a philosophical standpoint that recognises the inherent power and resilience of individuals and communities'* (Browne, Mokuau and Braun, 2009: 255).

Rowe and Kahn's (1998) research on successful ageing was an important and pioneering contribution to moving gerontology research away from its traditional pathology-orientated focus. Resilience does, however, provide an even greater shift in thinking than that demonstrated by Rowe and Kahn (1998) by accepting what Masten (2001) later referred to as 'ordinary magic'. This is because it goes beyond a group of elite older people, or 'successful' agers, to recognise that *all* older people have the potential to achieve resiliency. In effect the resilience concept when applied in ageing research challenges the exclusivity created by concepts such as successful ageing (as discussed in the previous chapter) by acknowledging that it is possible for many older adults to be resilient despite physical or cognitive impairment, and regardless of social or cultural backgrounds (Harris, 2008: 59).

Resilience research has most commonly addressed risk identification and an exploration of protective factors or assets that counteract risk to enhance resilience and adaption. For older people many factors have been identified that pose a risk to health and wellbeing. These include disadvantage and economic vulnerability, elder abuse, bereavement, health challenges commonly associated with later life such as dementia and physical frailty, and even changing social roles. A research emphasis on resilience, as used in this thesis, addresses how older people cope when faced with negative life events, and life transitions (Wiles *et al.,* 2012b; Hildon *et al.,* 2010; Bauman, Adams and Waldo, 2001). With this perspective in mind Harris (2008) argues that

> *'perhaps we have been striving for the wrong goal. The true quest as we age should not be for successful ageing (as traditionally defined), but our goal should be for resilience, an undervalued and not fully examined concept of ageing'* (Harris, 2008: 3).

By applying the concept of resilience to research on older people the assumptions that are made about older people are disputed. Rather than hoping for disease-free older age the resilience concept provides a much more realistic construct to examine health and wellbeing in later life. However, according to Wild *et al.,* (2011; 2013) there is still much work to be done to understand resilience in later life. Luthar *et al.,* (2000) suggest that there is a burdening conceptual problem with the concept of resilience because it lacks theoretical consistency and yet despite this it is becoming an important buzzword. The focus on resilience has become prominent at a time when there is increasing talk about 'risk' and the challenges facing society over the coming years (Beck, 1992; Giddens, 1999). One of these challenges is of course the changing demographic structure. Robine and Michel (2004) suggests that future trends on population health, in the context of population ageing, will depend on the longevity of people living with chronic illness, the ability to control the progression of chronic disease, improvements to the health status of older people, and increasing numbers of very old and frail people. Perhaps missing from their prediction is the potential role of health promotion in developing resilience in determining future population health.

The work of health promotion, and the theoretical perspective of salutogenesis, can be located within the health-resilience framework, where resilience is regarded as an achievable outcome when vulnerability is balanced with wellbeing (Wiles, *et al*., 2012b).

The application of the health-resilience framework in ageing studies offers a positive view of health in later life. Like salutogenesis, it accepts the possibility of ageing healthily despite experiencing illness. Resilience in later life has been defined as

> *'a combination of abilities and characteristics that interact dynamically to allow an individual to bounce back, cope successfully, and function above the norm in spite of significant stress and adversity' where 'an interplay between the individual and the broader environment is responsible for the level of resilience'* (Tusaie and Dyer, 2004: 3).

The notion of resilience thus expands what it means to be healthy, and indeed provides an important dimension to the concept of health. Resilience adds depth to the health-disease dichotomy and effectively supports Antonovsky's construct of the health-ease-dis-ease continuum.

Discussions on health and resilience in later life accept that there are multiple pathways and scales at which health and wellbeing can be explored. These discussions also accept the important role of the environment in influencing capacities to cope. Ryff (1989) identifies six domains of resilience (also described as eudaimonic wellbeing): positive interpersonal interactions; sense of purpose; autonomy; self-acceptance; personal growth; and environmental fit. Other cognitive factors associated with resilience include optimism, intelligence, creativity, humour, a belief system associated with existential meaning, a cohesive life narrative, and an appreciation of oneself. While the resources for achieving resilience are perhaps operating cognitively, or internally, they may be regarded as the result of interactions with the environment, for example finding social support by joining a social club in the community (Bennett, 2010). Wiles *et al.* (2012b) further suggest that resilience among older people is embedded in the social and physical context, with older people finding their relationships with others an important resource contributing to their resilience. The study found that older people attribute their resilience to resources made available to them in their communities, and also opportunities afforded to them through the structural environment.

Kinsel (2005) found several factors contributing to older women's resilience, all of which can be understood as protective mechanisms, and engaging in resilient behaviour. Social connectedness was found to be an important source of resilience, where social connections are made through friendships and by extending the self to others, for example

through volunteer work, or providing instrumental or emotional support to other people. Social connectedness also appeared to be related to religiosity. Further to this, religiosity was associated with resilience as spiritual grounding, for example relying on a higher power or drawing on spirituality as a resource in daily life. Older women demonstrate resilience by moving forward in life following tragic circumstances, but moving forward in life was made possible by finding meaning in the circumstances (Kinsel, 2005). Other examples of resilient behaviour demonstrated by older women include for example having a curiosity about life, engaging in life-long learning and continuously building skills, having a head-on approach to a challenge and feeling confident of their ability to care for themselves, being proactive in providing a sense of security for themselves, feelings of self-worth and motivation, and a desire to be independent. Resilience in older women was also associated with resisting gendered norms. Kinsel (2005) also found that by applying themselves to achieving goals the women appeared to be able to maintain their self-esteem, and on-going continuity of themselves. What was common among all those interviewed was a multi-faceted sense of self; maintaining the ability to apply multiple processes in order to define themselves and their identities. Research by Wiggins *et al.* (2004) indicated several community factors that contribute to quality of life in old age including 'friendly neighbours', 'people looking out for each other', 'a good community spirit' and 'a good mix of people'. Given this brief review of factors found to contribute to resilience, it, like health, can be understood as a process with many contributing factors operating across space and time (Kinsel, 2005; Rutter, 2001).

What is presented here are the input factors that fuel the potential for developing resilience. Embracing these factors to develop resilience is not, however, dependent solely on whether or not the resources are available in the first place. It is also dependent on the individual or community's interaction with them. Resilience could be regarded as the result of the psychological relationship one has with one's physical, social or cultural environment. When adversity arises the individual or group will cope in a manner that is reflective of this person-context relationship. Bennett (2010) identifies four pathways to resilience: being consistently resilient, gradually achieving resilience, developing resilience following a significant turning point, and moving towards resilience in response to several turning points occurring gradually over time. It has also been suggested that resilience increases throughout life as an individual encounters adversity and manages to cope (Wagnild and Collins, 2009). Resilience is perhaps best viewed as the result of coping.

Coping takes on three separate forms. The first is avoidance, where there is no engagement with the problem to find a solution, or pretending that the problem does not exist in the first place. The second is adaptation. This form of coping is about adapting oneself to living with the problem. Finally, the third form of coping is development. This is solution driven coping, which requires the individual, or community, to engage with adversity in a positive way and learn from the problem (Folkman and Lazarus, 1980).

The issue of scale

The social determinants of health model (SDoH) considers health to have many layers of influence, incorporating lifestyle factors such as behaviour, the influence of social networks and community life, living and working conditions, and access to facilities and services. All of these operate within a wider set of structural determinants on a broader scale, such as macroeconomics, and wider social conditions (Wilkinson and Marmot, 2006). Each of these layers has a complex structure. The SDoH model is interesting to the geographer's spatial imagination because there is a strong geographical perspective to the corresponding layers and scales. The SDoH model is a scalar construct taking us across scales of influence to explain health outcomes, from the influences operating at the individual scale, to those operating across the local or neighbourhood scale, right up to broader national and international influences. While the scalar nature of the SOC has not yet been explored in salutogenic research, and only hinted at by Antonovsky (1987), resilience has been considered with relation to scale. Resilience is traditionally explored at the microscale of the individual and family unit. More recently public health and community development has applied resilience to the macro-scale for analysis (Reich, Zautra and Hall, 2010). Figure 4.2 illustrates how scales of resilience are potentially overlapping and interconnected.
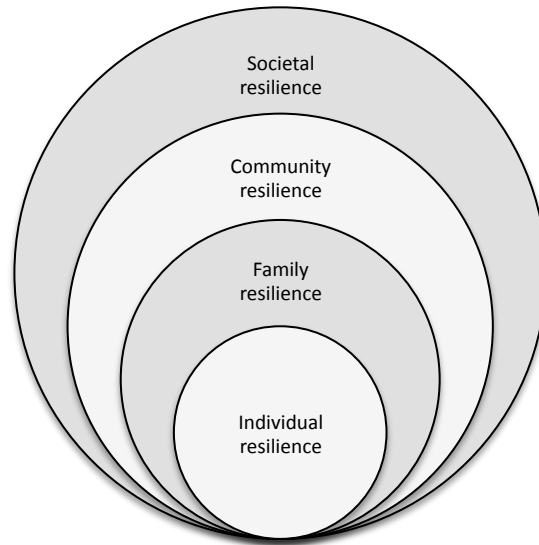
Figure 4.2 Health, scale and resilience influences

Locating health promotion: The upstream model is problematic

The existing public health model is problematic. The model itself is based in problem-solution design. The objective of this model is to identify risk factors of disease and develop interventions, usually biomedical in nature, to reduce poor health outcomes. Syme and Ritterman (2009) identify three main problems with this model. Firstly, they take heart disease as an example of one problem with the model. The risks for heart disease include smoking, high lipid levels, high blood pressure, obesity, a sedentary lifestyle and diabetes. According to Chang *et al*. (2001) these risk factors account for less than half of the heart disease cases in the U.S., and so it seems there is another explanation beyond biomedical factors that can account for the other 50% of heart disease cases. This suggests that the current public health model is not by itself sufficient in identifying all risks associated with heart disease. Secondly, Syme and Ritterman (2009) argue that focusing on individual behaviours has proven fruitless in many cases (also Minkler, 1999). This is perhaps explained by the subjective nature of risk taking behaviour, and the gap between the way people lead their lives and the imagined lives granted to them by the 'experts'. The final problem Syme and Ritterman (2009) put forward is the most complex, and poses the greatest difficulty in solving. The current model of public health does not fully address the fundamental social forces that create problems within communities. This is because the model tends to focus on the individual. Increasingly, however, it is recognised that it is

necessary to place risk factors in a wider context of environmental, community and social forces that are impinging on the health and wellbeing of populations.

Bringing about change to the current public health model is difficult to set in motion because it is difficult to convince those working both inside and outside of the curative health model that resources need to be deferred 'upstream' when there is such a high demand 'downstream'. Syme and Ritterman (2009) provide a compelling metaphorical story to emphasise the difficulty with the deference of resources upstream. Syme and Ritterman's (2009: 5) story is reproduced here.

Imagine a mountain along which a winding road has been constructed. At one point along the road every month several vehicles fall off the edge down the mountainside. When the vehicles hit the ground below the drivers and passengers suffer serious injury or are killed. Head and spinal injuries are the most common, and casualties require skilled medical attention. The local medical team is however not able to cope with the demands on its system, and so casualties are transported via helicopter to the biggest hospital. The issue is how do the local health planners deal with the problems these events pose? Here are the options:
a) Build a state of the art health promotion and injury prevention program in the locality.
b) Certain groups of people are prevented driving along the road, for example learner drivers and older people.
c) Car manufacturers are required to strengthen the vehicles to withstand the impact of car crashes.
d) A new hospital is built, employing the best neurosurgeons, orthopaedists and other specialists.
e) Finally, grant universal health care.
Or
f) The alternative option is to address the design of the road and invest in a redevelopment of the road network thus diverting funds from the treatment of the injured to the construction project.

In essence it appears that the truly effective health promotion program is the alternative one (f) that addresses the fundamental causes of the problem. This is a future investment strategy but does little to address the immediate needs of those already affected. The point made by this metaphorical account is that the concept of prevention is a difficult one to operationalise. The challenge here lies in implementing a health model that focuses on the environmental influences on health outcomes when the direct cause of poor health outcomes are immediately apparent. The environmental influences on health appears much more remote, less urgent and insignificant when faced with readily identifiable risk factors, such

as smoking or obesity. Thus it is a much more challenging decision to plan a health care system with far reaching health goals for communities and nations than for individuals. Indeed an individual focus, while effective for example in encouraging people to stop smoking, does little to influence future generations from avoiding such risk taking behaviour because the environment remains the same. One challenge for researchers is to identify and define the exact pathways through which the broader environmental and social context shapes population health. Can the SOC construct provide the analytical framework to understand these pathways?

Syme and Ritterman's (2009) argument regarding the focus of public health reflects salutogenic thinking. Antonovsky (1987) used a metaphor to explain salutogenesis as a way of looking at life, or to illustrate how salutogenesis is the question and the SOC is the answer. This metaphor considers up-stream down-stream public health activity and it is a reactionary viewpoint to the contemporary western medicine model. According to Antonovsky western medicine is technologically sophisticated, and its purpose is to 'pull drowning people out of a raging river'. In doing so the western medical practitioner does not 'inquire upstream, around the bend in the river, about who or what is pushing all these people in' (Antonovsky 1987: 89). Antonovsky continues his metaphor of the river, stating that

> *'my fundamental philosophy assumption is that the river is the stream of life. No one walks the shore safely. Moreover, it is clear to me that much of the river is polluted literally and figuratively. There are forks in the river that lead to gentle streams or to dangerous rapids and whirlpools.'*

He continues to ask the question 'Wherever one is in the stream – whose nature is determined by historical, socio-cultural, and physical environmental conditions – what shapes one's ability to swim well?' In other words, what is shaping their ability to cope with the stress and not fall ill? He reminds us that being male or female, black or white, upper or lower class will all affect life experiences and will to some extent influence an individual's SOC. This latter point alludes to the SDoH model.

There is a certain caution to be taken when proposing the value of resilience in health development and research. This is because, like health promotion and health prevention, resilience is a concept caught up in arguments for victim blaming and transferring responsibility. Researchers must be careful not to romanticise the assets and capabilities of those living with chronic adversity. The assets based approach to health development may

turn out to be regarded as what Spreitzer and Sonenskein (2004) term 'positive deviancy', and thus potentially communicating a misrepresentation of a population group or community. This is particularly sensitive where there are pressures to cut services due to fiscal constraints and a suggestion of coping abilities may be used to justify any cuts made. Massey *et al.* (1998) argue that a significant challenge for researchers working with non-pathogenically orientated models is to identify the positive capabilities of people and their communities without undermining the consequences of structural disadvantage. The question is posed to the non-pathogenically orientated researcher:

> *'How can we celebrate an individual's accomplishments and wellbeing in adverse situations without either blaming those whose lives show less cause for celebration, or dropping the critique of the contextual structures that promote the adversity?'* (Massey *et al.*, 1998: 338).

Similarly it has been argued that resilience research is very individualistic in its approach, and supports the neoliberal emphasis on removing responsibility from the State and placing it on the shoulders of the individual and community:

> *'This transfer of responsibility for risk assessment and management decisions to the individual keeps pace with wider processes of individualization and [...] State power shrinkage'* (Sapountzaki, 2007: 284-284).

Summary

The shifting perspective of health has meant that public health, and the achievement of health, has become everyone's business, and this is particularly evident in policy responses to an ageing population. For example, the role of the community and voluntary (C&V) sector in promoting the health of older people has formed a considerable basis for health policy in Ireland. It is important not to undermine policy approaches that emphasis the role of the C&V sector as simply a government's attempt to shirk its responsibility for population health. Rather, given the shifting paradigms in terms of our understanding of health, public health and health policies over the last number of decades, it is perhaps a good time to consider the potential of up-stream efforts where many of the C&V sector activities are located, as a genuine approach to improving health and wellbeing in preparation for population ageing. The C&V sector's role is not only to provide instrumental support, they also contribute to health in the holistic sense, especially the quality and conditions of

community life. The C&V sector are often in tune with the fabric of community life (Walsh and O'Shea, 2008), and grassroots work, such asset-based community development, might be more effective when organised locally than any government led initiative in promoting health and wellbeing at the local level (Ledwith, 2010).

To understand how health can be promoted upstream, it is necessary to look at what is actually happening 'upstream', what are people doing, what are they feeling, how do they relate with the world around them, what do they see when they look outwards, what do they see when they look inwards, and how does this contribute to their movement downstream into the choppy waters of risk and vulnerability, and eventually death. This is what the SOC attempts to explain. As will become apparent later in the thesis much of what is happening upstream is an expression of human nature, whether that is establishing bonds with other people, seeking purpose and meaning in life's daily activities, or seeking out existential truths. It is in the philosophical domain of understanding what makes us human that Antonovsky (1987) sought the answer to the salutogenic question – what creates health? From this location he devised the analytical construct of the SOC. He later put forward the salutogenic orientation as a possible theoretical basis for health promotion. Identifying the processes involved in developing the SOC and determining what the SOC looks like in reality might be one step closer to understanding what is required to make the activities of health promotion effective. Salutogenically driven policy and practice is not however entirely attractive because it lacks a sense of urgency.

The next chapter provides a more detailed critical analysis of Antonovsky's theory of salutogenesis.

Chapter 5

A critical analysis of Antonovsky's theory of salutogenesis and the Sense of Coherence

The policy and practice response to the chronic disease burden has largely taken a downstream, medicalised, and healthist (lifestyle focused) approach. Medicalisation and healthism problematise daily life by identifying the behavioural factors that are impacting negatively on health. The resulting narrow focus that looks at the individual's behaviour and their role in contributing to their ill health masks the impact of wider structural forces. In addition, medicalisation and healthism has also led to an identity shift from patient, a passive recipient of care, to simultaneous identities of consumer, customer, or client within the spaces of health care (Cheek, 2008). This follows the 'victory of capitalism, and of the ideology of consumerism' in penetrating health care (Sontag, 2002: 328) whereby the individual is regarded as autonomous and having the freedom to choose how they will cultivate their health and wellbeing. This opens up the discussion to include the role and responsibility of the individual in managing their behaviour and conducting themselves in a manner that is conducive to health, thus removing a significant share of responsibility from the State and/or the health care system. Operating within this paradigm of individualism, the health care management solutions to remedy health problems draw on behavioural change, and emphasise lifestyle change over and above changes to the wider structural forces that are influencing behaviour. Take for example the use of anti-tobacco slogans on Marlborough cigarette boxes 'smoking can cause a slow and painful death' or 'smoking seriously harms you and those around you'. Such campaigns are derived from the behaviour-orientated health promotion paradigm. The intention of this campaign is to speak to the individual's emotional and rational thinking and encourage them to quit. This campaign provides a very simplistic example of a behaviour-change-orientated health promotion policy. For the sake of introducing the notion of the individual's ability to think about the health consequences of their decisions it provides an interesting example. The individual is confronted with choices, which originate in their environment, and are derived from the wider structures of society, *but* the way in which they conduct their behaviour might ultimately be determined by their SOC.

The purpose of this chapter is to critically analyse Antonovsky's (1996) proposal that the salutogenic orientation and the Sense of Coherence can inform the theoretical basis for health promotion (Erikson and Lindstrom, 2008). While it is understandable that an

international health directive such as health promotion requires a theoretical basis it is also necessary to study any proposed framework closely to ensure that the outcome is favourable, just and equitable across the population. While there is a considerable push for the salutogenic orientation, and in particular its recent adaptation in the form of asset based community (health) development, it is important to revisit the original thinking and to challenge the ideas put forward before a policy commitment to salutogenesis is established at the national or international scales. Antonovsky's ideas will be examined with relation to individualism and collectivism. This will include a discussion on the use of the Orientation to Life Questionnaire as an investigative tool in health promotion research and the potential implications of applying the SOC construct to health promotion policy and practice. The general argument made is that Antonovsky is perhaps more sympathetic to the philosophy of individualism and the role played by the individual in determining their health outcomes than the proponents of his thinking appear to consider, perhaps because insufficient attention is paid to the philosophical foundations of Antonovsky's work. This shortcoming will be addressed in this chapter.

The Ottawa Charter: A collectivist model

Health promotion, as outlined by the World Health Organisation in 1986, is committed to the improvement of the health and wellbeing of populations, and these improvements are to be made through societal change rather than through narrowly focused behavioural change. If we take the actions put forward in the *Ottawa Charter* (WHO, 1986) to guide health promotion it is evident that the individualist focus was never intended to inform the application of the *Ottawa Charter* (WHO, 1986) as a guiding framework at the national policy scale. Rather what we find is, very distinctly, the collectivist philosophy associated with the ecological perspective. The following quote relating to the creation of supportive environments for health is grounded in a collectivist philosophy:

> *'The overall guiding principle for the world, nations, regions and communities alike is the need to encourage reciprocal maintenance – to take care of each other, our communities and our natural environment'* (WHO, 1986: 2).

Health is not viewed as something solely within the control, or even the responsibility of the individual, rather it is the result of a wide range of interconnecting relationships and actions,

involving a wide range of actors and determinants. Responsibility for both individual and population health thus lies within this network.

> *'Health promotion goes beyond health care. It puts health on the agenda of policymakers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their* responsibilities' (WHO, 1986: 2).

The very notion that health is not confined solely to the remit of health care is an important indication of the underlying social philosophy of the *Ottawa Charter* (WHO, 1986). As discussed earlier, with individualism health is narrowly confined to functioning at the cellular level and is only accessible through medical care, and influenced directly by the individual's decisions and behaviour. According to the above quote from the *Ottawa Charter* (WHO, 1986), health consequences are beyond the responsibility of the individual, and lie instead with the policymakers. Responsibility for health and the generating of safe, stimulating and enjoyable conditions in the environments where we live, work and play is thus dispersed across a range of actors.

The *Ottawa Charter* (WHO, 1986) established that responsibility for health and its enhancement extends beyond what can be called a 'curative' health system, and thus defined a new agenda for the health system. Subsequent to this shift the Charter called for the re-orientation of the health services, whereby they still contribute to the pursuit of health, but now work in partnership with individuals, communities and other sectors. Through this partnership working the health sector's activities are no longer confined to clinical and curative services. Also emerging within the same rhetoric of re-orientating the health services, and partnership working for health, is the emerging role of community development in health:

> *'Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is empowerment of communities, their ownership and control of their endeavours and destinies* [...] *Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support'* (WHO, 1986: 3).

Health promotion as practice has received much criticism from the social sciences for its focus on personal lifestyle, individual risky health behaviour and decision-making, meaning disease stigma is preventing public health from reaching the real sources of ill health (Puhl and Heuer, 2010). Of the five actions for promoting health put forward in the *Ottawa Charter* (WHO, 1986) only one action specifically addresses individuals as agents in making choices. In relation to both individual and social development it is proposed that health promotion should support

> *'personal and social development through providing information, and education for health and enhancing life skills. By doing so, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health'* (*Ottawa Charter*, 1986: 3).

Notably, a role is set out for a range of actors in supporting personal development and to be facilitated in school, home, work and community settings. It appears that practical approaches to health promotion have drawn heavily on this single proposed course of action. What was put forward in the *Ottawa Charter* (1986) was a vision grounded in the collectivist philosophical perspective, where the practical application of the policy was to be put into action through state policies, action or community groups, and lay people, with limited contributions to be made by 'curative' health professionals. Practice did not always, however, match the intent of the policy, and when practice was targeted at the individual the focus for intervention was removed from the broader determinants of health, and responsibility was placed with the individual. When health promotion was applied in practice using the individualist standpoint its ontology was disregarded. Individualism in health promotion fails to recognise that the individual is not an isolated or atomised being but rather exists relative to social relations. Health promotion locates people within a mediating system encompassing both human agency and structure. The quality of this reciprocity determines the quality of one's environment and its impact on their health (van der Maesen and Nijhuis, 2000).

Ill health prevention and neo-liberalism

The emergence of preventative health strategies in countries such as Ireland, the UK and Canada, comes at a time when a neo-liberal agenda predominates the political and economic agendas, and liberal principles inform political rationale (McGregor, 2001; LeBesco, 2011).

Ontological security is to be derived from an abstract health care system driven largely by market forces, and 'expertise' grounded in reductionist and traditional understandings of health, and this has arguably removed 'the human face' from health care (McGregor, 2001). One of the most significant trends within neo-liberal thinking is the replacement of welfare dependency with active entrepreneurship. Notions of risk during the welfare-era were mediated through the welfare state. Giddens (1996) describes the relationship between risk and the welfare state as follows:

> *'The welfare state has always been above all a security system, designed to combat the hazards that individuals and groups face. It developed, both pre- and post- 1945, mainly as a means of dealing with external risks – misfortunes that affect people through no fault of their own. Thus individuals find themselves deserted by their spouses, living in poverty, out of a job, sick, disabled, getting old and so forth* (Giddens, 1996: 253).

Giddens (1996) regards risk as something that is manufactured, and the result of a complex relationship between what we make happen and what happens to us.

Neo-liberalism is about creating a sphere of freedom within which people exercise their autonomy and freedom to choose, and thus within the neo-liberal context health can be understood to some extent as a choice. One makes a decision to be healthy and achieves health by making healthy choices. According to Reeves (2004) the freedom to choose associated with the neoliberal political context represents a shift from the State 'rowing' its population towards health to an 'enabling State' which is about 'steering' populations, or guiding them towards a healthy lifestyle. Within this thinking individuals are free to choose but are ultimately accountable for their own health outcomes. For Rose (1993) neo-liberalism applied in health care is about the individual's capacity to care for themselves. Within neo-liberal thinking life is an enterprise and the individual's job is to manage this enterprise through self-governance. The ability to care for the self as a political endeavour is bound up in the objective of relieving the State of the burden of the individual. Risk management as a preventative tool in addressing disease burdens is concerned with the redistribution of the responsibility for health, and is carried out through the social body rather than by the State (Petersen, 1997). There is a continuous and persistent shift in emphasis from health as a basic human right to health as a duty (Galvin, 2002).

Within political discourse, particularly since the emergence of health promotion as a policy directive in the late 1980s (WHO, 1986), citizens are ascribed a moral responsibility

to take care of their health. Galvin (2002) for example argues that in the advanced liberal society it is becoming increasingly unacceptable to be physically incapacitated because it clashes with the image of the 'good citizen' – that is an individual who actively participates in both social and economic life, and is independent, self-reliant and responsible. Anyone who does not demonstrate these characteristics when faced with adversity or risk results in moral failure, and this moral failure demands a political response. This view reflects a lack of consideration for the role of wider pressures and influences that can determine health outcomes. According to Fitzgerald (1994) the pursuit of health is a social responsibility, and that we owe it to society to stay healthy by controlling our behaviour. Accompanying this is the emergence of 'healthism', a concept first introduced by Crawford (1980) and bound up in what Sontag (1995) refers to as 'the cultivation of the self and private wellbeing'. Healthism is the belief that health can be potentially perfect and it rejects disease, ageing and even death as unnatural and remedial phenomena, and therefore to live longer is to live younger (Cheek, 2008). Healthism is supported and encouraged by neo-liberalism, particularly the belief that money must be spent to achieve 'perfect' health, that is, youthful vigour, aesthetically pleasing features, and a 'sought after' body can be bought. There is a complete contrast between healthism, as an emerging paradigm in popular health, and Illich's (1974) idea of what true health is, a view that is reflected in Antonovsky's (1987) theory of salutogenesis. Illich (1974) regarded true health as the ability to competently cope with the integral parts of life such as pain, sickness and death. By classifying the natural problems of humanity as medical problems, or problems to be solved through intervention, individuals would lose their ability to improve or return to good health independently.

With the broad definition of health associated with the ecological approach and the social determinants of health model, as applied in the *Ottawa Charter* (WHO, 1986) it would seem that individuals are continuously subjected to risk filled environments, whether it is tempting food environments (Cummins and Macintyre, 2006), smoking (Leatherdale *et al.*, 2005) alcohol (Nolen-Hoeksema, 2004), or drugs (Rhodes, 2009). These risky environments paired with a neo-liberal society where the autonomy and freedom of the individual to choose is valued, notions of risky behaviour, and 'at risk' or vulnerable populations are considerably expanded. Balancing protection and individual freedom is essential to reduce risk. Granting an individual autonomy over their health behaviour and health decisions, in a context of emerging consumerist health care, represents a transferral of both power and responsibility. It assumes the individual can make correct decisions about

health and health behaviours, it leaves the individual susceptible to broader influences acting to negatively impact on health, it intensifies the market's influence, it disperses risk across the population, and it may even reduce the visibility of 'at risk' groups (Alaszewski *et al.,* 1997). While these are the challenges of risk associated with individualism, collectivism also poses a challenge for risk management. With collectivism comes increasing trends of de-institutionalisation, and the removal of 'at risk' or vulnerable groups from institutional spaces where their health is heavily managed and monitored. Risk is re-placed in the community setting to be managed in the general spaces of daily life. Removing risk from institutional spaces results in the reconstruction of what is considered to be risky (Alaszewski *et al.,* 1997).

Health is a basic human right. With the emergence of the neo-liberal agenda there has been increasing political discourse on cost-effective solutions. However, as pointed out by Farmer (2008) 'cost-effective solutions' and 'effective solutions' mean different things in protecting people's health. Health care has become a commodity, and patients are becoming increasingly referred to as consumers in health policy. For those living in poorer financial circumstances this form of health care management results in a sharp rise in health inequality because it makes health care inaccessible to many. Thus, achieving population health and accepting health as a basic human right cannot be fulfilled by a political system opting for a neo-liberal approach in managing its health care system. The right to health care does not equate with providing individuals with a functioning health care system that incurs costly fees for its use. Within the context of neo-liberalism and risk management, an approach to ill health prevention that focuses on behavioural intervention removes the social determinants of health as a site of intervention from the agenda. In doing so fulfilling the right to health for the population is compromised. While it is the State's duty to protect the rights of the individual the emergence of co-responsibility, particularly with the health promotion thinking of the new public health agenda, social fragility and risk management requires 'the citizenry to engage in an active construction of society's responsibility to guarantee the right of all' (De Negri Filho, 2008: 98). With regard to the ecological approach to understanding health, a rights based approach would conceptualise environments as being ideally protective of health. Social spaces within the 'health as a human right' framework must guarantee safety, protection and security. According to De Negri Filho (2008) human rights can only be realised in specific social territories, and so these territories are important sites for addressing causation. By adopting a concept such as

social territories the problems of health are placed within social and political spaces, and a focus on these spaces provides a viewing point from which people's exposure to the social determinants of health in their living spaces can be observed. The application of the social territory idea provides an opportunity to exercise intersectionality, and this can be done through the decentralisation of the Welfare State for example. Relating this back to the *Ottawa Charter* (WHO, 1986) the implementation of healthy public policy as a health promotion action may be translatable at this social territory level. The pairing of decentralization and healthy public policy in theory moves governmental processes closer to local realities and in doing so the causal chains and pathways of health determinants are made more accessible. De Negri Filho (2008) argues further that to put ethics first on the health agenda tasks need to be re-orientated and priorities need to be inverted, as with the assets based model. There is a need to look beyond the deficit model to acknowledge the resources already available in these local territories. In doing so all that is needed to concretise the right to health and quality of life is attainable.

Salutogenesis and the social philosophies guiding health policy

Antonovsky (1996: 11) puts forward the case that the 'adoption of a salutogenic orientation in and of itself would be a valuable foundation for those engaged in health promotion, working with anyone at any point on the health-illness continuum.' Later Eriksson and Lindstrom (2008) agreed that the salutogenic framework is indeed a suitable theoretical approach to inform and support both the philosophical and practical intentions of the *Ottawa Charter* (WHO, 1986). This section will closely examine Antonovsky's work and discuss several different aspects of his thinking with relation to the philosophical collectivism associated with the *Ottawa Charter* (WHO, 1986) and the debate for altering the structural determinants of health in order to address health inequalities.

The individual-collective dichotomy is very blurred within salutogenic thinking. Given the previous discussion on the role of individualism in health promotion, and particularly in terms of its policy and practical application, it is necessary to undertake a deeper examination of the social philosophies that are evident in Antonovsky's thinking if the theory of salutogenesis is to inform health promotion policy and practice. The fundamental understanding of health underpinning Antonovsky's theory of salutogenesis is an important starting point in this discussion. According to Antonovsky (1996: 11)

> *'all human distress is always that of an integrated organism, always has a psychic (and a social, I might add) and a somatic aspect.'*

The concept of 'psychosomatic' illness is the belief that something in the mind leads to somatic disease. Therefore it would seem that Antonovsky from the outside regards the source of health as something that lies fundamentally *within* the individual. There is however an externality too. When an individual is faced with adversity they draw on generalised resistance resources which exist both internally, within the person, and externally in the environment in which they live/exist. The commonality among these GRRs is that they help the individual to 'make sense' – cognitively, instrumentally and emotionally – of their stress and thus aids them to cope with it. The individual according to this thinking internalises the salutary mechanisms to deal with this stress and from this health outcomes are derived. The Sense of Coherence and its components are closely related to the earlier idea of the locus of control (Fournier and Jeanrie, 2003) introduced by Rotter in the 1960s. This refers to the level or degree of control that an individual perceives to have over their environment. According to Rotter (1966) people differ greatly in terms of how they perceive their level of control or influence. Thus a key similarity between the concepts of the SOC and the locus of control is the notion of perception.

The manageability component of the SOC is similar in how control is treated to Rotter's (1966) concept of the locus of control. Manageability is determined by one's perception of the degree of control they have over their internal and external environments. Many different factors are said to influence the individual's perceived sense of control. For the SOC what matters is the individual's life experience. According to the SOC model the individual develops, throughout the life course, an ability to reach out and apply the resources available to them to promote and enhance health. Antonovsky suggests that the SOC is a dependent variable that can be shaped and manipulated so that it can be used in promoting health. It is with this suggestion that some confusion arises as to the place of individualism within the salutogenic orientation. It is not all that clear where Antonovsky stands on the issue of lifestyle influences on health in shaping outcomes. While he acknowledges that life experiences are moulded by the individual's position in the social structure, he also emphasises that people are proactive in life and make choices. By committing to positive decision making and behaviour the individual is shaping and improving their SOC, and thus they are improving their chances of positive health. By

altering their SOC the individual is setting out a path for making major changes to their life circumstances. It would thus seem that the SOC is perhaps more aligned with the individualist health promotion than the collectivist ecological approach. The collective, or ecological, role in stimulating and enhancing the SOC is, however, broached by Antonovsky (1996: 16) in asking

> *'what can be done in this 'community'[...] to strengthen the sense of comprehensibility, manageability, and meaningfulness of the persons who constitute it?'*

While this is suggestive of an interest in collectivism the ultimate goal is to shape the individual's psyche, because what is asked is that the community draws together its GRRs and make them available to the individual to provide them with a sense of internal control over their external environment. Ultimately the individual must internalise the knowledge that the resources exist and the onus is on them to use their own energy to utilise what is made available to them. A popular saying in health promotion is 'make the healthier choice the easier choice' (Department of Health, 1995), but this statement is about facilitating lifestyle choices and encouraging people to take responsibility for the choices they make and the resulting health outcome. In the case of the SOC the community is encouraged to organise the GRRs and make them available to the individual. But ultimately it is with the individual that the SOC is located and used. It is also the individual that decides whether or not their life is meaningful, manageable and comprehensive. Indeed the Orientation to Life Questionnaire, which was developed by Antonovsky (1987) and used to measure the individual's SOC, is focused on the individual and their perception of their lifeworld. Importantly the meaningful component of the SOC is identified as the key motivating factor in determining the decisions an individual makes. If an activity does not make sense emotionally to the individual then they will not be motivated to act. If for instance an individual does not feel compelled to give up smoking when given the opportunity to do so, and are not convinced by the gory visual campaigns, this can be interpreted using the SOC as a task that does not speak to the individual's emotional consciousness. Anti-smoking campaigns usually have a small note saying 'willpower required'. This willpower arguably originates from the SOC.

The role of personality disposition in transcending the conditions of the context

The SOC as devised by Antonovsky does not fit neatly with collectivism, introduced earlier in the chapter. Rather with the SOC the focus is narrowed to the personality disposition of the individual, thus strongly indicating that Antonovsky was concerned primarily with the individual's thought processes over and above the structural conditions present in the context. Consider the pilot study undertaken by Antonovsky (1987) to develop the SOC theory and identify its components. Antonovsky selected the research participants using specific criteria that identified them as 'deviant cases'. Participants were selected on the basis that they experienced serious trauma at some point in their lives but were appearing to cope remarkably well and live successful lives - for example the chosen participants were either victims of war, they experienced forced migration, they were living with a disability, or they lost several family members in violent circumstances (Antonovsky, 1987: 64). Antonovsky was interested in the individual who had displayed resilience and strong coping abilities in the face of such adversity, thus demonstrating the strength of mind over matter. Therefore at the initial point of theory formulation Antonovsky was less interested in the structural determinants of outcomes, and more interested in the ability of the arguably atypical individual to transcend their circumstances.

Using the data derived from the interviews conducted with the 'deviant cases' Antonovsky validated the SOC theory and compiled the Orientation to Life Questionnaire. The questionnaire used to measure an individual's SOC was primarily concerned with the cognitive processes of perception and how that individual saw their world. This was how Antonovsky (1979: 124) originally described the SOC as 'a generalized and long-lasting way of seeing the world'. He later referred to the SOC as a personality disposition, an individual characteristic that had social sources:

> *'In sum one can speak of the SOC as a dispositional orientation. The fact of having grown up in a world of experiences shaped by the culture, social structure, and historical period in which one lives, as well as by the pattern of idiosyncratic events in one's life, which push predominantly toward one or the other pole of consistency, load balance, and participation in socially valued decision making, determines one's location on this dispositional orientation'* (Antonovsky, 1987: 184).

The use of the term 'disposition' is important in determining which of the two social philosophies described earlier that Antonovsky is most sympathetic to. The term

'disposition' as it is defined in psychology is concerned with the common behavioural characteristics of the individual, that is 'a tendency to behave in a similar manner at different times and places; The sum total of an individual's characteristic tendencies, such as basic temperament, attitudes, inclinations and drives; The total attitude of a person at any one time' (Corsini, 1999: 288). From the psychological definition of the term disposition, and Antonovsky's use of the term to describe the SOC, it would appear that the SOC is closely aligned with the individualist behavioural thinking that underpins one side of health promotion discourse. When undertaking the task of identifying a relationship between the SOC and positive health outcomes the researcher is essentially deriving an explanation or understanding of a phenomenon by dispositional attribution, that is 'explaining any behaviour as due to underlying psychological factors' (Corsini, 1999: 288). The application of the SOC in health promotion, thus attempts to explain health outcomes in terms of the cognitive processes of perception used to make sense of the lived life. In taking the SOC components of meaningfulness, manageability and comprehensibility and applying them in a qualitative study, as this thesis does, the researcher is engaging in dispositional inference to draw conclusions. That is 'in observing the overt behaviour of a person, the assumption that a second person can make valid inferences about covert and inner behaviour of the first person' (Corsini, 1999: 288).

Antonovsky makes the case that the SOC should not be regarded from the psychological reductionist position as a straightforward character trait, because it is more than a personality attribute. It is instead what he refers to as a 'dispositional orientation', referring to a much more broader and fundamental dimension to the individual's personality framing how the individual sees their social world, and their place in it. Or perhaps to refer to his objective of putting order on chaos it is the individual's understanding/coherence of the world within which they are immersed. The use of 'trait' to describe the SOC potentially disregards the role of the cultural-historical context in shaping the development of the SOC, and viewing the SOC as merely a trait would fail to recognise the socially structured situations within which it is expressed, or the contextual opportunities, constraints and pressures to which it is sensitive. Trait also suggests an independent inner life that is largely detached from the circumstances of the external environment, unlike 'global orientation', which provides the individual with a referential context from which their judgements are made.

Using the Orientation to Life Questionnaire to understand the SOC qualitatively

A closer look at the Orientation to Life Questionnaire (Table 5.1) is necessary to further explicate Antonovsky's preoccupation with the inner workings of the mind, and how the relationship between thought processes and the external environment manifests as health outcomes. In addition the explanation provided of each of the components is underdeveloped, and so the survey questions offer additional insight on what Antonovsky thought was most important in determining the SOC. Each of the questions on the survey was formulated to correspond with the three SOC components, meaningfulness, manageability and comprehensibility. These components relate to the environment in terms of the individual's interaction with what are termed generalised resistance resources (GRRs). Importantly, the GRRs are believed to give rise to a strong SOC, thus making the SOC a product of the environment. The SOC attempts to understand what is common to all GRRs. The questionnaire requires the participant to evaluate the totality of their environment, including the GRRs. In their substantial investigation of the SOC and their application of the questionnaire, Amirkhan and Greaves (2003) identified the three mechanisms present in the Orientation to Life Questionnaire that are intended to explain the relationship between the SOC, coping and health. These mechanisms are perceptual, cognitive and behavioural. According to Amirkhan and Greaves (2003) the perceptual mechanisms associated with the SOC relate to the ability of the SOC to tint how an individual perceives a stressor and the stronger the SOC the more likely the individual is to perceive the stressor as benign. Rather than classify the stressor in terms of its size, impact or intensity, the individual with a high SOC will look at the stressor in terms of its perceived meaningfulness, asking if it is worth investing in. The person with the high SOC perceives the world and its stimulus as less chaotic, more manageable and can derive a sense of ontological security form their internal and external environments. On the Orientation to Life Questionnaire the questions that relate to the perceptual mechanism are for example 'Think of the people with whom you come into contact daily, aside from the ones to whom you feel closest. How well do you know most of them?' and 'Most of the things you do in the future will probably be completely fascinating, or deadly boring?' The use of the terms 'judgement' and 'predictable' suggests the role of cognitive processes used by the individual to analyse the stressor in terms of its origins, its effects, its reccurrence, the course of action to solve the problem and future orientation. The person with the strong SOC may judge the causes of a stressor to be more stable or controllable than the person

with the lower SOC, thus mitigating the emotional pathogenic impacts of the problem. It may be possible that the SOC is an important factor in determining actions and coping strategies. Depending on the effectiveness of the strategies, the health benefits of the SOC might be explained through its impacts on behaviour. According to Antonovsky (1992) the stronger a person's SOC, the more open they are to feedback on changing their behaviour in order to reduce the impact of a given stressor.

In their study on the SOC as an indicator of a healthy disposition Amirkhan and Greaves (2003) presents the challenge of understanding the level of impact the SOC has on health. If the SOC determines coping responses, and if the coping mechanisms is what mediates the level of pathology that results it is important to determine if the SOC acts as a 'whole mediation' i.e. the SOC is the very essence of behavioural tendencies and thus coping is the total influencing factor on health. Or alternatively the SOC acts as a 'partial mediation' and so coping only accounts for part of the relationship between the SOC and health. The results of their laboratory and field investigations are significant in that they identify the characteristics of the individuals with both low and high SOC scores. Firstly, their studies established the existence of a relationship between the SOC and coping behaviour. Secondly, they found that individuals with a high SOC were proactive in solving their problems demonstrating a non-avoidant and problem-focused response, rather than withdrawal and distraction. Thirdly, the coping pattern associated with a high SOC was found to be effective in preventing stress related mental illness such as depression. Fourthly, they found that the individual with the higher SOC was more likely to view a stressor as benign and manageable. Amirkhan and Greaves (2003) findings provide evidence for their initial hypothesis that the SOC operated as both a perceptual and a behavioural mechanism. However the third mechanism, the cognitive mechanism, was not found to be related to the SOC because people with both low and high SOC scores were found to be equally likely to typify their stressors and identify the attributes. The reason for including this study here in such detail is because of its implications for the potential application of the SOC in health promotion policy. The study provides a substantial indication of the role of personality in health and stress, and further to this it provides supporting evidence for the potential application of the SOC in designing health promotion interventions targeting behavioural mechanisms. The study subsequently provides a very good indication of how the application of Antonovsky's thinking and the SOC in research on health stress and coping predominantly supports the individualist perspective.

Recent research applications of the SOC and the Orientation to Life Questionnaire (Moons and Norekvial, 2006; Wrzesniewski and Wlodarczyk, 2012; Muller, Hess and Heger, 2013) found that the SOC as a personality trait is a strong predictor of quality of life – those with a high Sense of Coherence were more likely to report having a satisfactory quality of life. Another study by Richardson and Ratner (2005) found that the SOC acts as a buffer against stress. It would seem that even for those with chronic illness the SOC can have a profound effect on quality of life, perhaps because a high SOC suggests that the individual actively draws on the GRRs available to them to promote their health and enhance their wellbeing. They thus demonstrate considerable agency and influence on their health. But what do these empirical findings, which are individualist in their approach, mean for the application of the salutogenic orientation in health promotion policy and practice as proposed and supported by Eriksson and Lindstrom (2008)? It would be theoretically inconsistent to treat the SOC as a separate concept unrelated to the salutogenic orientation. In order to propose salutogenesis as a theoretical basis for health promotion the stance taken on individual versus collective responsibility for health debate would have to be resolved. In closely examining the salutogenic theory it would seem that it pushes for individual responsibility for health, where personality is a strong predictor of health and quality of life. A salutogenically inspired health promotion policy, if it is to take a relatively unmodified version of Antonovsky's original theory, would view the individual as having considerable agency in terms of their health, would define the individual using a positive concept of the self, and would perhaps fail to fully address the broader structural determinants of health, including place, because of its narrow focus.

Sense of Coherence – Orientation to Life Questionnaire (Antonovsky, 1987)
(The wording of the questions are unchanged, and answers are given in the original survey using a 7-point likart scale)

C = comprehensibility Ma = manageability Me = meaning
1. When you talk to people, do you have the feeling that they don't understand you? (C)
2. In the past, when you had to do something which depended upon cooperation with others, did you have the feeling that it: Surely wouldn't get done or surely would get done (Ma)
3. Think of the people with whom you come into contact daily, aside from the ones to whom you feel closest. How well do you know most of them? (C)
4. Do you have the feeling that you don't really care about what goes on around you? (Me)
5. Has it happened in the past that you were surprised by the behaviour of people whom you thought you knew well? (C)
6. Has it happened that people whom you counted on disappointed you? (Ma)
7. Your life is full of interest or completely routine? (Me)
8. Until now your life has had no clear goals or purpose at all or very clear goals and purpose? (Ma)
9. Do you have the feeling that you're being treated unfairly? (Ma)
10. In the past ten years your life has been full of changes without your knowing what will happen next, or completely consistent and clear? (C)
11. Most of the things you do in the future will probably be completely fascinating, or deadly boring? (Me)
12. Do you have the feeling that you are in an unfamiliar situation and don't know what to do? (C)
13. What best describes how you see life – one can always find a solution to painful things in life or there is no solution to painful things in life? (Ma)
14. When you think about your life you very often feel how good it is to be alive or ask yourself why you exist at all? (Me)
15. When you face a difficult problem, the choice of a solution is always confusing and hard to find, or always completely clear? (C)
16. Doing the things you do every day is a source of deep pleasure and satisfaction or a source of pain and boredom? (Me)
17. Your life in the future will be full of change without knowing what will happen next, or completely consistent and clear? (C)
18. When something unpleasant happened in the past your tendency was 'to eat yourself up about it' or to say 'ok that's that, I have to live with it' and go on? (Ma)
19. Do you ever have very mixed-up feelings and ideas? (C)
20. When you do something that gives you a good feeling it's certain that you'll go on feeling good, or it's certain that something will happen to spoil the feeling? (Ma)
21. Does it happen that you have feelings inside you would rather not feel? (C)
22. You anticipate that your personal life in the future will be totally without purpose or meaning, or full of meaning and purpose? (Ma)
23. Do you think that there will always be people whom you'll be able to count on in the future? (Ma)
24. Does it happen that you have the feeling that you don't know exactly what's about to happen? (C)
25. Many people – even those with a strong character – sometimes feel like sad sacks (losers) in certain situations. How often have you felt this way in the past? (Ma)
26. When something happens have you generally found that you overestimated or underestimated its importance, or you saw things in the right proportion? (C)
27. When you think of the difficulties you are likely to face in important aspects of your life, do you feel that you will always succeed in overcoming the difficulties, or you won't succeed in overcoming the difficulties? (Ma)
28. How often do you have the feeling that there's little meaning in the things you do in your daily life? (Me)
29. How often do you have feelings that you're not sure you can keep under control? (Ma)

Box 5.1 Orientation to Life Questionnaire (Antonovsky, 1987)

The Sense of Coherence as a group property and explanatory concept

Antonovsky is not so precious about his work that he views the SOC as a conclusive and final theory. Rather he encourages the reader to depart down alternative pathways of investigation using a varied range of methodologies, in order to add further coherence to the chaos (Antonovsky, 1987). One of the questions that remains inconclusive at the end of *Unravelling the Mystery of Health* (Antonovsky, 1987) and requires further exploration is the matter of examining the SOC as a group level property. This represents a methodological challenge relating to issues of scale or the unit of analysis. Group properties are difficult to measure and define, unlike structural characteristics, which are clearly measurable and possible to classify for example in terms of age, gender, or religion. While he consistently applies the SOC to the individual level he suggests throughout that the concept can also be applied at the society level.

> *'Though the point is most clearly seen in considering a ruling class, a strong Sense of Coherence can characterise any social unit, from the Jones family to a neighbourhood, a city, a region, or a country; from a local voluntary association to an apocalyptic religious movement; from underdogs to over dogs'* (Antonovsky, 1987: 171).

He put forward the question 'can a collectivity, as such, be characterised as having a common way of seeing the world?' (Antonovsky, 1987: 171). If this is to be investigated how can this be done and measured separately from the individual's SOC without resorting to aggregating the individual level results of the survey to the group level? Aggregating the data derived from the questionnaire to the community level may result in ecological fallacy where incorrect assumptions are made about its members based on the data generated from a limited representative sample (Robinson, 1950 cited by Fotheringham *et al.,* 2000). Indeed in attempting to examine the SOC of the collective the Orientation to Life Questionnaire is made redundant, leaving just the three components of the SOC to work with. These components, as a frame of reference applied to the group level, are in themselves a problem because the components do not lend themselves well to an analysis of a group. This is probably because the components were originally formulated using data generated from the retelling of life stories by individuals, and were subsequently intended to establish the personality disposition of individuals. In applying the components to the group level there is a risk with assuming that the attributes of an individual, in this case the SOC as an attribute,

actually apply to the area level of analysis. In the end Antonovsky does not put forward a viable strategy for potentially applying the SOC at the group level without having to focus on individual level perceptions of the world initially.

The methodological challenges associated with the application of the salutogenic orientation to health promotion policy and practice presents an epistemological problem in terms of the capacity of the salutogenic orientation to explain reality. At the time Antonovsky was formulating his ideas he was working within a largely positivist paradigm in social science research, and this is reflected by his use of a questionnaire to gather the empirical evidence. Fast-forward, and take into account, almost 30 years of paradigmatic changes in research epistemology and methodologies, and a certain degree of scrutiny will emerge with regards to the ability of the questionnaire to provide sufficient empirical evidence to support the relationship between the 29 questions asked in order to measure (including subjective measures) health and wellbeing. Really the challenge is not so much about establishing a relationship between the two phenomena, but rather in explaining the relationship, so that the SOC and its components, as analytical concepts, can be moved forward and applied in practice. Take for example the comprehensibility component, represented by questions 1, 3, 5, 10, 12, 15, 17, 19, 21, 24, and 26 on the Orientation to Life Questionnaire (Table 5.1), and its definition as an individuals perception that stimuli deriving from the internal and external environments are ordered, clear, understandable and structured (Antonovksy, 1987: 16-17). How can this component be made practically operational in community health development, and what would it look like? Using the questions on the questionnaire to somehow inform such activities seems futile. The focus is on the individual's emotional and cognitive understanding of the world around them, so perhaps the operational definition of comprehensibility requires an educational or philosophical focus and self-reflection. Or given that the SOC is thought to be something that is set in early adulthood, perhaps one approach might be to focus on improving the emotional intelligence of children and adolescence so that they can relate to and engage positively with their internal and external environments. This would however require a marriage of Antonovskys's SOC with other theoretical perspectives to make it fully operational, for example Goleman's theory of emotional intelligence (EI) (Goleman, 2006) and the value of self-awareness, self-regulation, motivation, empathy and social skills. Although much broader than comprehensibility the merging of comprehensibility with emotional intelligence might be one way forward. The use of EI here is merely an example

to make the point that, on its own, the SOC component of comprehensibility appears to make little practical sense. The potential operational and practical application of the components will be explored in much greater detail later when they are further expanded using data from the participant's interviews, and examined from a range of conceptual perspectives.

The SOC was developed to predict health outcomes; if an individual has a high SOC it is hypothesised that they will experience positive health. Consider this with relation to the objective of epidemiology to explain the development of disease. The most precise prediction an epidemiologist can give for ischemic heart disease for 'at risk' men for example is 1 in 6. This does not tell us which one of these men will develop the disease and why only one of these men develop the disease while the other five men do not (Smith, 2011). The issue here is the scale of analysis. According to Smith (2011) the reality of epidemiological predictions is that they are meaningless probabilities because the individual is not the target of epidemiological understanding. Furthermore, individualist predictions are in fact unachievable because

'A major component of inter-individual differences in risk of disease is accounted for by events that are not epidemiologically tractable, including stochastic events ranging across the cellular level, to chance biographical event and idiosyncratic gene environment interactions' (Smith, 2011: 557).

With the SOC the potential for an accurate and significant measurement at the group level presents the same problems Smith (2011) identifies with epidemiology. Unlike epidemiology the SOC is concerned with the intimate subjective scale of the individual. However, like epidemiology many studies using the SOC have tried to provide a measurement at the group level of analysis to predict health outcomes by representing the SOC results as a collective. Arguably, the SOC measured at the group level tells us little of value because of the personal nature of the questions and its thematic components. In addition to this, the ability to predict health outcomes are significantly undermined by what Smith (2011) refers to as stochastic events and the non-shared environment. The potential influence of stochastic events on health outcomes is an unscientific regard for differential cases of bad luck versus good luck. The one man in a group of six 'at risk' men who develops heart disease is, according to this thinking, a victim of bad luck. While the notion of the non-shared environment as a predictor of health outcome provides an equally slippery

route to understanding the distribution of health outcomes. Smith (2011) provides the perfect example of a deviant health outcome, Winnie, the one hundred year old life-long smoker. Antonovsky was, as discussed earlier, curious about the deviant cases. According to the thinking on stochastic events shaping health outcomes, Winnie's longevity despite her lifestyle choices, is due to the same equally random series of events that results in the one individual developing heart disease. Attempting to identify patterns of causation and predict health outcomes, or answer Antonovsky's question, what creates health, is according to the good luck/bad luck hypothesis, futile. The 'gloomy prospect' of determining the specific pathways linking health and ill health certainly puts a sting in the tail of the health researcher. Smith (2011) identifies the non-shared environment as an important determinant of health outcomes. The non-shared environment can be understood as the unique and experiential life world that is as unique to the individual as their fingerprint. Methodologically this notion of the non-shared world poses a significant challenge, how can the health researcher account for the unshared world? Likewise how can we account for the SOC components, which are intensely personal and individualistic, and develop in response to this non-shared world?

The potential application of the SOC in health geography: Personality disposition and place

Similar to the salutogenic orientation and the SOC's preoccupation with the individual's interaction with their environment, as the flow of information between the external (context) and internal (conscience) environments, health geography is also concerned with this flow of information and the health implications of people's interaction with their environments (Kearns and Moon, 2002). Traditionally health geography has been concerned with the patterns of disease, their causes and understanding risk factors, and also the planning of health services (Gattrell and Elliott, 2009). Further to the existing body of health geography research the application of Antonovsky's salutogenic orientation and the SOC may provide yet another lens through which the relationship between health and place can be explored. In addition to this the SOC construct may also contribute to advancing the concept of place.

According to Macintyre and Ellaway (2003: 26) 'the distinction between people and places, composition and context, is somewhat artificial. People make places and places make people.' According to this relational understanding of place, people are made and moulded by both their geographies and their histories. This reciprocal relationship between

place and the self is perhaps a useful way of placing the SOC into geographical theory. The individual develops their SOC in reaction to their external environment, and they consequently continue to re-produce this environment and its GRRs to make them accessible to the next individual. This thus results in the sustainability of communities and their assets. Similar to the concept of social capital, which acts as 'some kind of intangible community force' (Tunstall, *et al.,* 2004:7) the SOC concept might provide a useful means of analysing the spatiality of health and illness. However, like social capital, the intangible force of the SOC may lead to similar criticisms of its application in practice. For example the variables that comprise the SOC might not actually explain or even be represented in data gathered because of the difficulty in clearly defining what exactly the variables are and what they look like in reality. Indeed as difficult as it is to define social capital variables it is even more difficult to define those of the SOC as they might look at the collective scale because it is uncertain whether they can even exist at any scale higher than the individual. How can we say exactly what a group finds meaningful, or more difficult still, how can we say for sure what motivates a group or how they make sense of their (chaotic) lives? For example with social capital membership of social groups is used as one measurement variable, however this might not actually be an indication of social capital (Gattrell and Elliott, 2009). Later in the thesis the role of faith and religion in the daily life of older people will be examined with relation to their SOC and in particular the meaningfulness component, but can participation in religious lives tell us anything about a population's collective SOC, and subsequently lend us any explanation of the distribution of subjective health and wellbeing at the broader scale? Much as the concept of social capital has come under scrutiny as the 'sociological equivalent 'of blaming the victim', where communities, rather than individuals, are held accountable for 'not coming together' or 'being organised' (Muntaner and Lynch, 1999: 72), the SOC may suffer a similar theoretical fate. The SOC, as already suggested, pins the individual and their personality as an important influence on the success and quality of their lives, thus placing all other influences at the margins of importance. Given the original formulation of the salutogenic orientation it is tricky to identify its potential application to non-individualist based health promotion policy and practice.

Yet, if we take the widely used structural determinants of health model and consider its use in explaining health inequalities, and its application in health geography the SOC might provide an additional yet important dimension in breaking down the relationship

between structural forces and health outcomes. Remember the salutogenic question asks what creates health, thereby questioning the intrinsic healthful processes that are derived from an individual's positive engagement with both the internal and external environment. This includes the individual's engagement with the broader structural forces as they are translated into place. In applying the salutogenic orientation to the already established SDoH further explanatory pathways linking the structural forces to health might be defined, thus providing complementary conceptualisations of the influences of health. While the *Ottawa Charter* (WHO, 1986) is concerned with gaining control of the SDoH by addressing the structural causes of disadvantage manifesting in various forms in the external world, the SOC looks to the generalised resistance resources present even in contexts described predominantly in terms of their social inequalities. The SOC introduces an element of agency to this relationship.
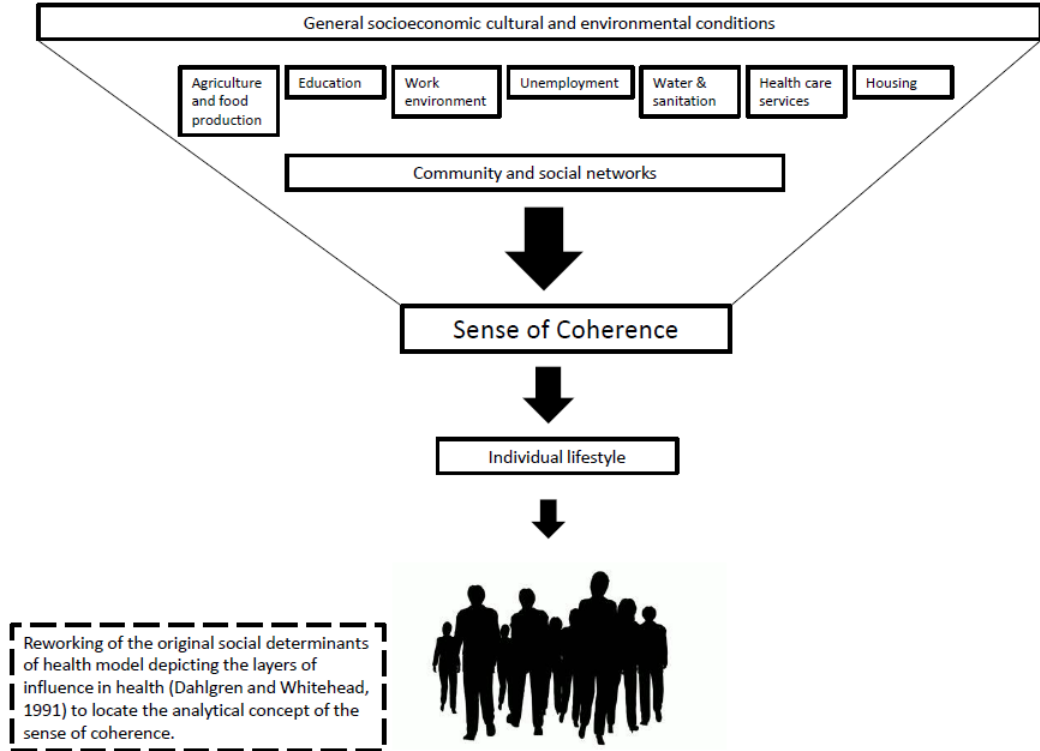
Figure 5.1 Locating the Sense of Coherence on the social determinants of health model

Figure 5.1 is a reworked version of the illustrated SDOH model as first proposed by Dahlgren and Whitehead (1991). This illustration is informed by the previous discussion on the SOC. The purpose of this illustration is to locate the SOC within the model and to merge it with the salutogenic orientation. By locating the SOC within the SDoH model the

individualist philosophy again emerges. In taking Antonovsky's formulation of the SOC when applying it to the SDoH the SOC appears to form some sort of filter through which the structural forces are passed through. Again returning to Antonovsky's 'deviant case' (the individual who transcends the conditions of their internal and external environment to succeed) the SOC penetrates the layers of influence on health to derive positive health outcomes.

Bringing forward salutogenic theory into 21st century social science research and placing it in health geography

In order to bring the SOC and salutogenic thinking into health geography empirically a number of aspects of Antonovsky's (1987) original theory formation are carried forward. The original theory was chosen as the main influence on the design of this research because of inconsistencies recognised from a close reading of his work, and that of researchers working from the salutogenic orientation. In particular, the detachment of the SOC construct from asset-based community development, insufficient recognition of Antonovsky's individualism and stoicism in the formulation of the SOC, lack of methodological diversity in examining the SOC, and little engagement with some of his more nuanced ideas such as the deviant, boundary making, the crucial spheres of life and health as a continuum. In terms of its contribution to health geography the salutogenic orientation and the SOC certainly provide a new and interesting perspective to understanding the dynamic relationship between people and their environments. The SOC lends itself to a deeper understanding of how people view, experience, feel, and internalise their worlds. To ensure the salutogenic perspective is relevant and insightful the choice of research methods is paramount. The method used must access the SOC components, while providing sufficient scope to put the components into the context of the everyday places and spaces where people live, work and play. The life review was chosen for this reason, and the following chapter describes the method and the significance of using it in a qualitative investigation of health and wellbeing in later.

Chapter 6

Methodology

Salutogenic research and the qualitative approach

The design of this research accepts Antonovsky's suggestion to look beyond quantitative methods, and to consider other methodological approaches (Antonovsky, 1987: 88). In response to this, an original qualitative research framework, that uses a life review method, has been applied to explore health and wellbeing in later life, using the SOC as an analytical lens.

Qualitative research sets out to provide a contextual understanding of the phenomena under investigation, in this case the phenomena of health and wellbeing in later life. Thus, qualitative researchers do not attempt to produce results that can be applied to a wider population, or generalised. Indeed for this research the aim is not to develop a new theory, but to build on the existing theory of salutogenesis and the SOC construct. Nor is it to provide evidence that there is a positive relationship between the SOC components and positive health, because many studies have already done so, as discussed in the review of the salutogenic literature. Rather the research methodology is designed around the objective of further developing the knowledge base of the SOC. In particular providing more in-depth qualitative descriptions and definitions of the three SOC components. To avoid what Avis (2005: 7) describes as 'mindless empiricism that offers very little explanation for the topic under investigation', this research broadens both the theoretical and methodological basis of the salutogenic orientation by applying a qualitative framework in a unique way.

The decision to engage in qualitative research requires the acceptance of four methodological commitments throughout the research design and conduct (Morse and Field, 1995). These commitments characterise qualitative research, and are adhered to throughout this research. These commitments (Morse and Field, 1995; Holloway, 2005) are as follows:

Firstly, the collection and analysis of textual data is a priority for the qualitative researcher. Textual data provides a medium of expression in the words of the participants. In analysing qualitative data it is important that the narrative of the participant is preserved. This is done using quotes directly taken from the textual data. In the empirical chapters that follow extensive quotes from the transcripts are used to provide a good experiential context using the participant's words. Then the discussion hones in on selective quotes that provide meaningful insight. In research carried out on the SOC to date, researchers have rarely

moved beyond the Orientation to Life questionnaire, thus the voice of the research participant is absent, and the only voice reflected in the data is that of the researcher's. For health promotion research this poses an important philosophical problem given the emphasis on the importance of dialogical methods in this research field. This will be addressed later in the chapter.

Secondly, qualitative researchers must rely on extensive interaction with the research participants. The researcher must interact with the research participants over a reasonable period of time. This is to provide the participant with sufficient time to share their experiences of their social world, and the meanings they attach to it. Researchers are not considered passive subjects in the research, but rather active contributors in generating knowledge. The researcher is fundamentally learning from the participants rather than studying them, thus producing data.

Thirdly, qualitative researchers must adopt a flexible form of enquiry. Interaction with research participants is open and semi-structured. The qualitative researcher must respond constructively in this interaction to co-produce the necessary data.

Finally, qualitative researchers must apply naturalism in their study methods. Methodological naturalism requires the researcher to apply methods that are familiar to the research participant, and are not excessively structured or experimental in design.

This chapter presents the thesis' research methodology, which is focused on exploring the resources for, and causes of, health in later life through an adapted version of the life review interview.

Hermeneutic Phenomenology

The way in which the research question is constructed and understood will determine the research methodology applied. There is thus an important dialogue between the research questions asked and the method chosen. It was decided that the methodological approach of this research should include an appreciation of phenomenology in investigating the personal experiences of ageing-in-place. There are several factors that influenced this decision. Van Manen (1990) outlines the benefits of incorporating phenomenology into social science research. Phenomenology is regarded as progressive in its effect, because of its ability to humanise both human life and its institutions. Phenomenology also introduces overt thoughtfulness and reflexivity to the research process. This has two effects: firstly

phenomenological research should produce action sensitive knowledge; secondly, and related, this should enable tactful action (Van Manen, 1990).

This is not only a phenomenological study of the human experience of ageing. It is also a hermeneutical study of ageing. The phenomenological approach examines the human ageing process descriptively, with the intention of mining meaning from these experiences. This is supplemented with hermeneutics. The hermeneutical aspects of this study interpret the expressions of life lived, and the lived life, and also interpret the objectifications of the lived experience. This interpretation is about examining the meaning embodied in the lived experience. Importantly, this meaning is expressed through language, which is observed in a textual form for analysis – in this research the text is in the form of the interview transcripts.

Thinkers such as Heidegger (1962) and Ricoeur (1981) have considered the role of language in understanding the human experience. According to Heidegger (1962) language, thinking and being are the one, and expressing the human experience is made possible because we have language through which experiences are communicated. Ricoeur (1981) furthers this to argue that all human experience and interactions can be considered as texts. These texts become a device for analysing and are deconstructed to explore their meaning.

According to van Manen (1990), in carrying out hermeneutic phenomenological research the starting point for gathering empirical evidence is the everyday lived experience. This approach appeals to the most common of immediate experiences of our life world, and conducts a structural analysis of the familiar and the self-evident. Hermeneutics is interpretive research, and it involves writing sensitively about the lifeworld. While the aim of phenomenological research is to construct evocative descriptions of the lifeworld, where action behaviour, intentions and experiences are played out. In the descriptive phenomenological material 'the human being can be found' (van Manen, 1990: 19).

In asking a phenomenological hermeneutic research question the wording is very distinctive. In this research, the questions asked were devised with this in mind. Rather than asking how do people age healthily, the question is what is the nature, or essence, of healthy ageing? The nature or essence of healthy ageing is described so that a deeper awareness of the lived experience is awakened.

There is a long tradition of exploring the lifeworld in human geography. Geographers such as Tuan (1974), Buttimer (1976) and Seamon (1979) focused on the phenomenological experiences of space and place in early humanist geography, and left a

legacy of phenomenological research within the discipline that still influences geographic research nearly 40 years later (Simonsen, 2013; Ash and Simpson, 2014).

Antonovsky's approach to constructing the lifeworld

Antonovsky (1987) used life stories to identify and define the Sense of Coherence components, and to subsequently design the Orientation to Life questionnaire. Importantly, his analytical approach was strongly influenced by positivism. Here his approach is demonstrated, and the alternative use of hermeneutic phenomenology is argued for.

Antonovsky (1987) drew on the notion of Cartesian space to both design his research methodology, and to interpret his research results. The Orientation to Life questionnaire for example was designed using specified facets, and the important elements of each of these facets were recognised. This thinking was also applied by Antonovsky (1987) to interpret interview data. The particular combination of facets was used to formulate a given item on the questionnaire, or applied to the interpretation of the data. Each combination of facets was supposed to express one of the three SOC components – comprehensibility, manageability and meaningfulness.

The facets were:

- modality of the stimulus - instrumental, cognitive and affective;

- the source of the stimulus - concrete, diffuse, or abstract;

- the time reference - past, present and future.

Drawing from Antonovsky's (1987: 77) interpretive process of sentence mapping, a quote taken from an interview carried out as part of this research was 'mapped':

> *Respondent X responds to [modality] an 'instrumental' stimulus which has [source] originated from 'the internal' environment, and which poses [demand] a concrete demand, being in the [time] present response dimension.*

This sentence may be understood in a slightly more experiential sense, for example:

> *Respondent X's sight is currently his biggest functional impairment.*

The mapped quote is taken from an interview during which an 82-year-old woman discusses her 93-year-old husband's blindness, due to macular degeneration. In comparison to Antonovsky's sentence mapping approach, the actual, verbatim, quote provides a more

humanistic framing of the experience of an 'instrumental' stimulus that has 'internal' origins and is 'presently' posing a demand:

> *I think having lost his sight is the biggest thing, the biggest drawback for him.* (R12-Female-82)

The point demonstrated here is that Antonovsky's work is heavily grounded in the positivist tradition, and so the desire to measure and quantitatively construct the lived world is strongly reflected in his methodological approach to understanding both health creation and the three components of the SOC. It may be argued that because of the influence of positivism on his work Antonovsky (1987: 64) found conceptual clarification and the achievement of an operational definition difficult to connect. He further develops his difficulties claiming that this connection is made even harder when the words of 'ordinary people' are to be used. Indeed he acknowledges that the closed questionnaire that he has designed to measure the SOC 'is only one road to follow' (Antonovsky 1987: 88), while there is no mention of the potential use of hermeneutic phenomenology. Also note the use of 'R12-Female-82' to identify the participant here, later in the empirical chapter 'R12-Female-82' is introduced to the reader by giving her a name, and an identity of sorts, and attention is paid to the detail of her life as she experiences it.

What is perhaps missing from Antonovsky's (1987) approach is that meaning is left implicit in the texts or accounts of the lived experience, when it is deconstructed and re-represented in a different language than that used in the original narrative. Phenomenological research is however explicit, so in applying it to such research as this, the meaning is extracted from the texts or accounts, and the voice and the language of the participant is preserved. And so by applying a hermeneutic phenomenological methodological approach in this research the original work by Antonovsky is extended into a new and potentially progressive direction. It is here that this research contributes to salutogenic theory.

The importance of dialogue, and dialogical research methods in health promotion research

Following the introduction and development of health promotion, and its ideals, a number of authors expressed concern about the use of conventional positivist methodological

approaches. They argued that scientific and objectivist methods were insufficient for the objectives of health promotion, and its evaluation (Baum, 1995; Labonte and Robertson, 1996). To address this Labonte *et al.* (2000) put forward a storied or dialogical method with the intention of bridging the gap between the descriptive stories health promotion requires, and the rigorous explanations positivist approaches provide. The use of storied, or dialogical methods, developed out of the frustration of health promotion practitioners and researchers working together with positivist methodological approaches. It became increasingly recognised that positivist notions of acquiring an objectivist truth using methods that relied on controlled designs were not suitable for health promotion research and the development of evidence based practice. For them it was the absence of reality that made positivism an inappropriate framework. At the most basic level positivism would fail to articulate health promotion theory. This is because under positivism a generalised theory is privileged over particular experiences, and when it is applied in practice such generalised theory fails to sufficiently inform it. Therefore, an approach that accommodates particular (real life) experiences in generating generalised theory is regarded as necessary for the continual development of health promotion practice.

Freire and Macedo (1987) argue that the first step towards people's empowerment is to provide them with the opportunities to speak their worlds, and name their experiences. The adoption of dialogical methods represented methodological progress in health research, and in health promotion. Providing the necessary conditions for stories to be listened to and respected as a form of knowledge was in keeping with the health promotion ideology of empowerment. This is because an emphasis was created around the importance of the personal experience, and the individual and collective voice. The practical significance of the experiences shared when people 'speak their world' is realised in the formation of analytical themes from these stories. In 'speaking their world' people are engaged in generating knowledge through self-reflexivity. This reflexivity is missing from conventional scientific research.

A significant aspect of dialogical methods is the researcher-participant relationship. According to Labonte *et al.* (2000: 41) both parties engage in a 'reflexive contract'. This contract requires researchers to surrender any pre-existing ideas or assumptions around professional expertise and knowledge to begin developing and negotiating a shared understanding. The researcher's assumptions during this process must become conscious, questioned and negotiated. Nothing is taken for granted during this collaborative process.

Both issues and resolutions are re-examined with respect to the experience and knowledge of the research participants.

It is important to point out the weaknesses of relying on dialogical research methods. One of the difficulties is the ability to access revealing stories. It is then difficult to move beyond the concrete descriptions of these stories to abstract the findings for explanation, to identify and define patterns, and establish analytical categories. Researchers must avoid concentrating on the particulars of stories, and move to assessing and analysing the knowledge needed to generate actionable theories. This was the approach taken by Antonovsky (1987) in developing salutogenic theory and the SOC.

The hermeneutical circle and the purpose of narratives

According to Widdershoven (1993) the stories told about life provide its meaning, and therefore if stories are left untold the meaning of life cannot be determined. According to hermeneutical philosophy both life and story are intertwined. Not only is meaning found by telling the stories of life, but these stories must also be interpreted. Searching for meaning in life by engaging in autobiographical narratives is a method through which people can develop a sense of personal understanding, or what Freire (2013) would describe as 'conscientisation'. In developing such personal understandings through dialogue it is possible to consider identity formation as a continuous process, and also to recognise the person as an agent in their own lives, capable of bringing about positive, and indeed negative, changes.

The application of qualitative methodological approaches such as hermeneutical phenomenology in health research reflects growing interest in 'lifeworld-led health care', and a shift away from 'patient-led care' (Dahlberg *et al.*, 2009: 265). The writings of Gadamer (1976) and Heidegger (1962) are important in their application to such interpretive research. According to Healey-Ogden and Austin (2011: 86) hermeneutical phenomenology, as an interpretive approach, attempts 'to understand everyday human experiences that are hidden from view, yet shows itself within the tensions of life'. In their work they ask the question 'what is the nature of the lived experience of wellbeing?' and apply the hermeneutic phenomenological framework to answer it. Working from the hermeneutical circle the ability to recognise the concept of wellbeing in its various forms in the empirical data was fundamental. Subsequent understandings of wellbeing were identified as they

emerged from the past, present and future experiences described by the research participants. This methodological design was influential in developing the methodological approaches used in this research. Indeed accessing past, present and future experiences emerges as an extremely important indication of what ageing healthily in place means to the older people who participated in this research.

Narratives as methodology in ageing research

A large number of texts can be referred to as narratives. According to Riessman (2005) it is the presence of sequences and consequences that creates a narrative i.e. events or experiences selectively represented in the text or narrated account, and organised so that the connections are clear, can subsequently be evaluated as meaningful for a particular audience.

The emerging interest in narratives as methodology has many sources. One reason for the 'narrative turn' in ageing research represents a desire to move away from both positivist modes of enquiry and major theory to make room for emancipatory efforts (Riessman, 2005). Paulo Freire's thinking is again influential here.

> *'Embedded in the lives of the ordinary, the marginalised, and the muted, personal narratives respond to the disintegration of master narratives as people make sense of experiences, claim identities, and 'get a life' by telling and writing their stories'* (Langellier, 2001: 700).

The use of narratives to explore the personal experiences of healthy ageing over the life course, as used in this research, follows the traditions used in other social science subjects, such as psychology (Murray and Sargeant, 2012). This tradition focuses on extended accounts of lives shared over the course of a single interview. The use of such narratives in research has gained increased attention in recent years, extending beyond psychology, to form a core method in other research disciplines (Randall, 2012b). In health research the personal narratives shared by individuals have become recognised as a valuable source of information on health and illness. In ageing research the life-as-story metaphor has gained significant recognition resulting in the emergence of a new set of research methods under the new research paradigm narrative gerontology (Kenyon *et al*., 2010; Randall, 2012a; Barusch, 2012).

Narrative gerontology appreciates that to understand human ageing the biographical or narrative dimensions are equally as important as the biology of ageing. By developing an understanding of the narrated experiences of ageing, a balanced and optimistic perspective is achieved. The methods of narrative gerontology also provide an opportunity to honour 'the dignity, humanity and uniqueness of the lives of older people' (Kenyon *et al.* 2011: xiii). For health researchers focusing on older people, the narrative approach reaches the meaningful aspects of people's lives, which can be very telling, whereas under the traditional medical research approaches these aspects may go unnoticed. This also reflects the ideals of health promotion research practice as already discussed.

The narrative research approach is a hermeneutically based science. The stories, or data, produced when systematically analysed provide great insight into motivation and behaviour. Further to this, narrative research provides in-depth insight into an individual's relationship with their ageing body. Narrative gerontology is thus becoming increasingly recognised as having an important role in contemporary health care. For the ageing process to be understood, and subsequently the appropriate care offered to older people, knowing the person's individual story is important. With the development of narrative based interventions, and the corresponding notion of narrative care as core care, paying attention to person's life story while in care may be as important as paying attention to their food and medical needs (Kenyon *et al.* 2011).

Narrative research has predominantly been applied in research to understand degeneration, illness, experiences and adaptation. To a lesser extent narratives have been applied in health and ageing research to explore positive health, resilience, and health creation (Randall, 2012a). It is here that this research will contribute to ageing research, and build on gaps already identified by Sidell (1995) on the use of the salutogenic orientation as a framework for understanding healthy ageing.

With regard to analysis, narratives must be analysed because they do not speak for themselves. To provide useable data for social science research, they must be interpreted. How the researcher defines the narratives will determine the method of data analysis. It must also be noted that such data analysis typologies do not have clearly defined boundaries, and neither are these typologies mutually exclusive.

Life review interviews

The argument that narrative construction is essential for people to understand and reflect on their lives in order to make sense of them, and to establish meaning, is taken seriously in this research. Therefore a challenge of the research was to draw predominantly on narrative methods to understand health creation. The chosen method had to provide sufficient insight on the life course so that the three SOC components could be identified, and the relationship between these components and health and wellbeing could be explored, while at the same time paying attention to the context of current life. Several approaches were considered to explore, untangle and understand health creation over the life course. The life review was considered a suitable framework from which to draw influence in developing the interview design. The life review is an autobiographical narrative, which is developed over the course of an interview. The life review offers a medium through which the complex connections between an individual's history, their experiences and memories, and the formation and construction of their identity, can be drawn out (Tromp, 2011). It is defined as a structured reflection of one's life, with a certain degree of evaluation as the outcome (Haight and Haight, 2007). For the purpose of this research the life review provided a set of questions, that when answered, provided insight into health creation over the life course.

The theoretical framework for the life review is taken from Eric Erikson's work on the life cycle (Erikson, 1982). Erikson considers the last stage of life as a period characterised by ego-integration, and attempts to understand life overall in a meaningful and coherent way. By taking part in a life review exercise older people are asked to recall their pasts, and place their past experiences in the current vision of their personal lives, and their future. One of the expected outcomes of engaging in a life review exercise is that the individuals will look back over their lives with a sense of contentment and fulfilment, and can evaluate their personal contribution to life, and in coming to terms with their own personal history, they may share their wisdom thus placing their lives in a contributory relationship with the rest of humanity. The life review is often undertaken as part of a therapeutic process of engaging older people in reminiscence therapies. Such therapies are believed to have a positive impact on psychological wellbeing (Clarke, Hanson and Ross, 2003), and successful ageing (Wong and Watt, 1991). While the original use of the life review was for its therapeutic value, it is not the case here. It was thus necessary to adapt the format of the life review to suit this research. However, given that the life review was originally designed as a therapeutic conversation thus using it in a research project carries

with it some implications. These implications will be discussed later in the 'Personal Reflections' section of this chapter.

For the purposes of this research, to understand health creation, the life review provides a medium through which to explore the three SOC components, and explore their development over the life course and in context. This was also influenced by Antonovsky's (1987) own approach in exploring the autobiographies of his research participants. It is this combination of research method and analytical framework that makes this research unique in its approach. It also speaks to the geographer's interest in the life course (Fincher, 2009).

As with Antonovsky (1987: 64) the autobiographical narratives were obtained using open-ended questioning on the individual's life course. The interviews started with a simple question 'tell me about your life', as Antonovsky (1987) had done in his interviews. The participant, having been previously informed of the purpose of the research, was aware that while reflecting on their lives, memories or experiences that pointed towards physical and mental health and wellbeing were important. During the interview, interruptions to the participant's narration were kept to a minimum, however questions were used as prompts to keep the conversation going, and when an interesting point came up the participant was encouraged to provide further detail and to 'tell more'. These prompt questions were taken from the life review interview guide (see Table 6.1 for examples of questions asked), although not all of these questions were used, it depended very much on the direction the participant wanted to go in their own narrative. The narrator answered many of the questions unprompted on the interview guide. This was an important indication of their engagement in the interview process, and the quality of their reflection. It was also important that as little of the researcher's 'voice' was present in the participants' accounts as possible. Therefore prompts had to be vague in their wording to give the participant the opportunity to express his/herself in their own words. During the interview process it was important that the core life review categories were addressed in the interview, because of the relevance of the categories to understanding the SOC's components. For instance questions about the social environment and close relationships were important in determining the quality of the older person's interpersonal world (particularly their wider community), as a crucial sphere of life defined by negotiable boundaries (Antonovsky, 1987). Questions relating to the activities of daily life, those that required the participant to reflect on their lives, and those that were future orientated were used to gain some insight on their inner emotional life, another crucial sphere of life identified by Antonovsky (1987). The inner

emotional life is often reflective of the quality of the external environment, so questions about friendships and neighbourliness for example are important indicators of the quality of community life. Each of these questions required a contextualised answer and so naturally references were made to space, place, and environment experienced across time and how these experiences are significant to health and wellbeing. The questions asked thus provided good insight on the relational geographies of ageing and the situated meanings of growing older, as well as addressing life course geographies (Hopkins and Pain, 2007).

Adulthood	Did you get married? If not, why not? Tell me about your career/work? Tell me about the good and bad times that you recall.
Relationships	Tell me about the people closest to you; How have your relationships/friendships changed over time?
Community Life	Tell me about your parish/the local community; Tell me about some of the resources available to you in your community; Tell me about your involvement in community life.
Current Life	Tell me about your typical day; What do you look forward to? Can you tell me about your current health and feelings; How do you cope under stress? Do you practice religion? Are you spiritual?
Reflection	What do you consider to be your most important success? What has been the most significant disappointment? What have been the turning points in your life? Do you have a life philosophy?
Future	How do you feel about growing older? What is the hardest thing about growing older? What would you like to accomplish? What are your plans for the future?

Table 6.1. Life Review Guide: Sample questions addressed in the interviews.

Participant recruitment: Initial Considerations and Theoretical Influence

It was found that the majority of overtly salutogenic researchers, including those citing Antonovsky as the key theorist informing their work, or using research focusing specifically on the SOC has paid little attention to the theoretical arguments made in the original work. The methodological design of this research has acknowledged Antonovsky's statement accepting his approach as only one of many suitable means of investigating health creation, and the construction of the SOC. In addition to this there are several main theoretical points about the salutogenic orientation, as described by Antonovsky (1987: 12), that were also

taken into account when designing the methodological approach of this research. These points must be addressed in the research design, and are of particular importance when indentifying suitable older research participants during the recruitment phase.

The salutogenic orientation requires us to reject the dichotomous classification, which distinguishes between the healthy and the diseased (Antonovsky, 1987). Instead of giving an absolute health status to an individual, the salutogenic focus concentrates on the individual's location on the multidimensional health ease/dis-ease continuum. An absolute health status would define individual's health in biomedical terms, referring to diagnosed conditions, treatment and the longevity of the illness or condition. This provides little opportunity to express the subjective experience of ill health and degeneration in an optimistic, positive or relational sense. It is these subjective understandings of (ill) health that may provide insight on restoring and enhancing positive health. Antonovsky's notion of the health-ease-dis-ease continuum has particular implications for research on healthy ageing, given the varied definitions used to understand the types, or forms, of ageing. In accepting the health ease-dis-ease continuum the dichotomous classification of health and illness is rejected, thus widening the focus from concentrating on the etiology, or even the spatiality, of disease, to incorporate the individual's 'total story' (Antonovsky, 1987), which includes the illness. This requires a method that will uncover the qualitative experiences of ageing in-depth. Therefore, the method chosen must address the question of ageing as a holistic process.

Instead of asking what causes illness, disease and degeneration with the advancement of life, this research addresses the notion of healthy ageing with an alternative question inspired by salutogenic thinking (Antonovsky, 1987). The question asked is "what are the factors involved in at least maintaining one's location on the continuum or moving toward the healthy pole?" In keeping with the salutogenic orientation to answer this question coping resources must be examined. These resources cannot be presumed but must be examined in the context of the lived life. The method applied must be able to identify such resources and their contribution to one's movement along the health-ease-dis-ease continuum. To identify such resources, and particular events that necessitate these, a review of life events and experiences is necessary. Therefore, the method must be flexible enough to allow the participants to elaborate on their life, to identify and explore the role of these resources, and express their lives and life experiences, in their own language.

Stressors are viewed as potentially salutogenic and thus not always pathological, depending on the character of the stressor and the resolution (Antonovsky, 1987:12). While exploring health creation, positive health and experiential health promotion, attention must also be paid to negative health experiences, illness, treatment and recovery. It is not enough to focus exclusively on positive health if we are to understand it. For example, one way of examining how stressors can be salutogenic is by exploring life's turning points, and the subsequent emergence of coping resources, or access to such resources.

The salutogenic orientation requires a search for the things that cause negative entropy. As understanding develops on what moves people towards positive health this knowledge may be used to help facilitate an individual's adaptation to their environment and their circumstances. To achieve this understanding through qualitative research, the chosen research method must provide the participant with the opportunity to reflect on his/her past and present environments; that is their personal, social, physical, cultural, economic, and spiritual environments (Antonovsky, 1987:12).

Participant sampling criteria

According to Antonovsky (1987) deviant cases should always be considered during an inquiry. With this in mind a sampling criterion was devised. Participant sampling criteria were drawn up to match the theoretical and methodological frameworks. Purposive sampling was undertaken to recruit participants for the life review interviews. The criteria for identifying potential participants was constructed bearing in mind the six key points on the salutogenic orientation already outlined, and adapted for ageing research. Considering Antonovsky's health ease/dis-ease continuum, and in light of the different definitions of 'healthy', 'positive', 'successful', 'productive' and 'active' ageing, the subjective perception of the individual's health was given weight. Consideration was thus given to their temporary location along the continuum, thus recognising their ability to move from poor health to good health, and vice versa. Regardless of the individual's biomedical health status if they considered themselves to be in good health, or in 'good form' they were considered suitable for the research, and were asked to participate.

Potential participants were identified using the demographic typology of 'old-old', referring to people aged over 75 years. In addition to the subjective measurements and definitions of health and wellbeing against which potential participants regarded themselves, potential participants were also considered in light of the standard optimistic definitions of

ageing. These definitions incorporate functional capacity, independent living in the community, continued engagement in family and community life, and sustained interest in hobbies and recreation. These factors were important indications of participant suitability.

Initial fieldwork for contextual insight

In an effort to gain insight on ageing-in-place at the outset of the research, and in particular to ground policy ideals of creating supportive environments for older people to live comfortably at home, interviews were conducted with individuals involved in supporting older people to live in their communities, and in promoting quality of life in a formal capacity. This initial phase of the research was carried out before the life review interviews. There were 8 informants in total, and they represented community development work (2), local and national level organisations with power to influence policy (3), and organisations providing practical supports to older people (3). These interviews were recorded and the information was used to inform the researcher's contextual knowledge rather than to provide empirical data[6].

Insight was also derived from observational work such as attending older people's social clubs (4 locations), and accompanying a Meals-On-Wheels volunteer on her route. In particular visiting and spending time at the social clubs provided a very useful opportunity to engage with and recruit potential participants. In addition it provided an opportunity to observe what actually happens at an older person's social club. One rural based social club that met for a couple of hours on a Wednesday afternoon was visited over a five-week period. These visits were undertaken prior to conducting the interviews and were an opportunity to become familiar with conversational topics for consideration when conducting the life review interviews. Again this observational work was undertaken to inform the researcher's contextual knowledge rather than to gather empirical data.

Recruiting Research Participants

Research participants were identified through direct contact, or through acquaintances. Information about the research was distributed using both personal and professional contacts to identify and communicate with potential participants. Research participants were also contacted through established organisations working with older people in a community

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[6] With the exception of one community development worker whose description of a research participant is used

context, for example social clubs, meals-on-wheels and prayer meetings. After information was shared with potential participants about the research project, they were given the opportunity to ask questions, and were invited to take part.

Purposive sampling was chosen as the most effective strategy to recruit participants because it maintained the recruiting focus on the characteristics of the older person defined using Antonovsky's (1987) notion of the deviant case, and the conceptualisation of the 'healthy' or 'active' older person. Because purposive sampling relies on the judgement of the researcher (Patton, 1990) when participants are recruited using personal contacts the recruitment is initially reliant on the subjective assessment of the contact, and in particular their understanding of the characteristics of the older person sought to take part in the research. When an individual was identified as a potential candidate by a personal contact the researcher still had the final say in whether that person was asked to take part in the research, and this depended on the description provided by the contact i.e. whether they were over 75 years old, active, engaged in family or community life, living independently. When participants were recruited through a contact there was no observable difference in terms of their suitability as a research participant. This is because the objectives of the research were explained to the contact in detail and so there was a clear understanding of what was being asked for in terms of the characteristics of the research participants. Indeed there was some benefit to this route of recruiting participants. The participants were more likely to engage with the researcher perhaps because the contact had already verified the credibility of the researcher.

Of the 22 research participants six were recruited using contacts, the remaining 16 were recruited through established groups and organisations visited in the early stages of the research. Of the 16 recruited through organisations and groups five did not give consent to have their interviews audio recorded, while all six recruited through contacts did give consent for the interviews to be recorded.

The size of the purposive sample is most often determined by theoretical saturation (Mack, *et al*., 2005). In order to determine the sample size for this research the data was reviewed and analysed as it was gathered, as recommended in conducting qualitative research (Mack, *et al*., 2005). Once there was sufficient data to provide an in-depth qualitative exploration of the SOC participant and theoretical saturation, recruitment ended.

The participants recruited were living in the East and South-East of Ireland, and were predominantly from a rural area. The Southeast region of Ireland is recognised as the

most disadvantaged in the country. The participants recruited for this research are living in the third most disadvantaged county in the Republic of Ireland, and is an area that has experienced significant socio-economic decline in recent years. According to most recent Census figures between 2006 and 2011 the county's relative position on the deprivation index fell from seventh most disadvantaged county in 2006, to the country's third most disadvantaged county in 2011. Additionally several Small Areas within the county had a deprivation score of much less than -20, giving them a socio-economic status of 'very disadvantaged' (Pobal, 2015). The county has one of the lowest levels of educational attainment in the country, with a substantial number of adults having received only primary level education, and in terms of third level education the county has one of the lowest levels of attainment in the country (Pobal, 2015). In recent years there have been reductions in the availability of public transport within the county with the closure of railway lines and the removal of bus routes serving rural parts of the county and linking these rural areas with Dublin and Waterford cities. This is a significant problem for older people who are relying on such transport services to access health care services located outside of the county, and makes their free travel pass redundant.

The county has signed up to participate in the Age Friendly County Programme which is part of a WHO inspired movement to make Irish communities good places to grow old in (http://agefriendlyireland.ie/). This research could potentially inform existing dialogue on area based 'Age Friendly' initiatives.

The positive response rate among potential research participants asked was low. Field notes recorded the experiences of recruiting research participants, and these notes provided insight for continued methodological reflections over the course of the fieldwork. Several factors explaining reluctance to participate in the research were identified and noted during the recruitment stage. The reasons were variable, and subjective. Depending on their location many people when asked said they felt tired of taking part in research projects. This is possibly due to the proximity of their social clubs to universities. Larger social clubs for older people were identified using internet searches, and these clubs in the past had been approached to take part in research projects, some of which were ongoing. Many people also felt that the research would demand a lot of effort on their behalf, in particular emotional energy, and were thus reluctant to commit to the project. However, during the recruitment stage, many people unwilling to participate in the research were happy to chat more generally about the virtues of the research project, their daily lives, and the

researcher's background, usually over a cup of tea. The opportunity then arose to ask why they were unwilling to take part. Quotes from these conversations were noted, and are discussed in the next section.

Sartre's 'The Look' and reluctance to participate

> *'I see myself because somebody sees me. I experience myself as an object for the other'* (Sartre, 1956 in van Manen 1990: 25).

The issue of subjectivity is awakened during the initial research stage of participant recruitment. By inviting individuals to take part in a research project on healthy ageing, and to enter into a dialogue on the subject of ageing, the issue of 'being' becomes apparent, and proves to be significant. From the outset potential participants are identified because of their age, and how they objectively appear to measure up against popular notions of healthy ageing. This has two effects. Firstly, there is an emerging sense of oneself as a 'subject', of interest to the scientific world of research. Secondly, it demands a heightened sense of oneself as 'being old', or ageing. There is thus a certain mode of awareness required of a participant when they consider engaging with research influenced by the phenomenological tradition. Indeed such reactions to this requirement appear to have greatly influenced the recruitment of participants. When approaching potential research participants the responses of individuals who refused to take part in the research were recorded in the field notes. These quotes provide some insight on the issue of subjectivity and the research process:

> *If I was to agree to do this interview I would have to admit to myself that I am old* (female, 78).

> *I have been unwell a lot recently. I do not think I am ageing very well at the moment. If my circumstances were different I would consider it* (female, 83).

> *No I couldn't talk about my life, it would be much too difficult. I have experienced a lot of sadness. It would be very draining, emotionally. I just couldn't talk to you* (female, 75).

> *No I do not want to discuss such personal details with anyone. I prefer to keep my thoughts and feelings to myself* (female, 84).

I wouldn't have much to say. I don't know what I could tell you. Maybe someone else would have more to say (female, 70s).

I was never very bright. My life was about rearing children. I hardly made it through primary school. No I couldn't tell you anything useful, I would have nothing to say (female, 80s).

No thank you, that would mean I would have to admit to being old (female, 70s).

An acute awareness for subjectivity and a heightened sense of 'being' among potential respondents is of particular concern when carrying out ageing research influenced by phenomenological traditions. A great degree of sensitivity of the issue of subjectivity is required when recruiting research participants. Indeed, referring to participants in phenomenological research van Manen (1990) states that

> *'Subjectivity means that one needs to be as perceptive, insightful and discerning as one can be in order to show or disclose the object in its full richness and in its great depth'* (van Manen, 1990: 20).

The quote given above from Sartre's *The Look* concerns descriptive existential phenomenology. Phenomenology is not just about providing a description of the lived experience it is also about providing a 'description of meaning *of the expressions* of lived experience' (van Manen, 1990: 25, author's own emphasis). These two descriptions differ. The first is an immediate description of the lifeworld. The second is 'an immediate (or mediated) description of the lifeworld as expressed in symbolic form' (van Manen, 1990: 25). Description thus requires interpretation so it can exist at all. Developing a mediated description of the lifeworld, which demonstrates subjectivity and an appreciation of 'being' on the part of the research participant, may prove challenging. This challenge is acutely recognised by those individuals choosing not to take part in the research. If we consider the responses quoted above this is evident. It is important to understand the reasons for the reluctance of older people to participate in this research given the recognition and value of representing people's voices in health research, and the health promotion mantra of 'engagement, participation and empowerment' through dialogue as expressed in the *Ottawa Charter* (WHO, 1986).

There are a number of factors that can be identified from these quotes that appear to determine their likelihood to agree to participate in the research. These factors can be

understood with relation to personal awareness of both subjectivity and being. Five such factors are identifiable in quotes demonstrating people's reluctance to participate in the research. Firstly, the acknowledgement of one's ageing reflects a personal awareness of the finite nature of life. Participating in this research required both an explicit awareness, and an acceptance of one's proximity to the final years of life. This was apparent in several responses to requests for research participants. Secondly, a definitional awareness of oneself, that is how one understands their current health circumstances with relation to popular images and discourses on healthy ageing, was not taken for granted. Participants were recruited on the basis that they deemed themselves to be in good subjective health. It was thus significant that they refused to participate based on their understanding of the research question. Thirdly, a vivid awareness of one's life experiences, and the ability to share these experiences in a manner that did not pose any emotional risk, was also a factor. The individual's recognition of their inability to share and explore these experiences with a stranger in, perhaps, the unfamiliar interview situation, determined their willingness to participate in the research. In terms of conducting ethically sound research that respected human dignity and was attentive of potential risks for the participants this was an important factor in determining participation. Fourthly, recognition of the right to privacy was also a factor in objecting to participating in the research process. Finally, not feeling confident enough in their ability to articulate and describe their experiences, and their lifeworld, and sadly not having the confidence to recognise that they have something worthwhile to share, was also found to be a common factor discouraging people from participating.

The recruitment of participants was most successful when it was done through mutual friends or acquaintances. Perhaps this was because from the outset there was a sense of trust established and the researcher seemed less anonymous. Even the feel of the research process was different when the participant had agreed to participate at the recommendation of someone else. The participants were more personable, relaxed and trusting at the outset. Those who agreed to participate when approached directly and without having prior knowledge of the research or the researcher, for example at a social club, generally choose to conduct the interview in the social club rather than their home, were more cautious about the process, took longer to relax into the conversation, and were keen to know how long it would take. Some decided not to participate on the day, and others preferred not to have the interview recorded. These are natural and understandable reactions given the nature of the interview. Despite these challenges those that did participate contributed a great deal of their

energy in sharing their stories with both dignity and honesty. Without their efforts this research would simply not be possible. Those that agreed to participate without knowing the researcher or having a mutual acquaintance are commendable. After the interviews were over many of the participants actually said they enjoyed the process and that it was not as difficult as they had anticipated. This outcome was influenced by an empathic approach taken by the researcher in looking at the research process from the participant's point of view.

In total 22 older people participated in the research and material from 16 participant's life reviews are included as empirical data. Those not included in the final edit had not agreed to the interviews being recorded thus making it difficult to represent them, or they did not provide sufficient insight required to make sense of the SOC components. Given the detail of the responses included in the empirical chapters, and the objective of teasing out the lived experience of abstracted concepts, there was sufficient material to work with to provide an in-depth discussion on the SOC, as a qualitative construct, in later life.

Two additional people are also referred to in the results. Julia's daughter sat with Julia during the interview, and she participated in the interview dialogue albeit infrequently. The other additional informant referred to in the results is a community development worker who acted as a contact in accessing potential research participants, and he also participated in interviews conducted in the early stages of the research to provide insight on supporting older people to age-in-place.

Name	Gender	Age	Marital status	Living alone	Audio Recorded
Terry	Male	86	Married	No	No
Kathleen	Female	78	Never married	Yes	Yes
Millie	Female	83	Widowed & remarried	No	Yes
Matt	Male	83	Widowed twice	Independent living space	Yes
Kay	Female	86	Widowed	Yes	Yes
Mag	Female	90	Widowed	No	Yes
Alf	Male	95	Widowed	Yes	Yes
Doug	Male	93	Married	No	Yes
Maeve	Female	82	Married	No	Yes
Maimie	Female	82	Married	No	Yes
Martha	Female	75	Widowed	Yes	Yes
Anne	Female	88	Widowed	Yes	Yes
Julia	Female	90	Widowed	Independent living space	Yes
Phillis	Female	76	Never married	No (lives with her sister)	Yes
Mick	Male	76	Never married	No (lives with his brother)	Yes
Helen	Female	75	Widowed	Yes	Yes
Not included					
Unnamed	Male	86	Married	No	Yes
Unnamed	Male	83	Married	No	Yes
Unnamed	Female	75	Married	No	No
Unnamed	Female	76	Unclear	Yes	No
Unnamed	Female	75	Married	No	No
Unnamed	Female	79	Widowed	No	No

Table 6.2 Participant's pseudonym, gender, age, marital status, living arrangements and if interview was audio recorded.

Organising and conducting the interviews

The interviews were conducted when possible in the individual's homes. In some instances this was not convenient for the participant, and a mutually agreed location was used instead. The median length of the interviews was approximately two hours. At the beginning of the interview the participants were provided with a consent form, background to the research, and were informed about the ethical considerations, including informed consent and confidentiality. They were asked if they felt comfortable with the interview being recorded. If participants objected to the interview being recorded notes were taken during and immediately afterwards. Participants were asked if there was anything they wished to have clarified before the recording began, once they were comfortable with the information provided to them the participants were asked to sign the consent form. Usually after the interview was completed there was an opportunity to chat informally and drink tea. This was an important part of the process because having discussed often emotionally heavy material it was good practice to allow the participant to unwind and relax, and to chat comfortably for a while. The importance of this winding down time became apparent over the course of the research. Immediately after the interview general observations on the process were recorded in the research journal. This reflexivity was useful to evaluate the progress made, productivity and to review the themes of the data generated. It also helped to identify improvements that could be made during the interview process to be applied in following sessions.

Analysing the oral narratives of the personal experiences of ageing

Health geographers have used narrative analysis to gain understanding of people's experiences of place in terms of their health and wellbeing (Parr, 1999; Wiles *et al*., 2012), and so its application here is not without precedent. In attempting to access the qualitative nature of the SOC, and given what the SOC is supposed to represent, the use of narrative analysis is an appropriate choice. This is because an individual's narrative can capture their understanding of the world, and what people give meaning to (Polkinghorne, 1991), something that has been attempted using the SOC as a measure and consequently lacking in detail. Even the existence of the SOC itself appears to be dependent on an internal dialogue or narrative that accompanies an individual throughout their life course. The narrative that we tell ourselves might then be considered implicit in the manifestation of our health.

Because narratives can capture the human experience holistically it provides a tool to investigate the holistic nature of health and wellbeing.

Narrative analysis also offers something that appears to be missing from research on the SOC, which is 'the ability to connect intimate details of experience to broader social and spatial relations' (Wiles, Rosenberg and Kearns, 2005: 89). The use of the narrative to expand the SOC thus brings the SOC closer to practical application, because the missing intimate and telling details offered in a narrative potentially supplies a basis from which to plan for health promotion.

A combination of narrative and thematic analysis is required in this research because as demonstrated by Wiles, Rosenberg and Kearns (2005: 97) thematic analysis alone can lose 'the multi-layered, contextualised interpretations of the conscious and less conscious meanings, moral ideas and values expressed' in a given narrative. The SOC, given its formulation, will be embedded in complex layers of meaning throughout a given narrative. So while a particular theme relevant to the SOC might be present, such as close personal relationships, an analysis of the individual's narrative will unveil the complex layers of social relationships, place and context, personal histories, and the individual's unfolding life story more broadly. While narrative analysis treats the individual's life story more thoroughly thematic analysis is useful in providing an interpretive strategy that allows for comparisons to be made between participants (Wiles, Rosenberg and Kearns, 2005).

Narrative does not pertain to the short-term experience, but rather the longer-term, and provides a means to order and make sense of experience. Importantly it allows for the temporal dimension of human existence (Polkinghorne, 1991). While conducting life review interviews and prompting the participant to 'tell me about…' a given theme or topic of interest, the participant is invited to embark on a lengthy narrative and to escape prescribed thematic boundaries in order to draw in the essential elements of their life story. While the theme will still be present, in creating the space in the interview to tell the story of the theme, it will not be abstracted from the lived experience. At the same time the personal story can tell us a great deal about life at the intersection of history and society (Kohler Riessman, 2002).

The themes presented in the results chapters were initially organised according to the SOC components and were identified based on how they spoke back to the SOC and their presence in the unfolding life story. Because the SOC components are developed and altered overtime, accessing the narrative of an individual's life can locate these components

as they make up the lived experience. For example the theme of continuity in later life, which incorporates the previous self, the current self, the future self and the relational self, requires a consideration of the multiple layers of life and lived experience in order to flesh out the processes that give shape to an individual's SOC. Likewise it is within the wider life narrative that the themes of close personal relationships and spirituality for instance are located, and most appropriately understood. Religiosity for example cannot be removed from the life course narrative because it is so thoroughly embedded in the lived experience, history and the wider social world, particularly for the participants in this research. Close personal relationships, as a theme, cannot be disengaged from the wider life narrative either, because an individual's narrative unfolds over a considerable period of time and in multiple places, and as a result people continuously enter and leave their lives, forming new bonds and breaking old bonds. Especially for the much older person who has outlived many people they had shared a bond with their narrative can take on an ethereal dimension, and move beyond a geographical context of space and place. This is one of the multiple layers of life that can be captured in the telling of one's life. So while the themes are present in the narrative, so is a commentary on an emerging and unfolding context.

The analytical method of interpreting the oral narratives as empirical data used in this research do not fit neatly into one particular model of narrative analysis. Rather a marriage of the most useful techniques from three distinctive models is applied. The three models as described by Riessman (2005) applied to this research are thematic analysis, interactional analysis and performative analysis.

    Thematic analysis: When applying thematic analysis to the narratives the focus is on 'what' is said rather than the 'how' it is said. The language used in the narrative is directed towards the meaning. Using the stories collected narrative analysts attempt to organise the data using identifiable themes. The findings are then represented as these themes. Vignettes are taken from the data to support the isolated themes. These themes are then used to elaborate on, or to develop, a theoretical perspective. There are some drawbacks to be aware of when carrying out thematic analysis. In forming thematic categories it is assumed that all narrative creators mean the same thing when their accounts are used in developing these themes. It is also important to be aware of deviant responses, the ones that do not fit neatly into a theme. Such content may thus be overlooked and excluded from the research. The

SOC components – meaningfulness, manageability and comprehensibility - were used to organise the themes.

Interactional analysis: The dialogical process between the narrative creator and the researcher is emphasised in interactional analysis. The process is considered conversational because both parties participate in creating the narrative. In addition any meaning taken from the narrative is thus the result of a collaborative process. In interactional analysis emphasis is not necessarily taken away from the personal experiences of the storyteller. The conversation, or narrative, is still focused on their lifeworld. The interactional element arises in the questions and answers that are exchanged between the two parties, and these interactions are included in the transcripts.

Under the previous two analytical approaches enacted and embodied gestures, and unspoken communications are not taken into account. For this reason *performative analysis* was also considered as a useful analytical tool to extend the narrative beyond the spoken word, and to pay attention to the performance of the conversation, the setting, and the dialogue between both participant and interviewer. A performative analysis of the personal narratives involved several data sources, including notes of observations recorded in the field notes of non-verbal communication during the interview process, and the transcribed interview narratives. The details gathered using all three models of analysis proved necessary to uncovering the details that inform the researcher of the participant's identity.

Identifying the themes

In the first instance, the narratives were examined for evidence of the SOC components this was to determine whether it would be possible to develop the SOC construct qualitatively using the life reviews gathered. When it was established that it was possible, the SOC provided the higher order under which emerging themes were grouped. The themes were subsequently used to ground the components, thereby providing the conceptual ideas of the SOC with an empirical basis. So for instance meaningfulness was identified in terms of activities, relationships, values, and motivations, comprehensibility was identified as a relational view of the self as a past, present or future orientation, and evidence of internal or external coping resources as an indicator of the manageability component ranged from dispositional traits such as optimism, to having access to a supportive environment. The themes of continuity, close personal relationships, and spirituality were identified as the most valuable in linking an expression in the narrative to the SOC as an abstract construct.

Continuity was a subtle theme that repeatedly emerged, as continuity of the self, or a sense of continuity in the relational world. The decision to focus on close personal relationships and spirituality was influenced by many factors. Firstly, they both spoke very strongly to the SOC. Secondly, they emerged as themes right across the participants. Thirdly, the interactional and performative analysis of the interview process necessitated a closer exploration. The performance of the conversation, or its spoken and unspoken tones, was particularly emotive in describing relationships in later life. As an interactive process it was clear that a very sensitive and important subject was emerging. A review of the literature to expand on the impact of relationships on health confirmed that it was indeed a pertinent theme worthy of exploration, and particularly in a new way as is done here with the SOC. Similarly, spirituality emerged from the data as a significant theme. Not only because it was present across the participants, and was an expression that strongly linked with the SOC, but also the nature of its emergence in the interaction between the interviewer, as a member of a much younger generation of Irish people, and the participant, as a much older generation of Irish people. There was a sense of adamants in how the participants spoke about the role of spirituality in their lives, which was often reflected in their tone and even their body language. Religiosity was undoubtedly a very effective coping strategy that formed part of daily life and routine, but also was a key resource during adversity. Additionally, the Orientation to Life questions provided a very valuable framing for unpacking spirituality. Exploring these three themes using the SOC and from the perspective of the geographer is a unique contribution to the literatures on salutogenesis, ageing studies, and geography.

Outliers and reliability of data

While it is expected that a qualitative data set will have some complex and contradictory findings (McPhearson and Thorne, 2006), there were no significant outliers in the thematic analysis. The thematic observations presented in the results section are well established by existing ageing research, such as evidence of continuity and the preservation of the self, and the importance of close personal relationships. The third theme of religiosity and spirituality and its importance as a coping strategy was echoed right across the participants with no outlier. This is most likely because of the homogeneity of the sample i.e. older Irish, white, rural, working class, and growing up in a staunchly Catholic society. If the sample were taken from a diverse urban environment, as opposed to rural Ireland, there would have been potentially more variation and some significant outliers.

The narrative data presented in this research was generated from recorded interviews (with the exception of Terry's account) and the results rely primarily on the preserved words of the participants taken from the transcripts, while the analysis itself speaks directly to the accounts provided by the participants. The purpose of including lengthy narratives where appropriate was to give the audience the conversational context, because with narratives there are many layers of meaning through which a theme is discussed and described. Thus the inclusion of the lengthy narrative was intended to prevent something going unnoticed, or taking it out of the wider context of their story. This contributed to the truth-value of the analysis. Throughout the results chapters existing literature was heavily drawn upon to make sense of the narratives presented and the stories told, and to inform the analysis and discussion. This was necessary because the purpose of this research is not to produce conclusive results generalised across a population or cohort, but rather to provide in-depth qualitative descriptions of the SOC using the data generated and examining it through the lens of existing ideas and findings from a review of the literature. The resulting analysis is thus reflective of both the individual experience, and what is already known theoretically.

Reliability of data can be a problem when a less structured approach is taken during the interview process (Conway *et al*., 1995). The participants might interpret the questions differently, they might answer the question in a round about way, or they might deliberately pass over a given question if they are uncertain of how to answer it. In an open-ended approach that begins with 'tell me about your life' such as here, the participant is invited to engage in a seemingly broad conversation. Although, while appearing to be open ended the approach taken was actually managed so that the core life review categories were addressed. The idea was to maintain control over the data gathered during the interview, but in a less intrusive way. This was done using standard prompt questions if the categories were not already examined more naturally in the unfolding of the conversation, which they often were. The prompt questions were usually in response to something that was said, or were used at a break in the dialogue. A less intrusive management of the interview process such as this allows for the voice of the participant to remain present, while at the same time maintaining control over the data gathered and its reliability.

Maintaining standards of ethical research

Before fieldwork commenced ethical approval was sought from, and granted by, the Ethics Committee of the National University of Ireland, Maynooth. There were several ethical considerations taken into account while this research was carried out. Fundamentally, the respect and dignity of all research participants was maintained at all times. The responsibility of the researcher towards individual participants and the wider community was also taken into account, with a particular sensitivity towards issues that could potentially arise due to inequalities of power.

NUIM ethical policy for researchers working with human subjects specifies a number of requirements that must be adhered to. Many of these were of particular significance for this research project. NUIM policy requests that risk is minimised to protect research participants. This involved considering if any of the participants would be considered vulnerable in some way. It is, in general, agreed that older people as research participants do not need special protection over and above any other research participant. There are however two exceptions – if the individual is cognitively impaired, or if they are institutionalised. No research participant were cognitively impaired or institutionalised. All research participants were asked to give informed consent. That is they were provided with a description of the research, and informed of their role in it in terms of what would be asked of them as participants. They were given the opportunity to ask questions about aspects they were not clear on, they were informed that they could withdraw from the interview process at any time, or from the research project up until it was complete. Participants were also provided with the researcher's contact details should they have any questions or concerns regarding the research in the future. All research participants were made aware of the research ethics committee at NUIM and were provided with the committee's contact details should they think it necessary to contact it with any concerns. The right to confidentiality for the research participants was also recognised and protected. All participants were guaranteed at the time of consent that no identifying personal information would be disclosed in the written or oral dissemination of the research.

Older people are not recognised under research ethics as requiring any special protection over and above any other research participant. It was however felt that greater sensitivity towards certain aspects of the research process were warranted. Thus guidance was sought in the literature on carrying out research with older people. Harris and Dyson (2001) offered pragmatic suggestions on conducting research involving older people, based

on their experiences. They made several useful recommendations for researchers working with older people. When carrying out research with older people greater sensitivity towards unspoken signs communicated by the participant is necessary. For example, recognising when the individual is growing tired, stressed or uncomfortable. They also recommended that the ability to give a concise explanation about the research, and what would be asked of them as participants, is necessary. They recommend that the researcher should be flexible in their approach to communicating and explaining the research. The researcher must continue to be reflexive during the process, continuously refining recruitment skills, explaining research objectives in a flexible manner, and ensuring that the participants understand their role and rights during the process, and the responsibilities of the researcher towards them. In conclusion they suggested that researchers should not underestimate the difficulty of recruiting older people to research, they stressed that sufficient time is required to ensure that adequate participant numbers are met, while at the same time maintaining a sufficient standard of ethical duty to the participant during the process.

Research ethics and the emotional self

The phenomenological approach questions the way in which we experience the world, and to know the world requires us to be in that world. The researcher becomes part of this world because they are intentionally attached to it through their research. Therefore, in keeping with the influence of phenomenology, and its suggestion that achieving direct contact with the (life) world the textual practice of reflective writing is required, the thoughts and observations recorded in a reflective research journal are incorporated here. These relate specifically to the research process and the experience of carrying out life review interviews. Many of the experiences recorded were found to reflect much of the insights published on the emotional and psychological experiences of conducting sensitive research. This section will discuss these reflections.

While undertaking qualitative research health researchers often encounter many difficult challenges. The most common challenges faced by researchers include developing a relationship with the participants, the ability to listen to sometimes upsetting stories, leaving the interview comfortably knowing that the participant is not upset, and emotional exhaustion (Dickson-Swift *et al.,* 2007).

When carrying out research of which one of the main methods is conducting a life review interview, the researcher must be emotionally and psychologically prepared for the experience. Morse and Field (1995) elaborate on what can be expected of such experiences:

> *'Data collection can be an intense experience, especially if the topic that one has chosen has to do with illness experience or other stressful human experiences. The stories that the qualitative researcher obtains in interviews will be stories of intense suffering, social injustices, or other things that will shock the researcher'* (Morse and Field, 1995: 78).

The heightened sense of awareness required of the researcher, incorporating performative analysis into the research, accounts for this intense research experience. When listening to the participants reliving and exploring their stories the researcher must listen attentively to the tone of voice used, recognise movements and gestures used to emphasis a point, and read facial expressions to understand the emotion behind what is said. The use of silent, emotive language is both telling and poignant. Over the course of this research it became apparent that learning to observe and interpret such expressions intensified the research process, and were crucial to forming a genuine empathetic research relationship.

In keeping with the commitment to carry out the research in a reflexive manner, several personal reflections were noted in the reflexive journal and the field-notes. These recordings and reflections often concerned the details of the interview process and the researcher-participant relationship.

Reflexive Journals in Qualitative Research

Researchers engaged in qualitative research are encouraged to discuss 'their presuppositions, choices, experiences, and actions during the research process' (Mruck and Breur, 2003: 3). Paying attention to this advice, and taking influence from Ortlipp (2008), it was decided that a reflexive research journal was an appropriate means of recording research observations and practices for the novice researcher. There are several advantages to keeping a research journal. It provides a paper trail of the research process, which shows the research methodological development and the navigation of ideas, theories and philosophies encountered and considered along the way. By documenting the research process regularly in the journal it is possible to reflect critically, and consciously engage with the research activities with a much deeper level of awareness. In keeping a reflexive journal there is a place made for self-disclosure, and the subjectivity of the researcher emerges. With relation to the earlier discussion on phenomenology, in drawing from the

reflexive journal the researcher is humanised, and becomes visible as a person (Ortlipp, 2008). As pointed out by Boden, Kenway and Epstein (2005) the reflexive journal is valuable to the novice researcher. The research process is not often taught to research students as a process of 'muddle, confusion, mistakes, obstacles, and errors' (Boden, Kenway, and Epstein, 2005:70). By keeping a reflexive journal the messiness of the research process becomes apparent. As does the contrasting reality of conducting research as opposed to the neat a linear manner in which the research process is represented in the research literature. For the novice researcher the reflexive journal provides an important tool to record their research experience and learn from these experiences through reflexivity. This provides a learning that cannot be captured in a survey of research methods books.

Using overarching themes identified by Dickson-Swift *et al.* (2007), extracts from the research diary will be discussed, with relation to the methodology and the methods used.

Personal reflections:

1. Caring attunement and identifying ethical dilemmas

Many qualitative researchers argue that developing a good rapport with their research participants is essential to the success of the research project. During the fieldwork phase of this research the development of the researcher-participant relationship was an uncertain process, and was largely dependent on how the participant understood their role and that of the researcher. As a result the interactions between the participant and the researcher varied significantly, thus requiring a capability of the researcher to adapt to, and be flexible in, whatever manner the interview situation presented itself. Examples of these researcher-participant relationships are given here:

> *After I turned off the recorder he insisted I have a cup of tea and sent me into the kitchen to make one. Meanwhile he was filling up a large glass of whiskey, and for a moment I thought 'Oh God, is that such a good idea?' When I sat back down with my cup of tea I said jokingly 'how come you get whiskey and I get a cup of tea?' he replied grinning 'young ladies, Sandra, shouldn't drink whiskey'. We sat and chatted for about two hours, talking about everything and anything. He confessed that he had set his alarm twenty minutes earlier that morning because he wanted to prepare for his 'special guest', by ironing his shirt and picking out his best tie. 'I'm very glad I did that now. If only I was 70*

years younger' he said winking at me. 'Oh, you would still be too old for me even then Alf'. We both just laughed and laughed. I was amused that even in their nineties men flirt! Looking back I think that this laughter was probably necessary, because he had been so upset talking about caring for his wife, in her final weeks and days, that the sadness seemed to hang in the air and in his voice as we continued to talk. I was glad I stayed to chat with him without the pressures of the interview. I felt confident that, as I said goodbye, the smiling man that greeted me at his front door had returned.

<div align="right">Research Journal, December 2011</div>

According to van Manen (1997) phenomenological researchers must have a caring attunement when conducting their research. This attunement may affect the development of a rapport between the researcher and the participant, and it also appears in this account to have a significant role to play in ethical research conduct. Similarly this caring attunement is present in the next account, and influenced the outcome of the interview situation where an ethical decision was required as to whether the interview should take place.

When we sat down I explained about the consent form and asked her if she minded the interview being recorded. She seemed very apprehensive about the whole process, and decided not to go through with the recording. I knew at this point that I had to treat this situation with care, and respect her feelings. I decided that we would have a cup of tea, sit and chat for a while, and maybe later we would consider the interview again. As we talked she told me about her life, that she didn't usually get involved with people, and kept her distance. Into the conversation she felt more comfortable in my company, and confided in me her feelings about her son's sexuality, and the difficulty she experienced in accepting him after he told her he was gay. She was a devout Catholic. We discussed this at great length. I was no longer a researcher, I wasn't taking notes, or thinking of my research questions, my role changed and I had to adapt to the situation. I entered the process as a researcher, but as it unfolded I became the lady's confidante for that short time. At the end of the conversation she thanked me for listening to her. I decided not to go through with the interview, and I didn't bring it up again, neither did she. She appeared to be

lonely and needed someone to talk to, and probably because I was a stranger she felt she could be open with me. In thinking about the research process perhaps participants consider it an opportunity to have a 'therapeutic conversation'.

Research Journal, February 2011

The ethical question that arose here was whether or not this lady was able to take part in the interview, and if the interview were to take place would she suffer emotionally as a result. Here the ethical responsibility of identifying an individual's vulnerability in the interview process was paramount. Not only is this an ethical issue, it also has methodological implications. The life review was originally designed as a therapeutic conversation, although for this research it was considered a very useful framework for addressing the research questions. As a result using the life review required the research relationship to be one of trust and understanding, and the researcher acquired the role of a therapeutic conversationalist, which demanded a stronger degree of sensitivity to the needs of the research participant.

2. Self-disclosure

During the interview process it became apparent that the researcher's willingness to share personal details was important in developing a rapport with the research participant. It was also found that what the researcher expected of the participants was also a task that the researcher must be able to engage with and complete. The following account demonstrates an argument made by Gadamer (1995) that social science knowledge requires, and brings with it, self-knowledge, and self-awareness.

When I am doing an interview, I forget that as I ask personal questions surely they can do likewise of me. If I expect them to be open and honest with me, then they in turn will sometimes expect me to be as open and honest with them, about my own life, my own thoughts and my own feelings. If I ask them to reflect on their lives, surely I need to be equally as reflective with my own life. Religion has come up time and again during the interviews, so much so that it is now a specific question, where I ask about the role of religion in people's lives. Today was different, today the question was turned on me, and I had to answer it, and

I couldn't. 'Who do you turn to when you are sick and sore in bed and it is the middle of the night?' I had no answer, and I didn't think he was waiting on one. But he demanded I answer him 'I am asking you, who do you turn to?' I was blank. He was questioning me, demanding of me to be as self-questioning as I was expecting of him. I left the interview still wondering about his question, and with an altered view of the research process. The life review expects and requires self-awareness of its research participants, and perhaps equally so of the researcher.

Research Journal, August 2010

3. Emotional intensity of the interview process

Phenomenological research requires the researcher to respond to the research participant as a human, and to align themselves with their world so as to understand it. This means that the researcher must be empathetic, patient and compassionate. However, as Ely *et al*., (1991: 49) argue 'if we undertake to study human lives, we have to be ready to face human feelings'. As described by Haight and Haight (2007), engaging in a life review style interview requires the interviewer to empathise with the participant, rather than feel sympathy for them. When having difficult conversations this may prove challenging for the researcher because they must maintain professionalism. When listening to participants discuss difficulties they experience in their lives, the researcher must remain composed throughout, carry on the conversation by knowing the 'right' things to say and have the ability to ask the right questions, or indeed know when to stop asking questions. The following provides an account demonstrating the emotional intensity of carrying out a life review style interview:

It was a really tough interview today. Because of the snow I walked to the lady's house and back again. On my way there I was cursing the snow, the cold and the winding country roads, but as I left her house I was relieved for the walk. I needed the air. I needed to compose myself, to pull myself together. The lady was 90, and very fit and active. We started to talk about what she found most difficult about ageing. She said that the hardest thing of all was seeing her friends pass away one by one. She told me she found going to parties and get-togethers very difficult because she missed her friends, her 'own crowd' as she

called them. At this stage all her close friends, those that she had socialised with, and shared her problems with throughout most of her life, had passed away. She felt she no longer fitted into a group, and it was sometimes lonely. When she described her friendships and how difficult it is to outlive friends, I felt her sadness. I felt overwhelmed by the need to cry with her, and the need to compose myself, say the right things, and gently move on. I felt emotionally unprepared and unable for this conversation. The sense of empathy, which I need for this part of the research, was perhaps a bit too intense.

Research Journal, December 2010

Similar to the previous account, which focused on self-disclosure, this reflection questions the position of the non-research self, and how it enters into the research process unintentionally. Glesne and Pehkin (1992: 83) asks 'how much of your non-research self can be visible as a person without contaminating or distorting the interview', or indeed how much of the personal self will affect the research process? One final point can be made here. In social science research where a hermeneutic phenomenological framework is used, and the research conversations are emotive in content, the researcher must be prepared emotionally, psychologically, and professionally to undertake them. However, it is perhaps necessary to engage with these conversations from the outset to gain the necessary experience to feel prepared to deal with sensitive topics when they arise during the interview process.

Chapter review

This chapter has dealt specifically with the hermeneutic phenomenological life review as a qualitative method to inform and broaden the knowledge base of the SOC construct, and to inform discussions on health and healthy ageing. It has been argued that there is a need to establish the 'voice' of the research participants in health promotion research, and to provide them with legitimacy as experiential experts on health, thus keeping with the philosophical traditions of health promotion. The design of the research also takes into account the ordinary experiences of daily life. The life review provides insight on a version of resilience, 'ordinary magic', in the context of late life. This 'ordinary magic' is to be found in the experiences of the everyday spaces of life, where one's sense of self and identity is located, experienced, produced and reproduced. Finally, this chapter has also

addressed the personal implications for the researcher in carrying out qualitative research, where there is a need to demonstrate sensitivity. Using extracts from the researcher's field journal it has explicated the need for researchers to prepare psychologically when embarking on research using the life review interview or similar methods.

Organisation of empirical chapters

The following empirical chapters are organised around three crucial spheres of life identified by Antonovsky (1987). Chapter Seven explores the sphere of the inner life, and draws predominantly on continuity theory and relational geography to make sense of the SOC, as it is expressed in the activities of the participant's daily life. Chapter Eight explores the interpersonal sphere, in particular the negotiation of the boundaries that determine who is allowed access to one's inner emotional world, as friends as opposed to 'others' that make up the social world. The implications of belonging, what it means to belong and the emotional intensity of belonging and not belonging is considered in terms of their impact on health and wellbeing in later life. Friendship is a particularly difficult issue for the very old because most likely they have outlived those closest to them. Chapter Nine explores the existential sphere, and examines the role of spirituality as a coping resource. This chapter looks specifically to the Orientation to Life questionnaire to locate spirituality in salutogenic theory.

Chapter 7
Resilience and continuity in old-old age: The relationship between the SOC and place

A central question guiding resilience research as proposed by Antonovsky, asks what differs about people who succumb when faced with adversity, and those who recover. Resilience research is about uncovering the underlying mechanisms that are important factors influencing how an individual reacts when they are faced with a challenge. A great deal of research literature focuses on the most extreme cases of adversity and people's response to them, such as abuse, violence, or disaster. While these enquiries are extremely important to provide insight on human reaction to the most harrowing of challenges, more work needs to be carried out to investigate what resilience looks like when faced with the more common challenges of ordinary day-to-day life. In examining resilience in the context of everyday spaces it is possible to expand our understanding of the physiological, psychological and social mechanisms involved in these challenges (Davis, Luecken, and Lemery-Chalfont, 2009).

The main objective of this chapter is to understand resilience in the day-to-day lives of older people as they age-in-place, by applying the SOC as a qualitative framework. Not all of the older people who participated in this research were experiencing significant challenges, but nonetheless they demonstrated significant resilience in their daily lives. Fletcher and Sarkar (2013) argue that resilience is not only about adjusting to adversity, but rather it is about adjusting to change more generally, even when these changes are positive. This is because any change requires an individual to demonstrate resilience characteristics to be able to adapt positively. For older people positive adaptation is very important when faced with the developmental tasks that accompany ageing. In order to understand the individual's reaction, adaptation and resilience, it is important to consider the socio-cultural context within which the individual is located (Clauss-Ehlers, 2008). The second objective of this chapter is to consider older people's resilience within their socio-cultural contexts. In particular this chapter provides an exploration of the SOC and its components, meaningfulness, manageability, and comprehensibility, within a socio-cultural context. So far the SOC components have rarely been considered relative to context, and this is a major shortcoming of salutogenic research identified by this thesis. The components were not sufficiently described by Antonovsky and so it is only through the wider positive psychological research literature that the components can be expanded. This shortcoming is

addressed here by taking the abstraction of Antonovsky's salutogenic theory and rooting it in the human particular and detailing the complexity of the SOC using qualitative data on ageing-in-place.

In this chapter, aspects of the research participant's lives will be discussed through the framework of the SOC, and supplemented by drawing insights from the gerontology literature, specifically Atchley's continuity theory (Atchley, 1999), the notion of self-concept in later life, and the relational geographies of age perspective (Ziegler, 2012; Lager, *et al*., 2013; Hopkins and Pain, 2007) applied to the concept of ageing-in-place (Wiles, *et al*., 2012a; Wiles, *et al*., 2012b). Ageing-in-place is understood in terms of the functional, symbolic and emotional meaning of home for the older person (Wiles, *et al*., 2012a). Each of the participants' accounts given in this chapter demonstrates resilience in different ways. By focusing on a small number of individuals it is possible to explore what the SOC components look like in daily life, and this provides some insight on what makes individuals resilient, and the relevance of this resilience in supporting the older person to age-in-place. It is necessary to understand the SOC as something that is both qualitative and experiential before it can be applied in practice. Because of the nature of the interviews, the difficulty in representing the qualitative diversity of later life experiences, and to achieve the goal of expanding the SOC components, focusing on a small number of cases works to reverse Antonovsky's generalisation and abstraction of the SOC theory. By limiting the focus to a small number of participants here a deeper understanding of what the SOC looks like in daily life is achieved. It is this level of insight and understanding that is lacking in SOC research, and it can only really be achieved by specifying the SOC as something that is lived, and something that can be expressed through qualitative research. By applying the SOC qualitatively, rather than using it as a measuring tool, it provides a good basis for progressing towards a Salutogenesis 2.0 agenda, (as an extension of Lezwijn's *et al*., (2011) Health Promotion 2.0 agenda), and to mould the SOC construct into something operational.

Further to this, given the absence of much of Antonovsky's philosophical and theoretical orientations, which are implicit in his theory rather than explicit in his writing, it is beneficial to draw them out and open up the SOC conceptually by introducing and merging different strands of relevant ideas from across disciplines. Currently, there is a vast array of conceptual ideas open to the salutogenic researcher, but were unavailable to Antonovsky (1987), that can contribute significantly to unpacking the SOC components,

and this chapter draws on some of the more relevant ideas for investigating what the SOC components look like in later life.

Continuity in later life: Activity and identity

The concepts of continuity and discontinuity are controversial in social theories of ageing. The classical social theories of ageing such as disengagement theory (Cumming and Henry, 1961) set the groundwork for these concepts. Disengagement theory viewed the process of disengagement as a necessary stage in the ageing process, which is the desire to detach from current life in preparation for death (Cumming and Henry, 1961). Disengagement theory, as a normative theory of ageing, fell out of favour, and was replaced by an opposing theory of continuity. The theory of continuity, attempted to provide a more accurate theory of later life, defining normative ageing as the continuation of activities undertaken during middle age into old age (Lemon *et al.,* 1972). Continuity was concerned with the preservation of the 'self' and identity, and the social relationships experienced in middle age. Atchely (1989) later identified these in terms of internal and external continuity. However, because old age is often defined by factors inhibiting the daily life of the older person, the older person is required to adapt to changing physical, mental, social and even spiritual conditions. In reality this adaptation requires both continuity and discontinuity (Freund and Baltes, 2002). Indeed, older people are not homogeneous, they do not have a shared experience of the ageing process, and so using generalised theories will only be applicable to a limited extent.

Of interest to the salutogenic researcher is Gergen and Gergen's (2006) work on positive ageing, which highlighted the continuous accumulation of resources by individuals as they move from childhood into old age. As they move through the life course the individual will grow and adapt, and this does not change even in later life. When met with adversity people use the (psychological) strengths they have accumulated throughout the life course to compensate for the losses they experience along the way (Baltes and Baltes, 1990; Baltes and Carstensen, 1996). When compensating for losses using the accumulated resources the older person actively determines their continuity of activities, by appraising the resources internally and externally available to them. The elements of continuity theory, much like the SOC, look to the internal and external environments to explain the formation of a stable self-concept. According to continuity theory the internal environment consists of personality, ideas and beliefs, and the external environment consists of relationships and social roles. The internal and external environments are more limited in scope for continuity

theory than they are for salutogenic theory. Furthermore, the external environment is thought of in much the same way as it is according to the SOC, whereas aspects of the internal environment important to continuity theory differ somewhat to the internal resources identified by the SOC, albeit they do add up to the same outcome i.e. a positive relational view of the self in the world. According to Nimrod and Kleiber (2007) adaptation, continuity and growth are important aspects of later life, and are not processes confined to youth and middle age. Antonovsky (1987) claimed that an individual's SOC did not change a great deal over the life course, but was set during young adulthood. Unless a life-changing event occurred, that had an impact so significant that it would change the individual's disposition, their SOC would remain otherwise stable across the life course. This provides little scope for personal development, and is a rather pessimistic view of human potential to overcome mental illness, for example.

Having a purpose, setting goals and taking on roles are important sources of meaning, especially when they are related to overarching identity projects and life themes (Csikszentmitihalyi and Beattie, 1979; Warburton and McLaughlin, 2006). Sustaining multiple meaningful roles over the lifetime leads to greater subjective wellbeing (McIntosh and Danigelis, 1995; Greenfield and Marks, 2004; Warburton and McLaughlin, 2006) and can help with adjustment following critical life events (Utz *et al*., 2002). The maintenance of roles throughout life has a notable gendered dimension. Warburton and McLaughlin (2006) for example suggest that women have more roles than men throughout the life course, and subsequently carry forward more roles into later life. This is advantageous to older women's wellbeing. While some roles are carried forward into later life other less meaningful roles are not. This is because some resources become increasingly limited, such as physical energy and health and as a result later life goal selection is acutely important. The discontinuity of roles represents an act of disengagement from less meaningful goals to pursue more central goals. In defining goals in later life people often integrate their personal biographies into meaning making. Meaningful goals and activities tend not to be future orientated, but rather are time-transcendent such as for example altruistic and socio-emotional goals like friendship and love. Love is identified by wellbeing theorists as an inherent first-order value - that is something that is valuable in and of itself, and acts as a basis for motivation and action (Ryan, Huta and Deci, 2008). These types of goals represent the more intrinsic dimensions of meaning, and are central to the individual's motivation. This is significant to the SOC, because what is considered meaningful is recognised as a

central motivational factor, and without meaning the individual's SOC will be weak. The integration of the biography in meaning making is an important aspect of constructing and maintaining identity and personal continuity in later life. The individual's biographical details are thus closely related to, and influence, their motivation. This will become apparent with the analysis of the participants' accounts described in this chapter.

Terry's Labour of Love

As would be expected several of the participants in this study were involved in caring for another adult individual, often this was an even older parent, a spouse or partner, or dependent adult son or daughter. Geographers have already contributed significantly to the caring literature more broadly (Milligan and Wiles, 2010; Power, 2010). Examining the role of the carer as it was presented in the life review interviews through the lens of the SOC provides an additional dimension of understanding the experiences of the carer. When these experiences are grounded in a motivation to support ageing-in-place they become significant to the geographical literature on caring. Keeping in mind that the SOC is about health creation and that the components are linked in some way to people's movement along the health-ease-dis-ease continuum through the application of the GRRs, somewhat of a paradox emerges. With this paradox it will become apparent, in this particular examination of the older person as carer, that a balancing of the SOC components is necessary to maintain and promote the health and wellbeing of the carer. When the meaningfulness and comprehensibility components of the SOC are discussed for example the reasons why these older people take on the role of the carer will become apparent, despite knowing the extent of the impact such a role will have on their lives. That is their motivation to take on such responsibilities. In addition to this the manageability component when applied to the act of care provision will reveal more on the buffers, or the GRRs, that are necessary for the older carer to maintain physical and mental health so that they can continue to perform their duties and fulfil their responsibilities as carers.

The following is an account from a life review interview conducted with an 86-year-old man, while the original purpose of the interview was a life review, much of the conversation dealt with the last 10 to 12 years of his life. Despite this some valuable insights on later life transitions and what these might mean for the SOC were identified. While Terry agreed to participate in the research he declined to give consent for the interview to be

recorded and so notes were handwritten throughout. The account presented here focuses on Terry's later life following his relocation to the countryside from Dublin city with his wife.

> *Terry and his wife Cathy moved to a rural area in the south east more than ten years ago following their retirement, having spent most of their lives living and working in Dublin. They had no children, and their families were dispersed throughout the world, and so they felt they were in a good position to pursue a better quality of life by selling their home in the city and relocating to the countryside. At the time of their moving Terry was 75 and had no health problems. For the most part their time living in the countryside was enjoyable. They kept a nice garden, grew vegetables and went walking most days. Over the last two or three years however Cathy's health began to deteriorate, she grew tired easily, and gradually started to show symptoms of dementia, she would easily become confused, repeat herself in conversation and forget important details. Gradually Terry assumed a caring role. While in the past he had enjoyed his independence along with their companionship, Terry was now preoccupied with caring for his wife. When he was leaving the house to pick up groceries or run errands he would have to take her with him because it was too risky leaving her at home alone. As Terry talked he reflected on his career in the army with pride, but now it seemed he had taken on a new role and that was to look after his wife. In moving from Dublin to the countryside as a couple they had redefined the purpose and direction of their lives. They sought the peace and tranquillity, and even solitude, of the countryside. However over a very short period of time their relationship began to change dramatically, the solitude of the countryside became isolating. Because they had moved into the area in later life they did not have the same social or support networks of those native to the area. What they sought as a 'younger' older couple was positive at the time, but as Cathy's health deteriorated the country lifestyle they had wanted, and indeed had for a while, proved to be more challenging than positive. When asked, Terry said he did not regret their decision to move, rather if they had not moved they would have probably regretted it more and left wondering 'what if'. It had been their plan for a long time and there was no way they could have anticipated the outcome because at the time of making the decision they were both in excellent physical and mental health. They found the local community supportive and welcoming, and even still they get involved as much as they can with the social clubs in the local Family Resource Centre, this has in fact been an important social outlet for them and a means to develop a social network. However, for Terry at the end of the day it is just himself and my wife. When asked about the care options opened to them Terry replied that he wanted to care for his wife, they had been together for over 50 years and he knew how to take care of her better than anyone. He said 'if I do it, it will be done right'.*

Listening to him talk about his current life, and reflecting back on their many happy years together it was clear he was devoted to his wife. In the months leading up to the interview he was under increasing pressure to provide the care and attention she required yet he was determined to provide her with what she needed himself. It was unclear whether or not help

was available to him, or if it had been refused. Regardless of this he believed he was the best person to take care of her.

For Terry, providing the care his wife needed was a duty that was meaningful. To use Antonovsky's phrasing providing the care his wife required made emotional sense to him, and from this Terry derived considerable motivation. Determining the sense of meaningfulness for Terry during this interaction was confirmed not by asking if he found the task meaningful but rather by his actions. His refusal to pass responsibility for her care even for a brief period of time, as daily respite for example, was indicative of his willingness to put aside his own needs, wants and desires to provide his wife with the care and support she required. In several ways his quality of life was suffering, and this brings to mind Victor Frankl's (2006) view on human suffering that if an individual can find meaning in their suffering they will withstand it. For Antonovsky the movement towards a positive outcome requires the individual to find meaning in the situation and to draw on resources in their internal environment to motivate them and strengthen their resilience. Terry's determination to provide his wife with the necessary care himself demonstrates the strength of the intimate bond between them, and his resilience. There is a paradox here. While Terry is demonstrating resilience and determination all of which have positive associations with the SOC, quality of life, health and wellbeing, there is a concern that his conviction in providing the necessary care for his wife, might be to the detriment of his own health and wellbeing. He is after all 86 years old, and with only a small network of social support he is taking on a great deal of responsibility. To draw on Antonovsky's notion of the internal and external environments from which the individual draws resistance resources, while Terry might have the GRRs present internally, such as devotion to his wife and her care, self-determination, motivation and a sense of purpose, it appears however that there is not a balance of GRRs readily available to him in the external environment. So for example while he attends the Family Resource Centre regularly, which has provided him with a readily established network of support, there is still a risk that he will become increasingly vulnerable because of an imbalance of internal and external GRRs. Antonovsky (1987) proposes that the individual with a strong Sense of Coherence is more likely to define the stressor in a positive light and is thus more likely to tackle the issue directly with the confidence that it will be a positive experience and that any confusion will eventually become comprehensible. This confidence is identified by Antonovsky as a resource in itself. The nature of the problem, Cathy's increasing ill health, has provoked an emotional

response from Terry that forms a motivational basis for action. Moreover, Cathy's condition appears to present Terry with a challenge rather than a burden; it is a challenge because Terry feels that he can draw from his internal resources and rise to the challenge even in the absence of a supportive network of family and close friends. The situation presented in the account here on Terry's health when analysed using the SOC suggests a positive outcome. According to Antonovsky (1987: 137)

> *'[T]he extent to which one approaches the world with the generalised expectation that stressors are meaningful and comprehensible lays the motivational and cognitive basis for managing and for preventing the transformation of tension into stress.'*

This understanding or interpretation of Terry's situation should not however underestimate the toll care-giving can take. Indeed the application of the SOC to the qualitative experience presented here raises some theoretical concerns. As was argued previously in the theoretical commentary the SOC might exaggerate the role of the individual in managing their health and wellbeing, or coping in this case, at the expense of underestimating wider structural forces and contexts. Antonovsky (1987) claims that the individuals who can find meaning in a given situation, can comprehend it and can find the necessary mental resources within themselves to face the stressors presented to them, have a head start. This thus leaves the individual to take on the responsibility, and if they cannot cope they are somewhat lacking according to the theory. It is possible to deduce from Terry's account that he has a high SOC however the person, regardless of their SOC measure, must be placed within a context. Terry's comprehension of the situation is based on insularity. His place in the world in recent years was defined by a life formulated by himself and his wife, and now taking care of Cathy's needs is a natural progression of that life as it changes over time. According to Siegrist (2000) people have agency through their social roles. These social roles reflect the fragile balance between the self and the social world, where changes to the social world can significantly alter an individual's social role and even their sense of self. So for example Terry identifies closely with the marital role, when Cathy's health deteriorated Terry drew on his internal resources such as his sense of self-efficacy and applied it to his personal development in the transition from husband to caregiver, his self-esteem derived from his potential to contribute positively to the situation at hand, and his desire to maintain self-integration through the maintenance of the husband-wife relationship, albeit in a different form than before. Siegrist (2000) refers to these three internal dimensions - sense of self-

efficacy, self-esteem and self-integration - as the three functions of self-regulation, and when considered with relation to the SOC here they can be understood as the basis for comprehensibility. The ideas of self-regulation and comprehensibility is closely linked to the locus of control, identified by Antonovsky as a construct closely related to the SOC.

In the next account we meet Kathleen. Terry's care giving experience is similar to that of Kathleen's. In addition they both demonstrate considerable resilience and motivation. Using Kathleen and Terry's accounts together it is possible to relate them to wellbeing through the SOC. Kathleen represents an emerging group of older people that are caring for their parents who have achieved exceptional longevity. Terry and Kathleen are in similar positions of providing care to a close loved one, and feel an intense sense of duty to meet their needs despite the risk to their own health, wellbeing and quality of life. Terry's account provided a good qualitative empirical basis on which to draw out the SOC components and to make sense of the SOC as an experiential construct that can be contextualised in the lived world. Kathleen's account given here provides further insight on the SOC, and to develop the link between the SOC components and wellbeing theory, Kathleen will be treated as someone who is pursuing the goals of eudaimonic living (Ryan, Huta and Deci, 2008). Terry's experience will also be drawn upon to explore eudaimonic wellbeing. The intention of this section is to develop the SOC and to make sense of its role in shaping and/or determining the wellbeing of the older carer.

Kathleen's Labour of Love

At the time of the interview Kathleen was 78 years old. Two years previously her mother died at the age of 96. At the end of her life Kathleen's mother was dependent on her daughter's care, because of frailty and cognitive degeneration. The following is an extract from the interview conducted with Kathleen:

> Kathleen: '...my mother broke her hip, well they say you break your hip and then you fall but I always say she fell and broke her hip, but the doctor says no the hip breaks and then she falls, so I minded her. I had her for a long time in a wheelchair and it wasn't easy, now in saying that if she was back again I would do the same. She was about seven months in St. John's[7] when she died. I just couldn't.... what I couldn't cope with is she would want to go to bed at eight o' clock and at twelve or one o' clock she would want to get up and she would keep shouting at you then 'are you going to sleep all day'. And she was incontinent and I had her in nappies and she could not bear the nappies on her

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[7] Community hospital for older people that provides respite care

and you would go down and find them on the centre of the floor and she was wet up to here [points to her chest] which meant I was changing her two and three times a night so I was getting no sleep whatsoever. I just wasn't able. I stuck it as long as I could and it broke my heart alright to see her go but you have to you can only do what you are able to do and that is it.'

Int: Did you get much help?

Kathleen: 'No because my sister is married up in [Wicklow] and my brother is down in [Wexford] and they have their own families. I did [get help] from Home Instead. She had Alzheimer's as well and she would do nothing that they would tell her, then I had a nurse coming in the morning and she used to wash her and dress her for me, which was help. I was able to manage her during the day time because I was able to get her down to the commode, she never wet herself during the day but God put her to bed and it wouldn't be two hours and she would be drenched and you know trying to change her in the middle of the night and trying to get her to bed, it was a nightmare now. But God help her she didn't realise it. She used to think it was the middle of the day and she should get up you know. As I said if I had her back I would look after her again. They had her in St. John's when she was up for rehabilitation after doing the hip in, they said to me 'are you sure you will be able to manage her' because she came home in a wheelchair and I said I will you know. Now when she came home first she wasn't too bad but I couldn't take my eye off her for five minutes because she thought she could get up and go, so eventually I had to strap her in the chair, which I felt terrible about too. That she was trapped there in the chair. I went out there one day to get coal for the fire and I came back in and she was down flat on her face after trying to get up to come after me, thinking that she could, I thought if she breaks the other hip I will be in a right stew, so I had to strap her in it. Of course she went mad. The nurses that came during the day, there was a physiotherapist that came out and she was lifting the wheelchair off the floor trying to get out of it, and she said to me 'God how do you put up with it all the time', and I said 'Oh Lord it is a nightmare'. If I wanted to go to the ICA[8] at night my brother used to come up and stay with her until I come back. Well that went on the long finger, like, because I couldn't go, he could come up every week to let you off, but for most things I found somebody would come in and sit with her, while I go to mass or things like that you know.'

Int: What about neighbours and that, would they help?

Kathleen: 'Well they would if I asked them, I said in my own mind well she doesn't know them. She wasn't a very outgoing person herself, she sort of kept herself to herself you know, and she didn't like change, she liked things around her that she knew about, so if she saw somebody coming in that she wasn't really familiar with I thought that maybe that might upset her. So I said I would stick it as long as I can and I said if I am not able I am not able, sure what could you do, you don't let strangers in on top of them. She was 96 when she died. Until the year before she died she was grand, able to get around the house, she was incontinent for a long time but I could cope with it when she was able to move about, but up until she broke her hip she never wet the bed, she

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[8] Irish Country Women's Association

wasn't able to get out of the bed. But you know we don't know what is in front of us do we.'

When Kathleen's mother's physical and mental health deteriorates she responds in accordance to her SOC, by attaching meaning to her family circumstances and deriving motivation from this meaning (meaningfulness), by putting some sort of order on an otherwise chaotic lifeworld (comprehensibility) and by drawing on her internal and external resources so that she can meet the challenges that she is confronted with (manageability).

It seems that for Kathleen providing the care her mother requires is predominantly an intrinsic, or meaningful, goal to pursue. She demonstrates an active personal commitment for something that holds an intrinsic value or intrinsic motivation, with only limited external coercion ('*I stuck it as long as I could and it broke my heart alright to see her go but you have to, you can only do what you are able to do, and that is it*'). In order to understand why providing her mother with the care she needs, and at the expense of her own quality of life, ('*I had her for a long time in a wheelchair and it wasn't easy, now in saying that if she was back again I would do the same*') it is necessary to look at the conditions that have elicited and sustained this motivation. Pursuing meaningful activities is described by Ryan, Huta and Deci (2008) as eudaimonic living and both Kathleen and Terry demonstrate this. Eudaimonic living incorporates four motivational goals. The first motivational goal is pursuing intrinsic goals for their own sake, such as love, friendship, or personal growth for example. These goals are irreducible, and are called first order goals. Acting out of love, such as taking care of a parent, spouse or child, represents the pursuance of first order goals. The second motivational goal involves behaving autonomously, volitionally or consensually. Kathleen has demonstrated immanent volition (Paton, 2014). She voluntarily took it upon herself to care for her mother as long as she was able to, despite other care options being available to her. The third motivational goal is about being mindful and aware. This could relate to the self and the other, so for example Kathleen was mindful of what she thought were her mother's preferences for living at home, and for familiarity ('*...if she saw somebody coming in that she wasn't really familiar with I thought that maybe that might upset her*'). The final motivational concept associated with eudaimonic living is the satisfaction of basic psychological needs such as competence, relatedness and autonomy. In caring for her mother Kathleen acted with both competence and autonomy.

Kathleen and Terry both demonstrate eudaimonic wellbeing in accordance with the four motivational concepts put forward by Ryan, Huta and Deci (2008). Both Kathleen and

Terry were pursuing inherent values of the first order (they were providing care from a place of love). However, it is apparent that they were overly investing themselves in order to enhance the lives of others. While this is admirable, their investment means that they are being drawn away from other aspects of eudaimonic wellbeing and living, and may not have the energy to fulfil other meaningful goals and motivations (Ryan, Huta and Deci, 2008). Yet, when their actions are unpacked using the SOC to reveal insights on their motivations they become more understandable.

To understand eudaimonia it is necessary to focus on the content and processes that determine how well one can live their life, and what this entails. Arguably this content and these processes are contextualised in a life world shaped by values, expectations, and needs. There is thus a sense of order required to make sense of the world, one's place in it, and one's relativity to others. It is here that the comprehensibility component provides an additional perspective to understand eudaimonic wellbeing. The relationship presented in Kathleen's account is a mother-daughter relationship. As an infant Kathleen's mother took care of her, and now in later life the roles are reversed and Kathleen is caring for her mother as one would care for an infant. ('*I had her in nappies [...] I was changing her two and three times a night so I was getting no sleep whatsoever [...] she would do nothing that they would tell her [...] I couldn't take my eye off her for five minutes because she thought she could get up and go*'). The mother-daughter relationship represents a continuum of mutual and reciprocal care, ordered and made comprehensible by established roles and familial principles. The continuity and adaptation discussed earlier in the chapter with relation to resilience in later life is evident in Kathleen's account. Even under stressful circumstances there is a sense of identity stability, and this manifested as a sense of duty to tend to the parent-child relationship, and carry it forward into later life. Adapting to the newly emerging relationship requires resilience, and this resilience is dependent on forming a new comprehension of the mother-daughter relationship dynamic. The intimacy and stability of the family unit, and the bond between mother and daughter, also takes on an important dimension in terms of continuity. For example the idea of '*somebody coming in that she wasn't really familiar with'* or letting *'strangers in on top of them'* might upset the stability of the family home. Despite her mother's cognitive degeneration Kathleen tried to maintain some sense of consistency for her mother in an otherwise chaotic life world, even though it made conditions more difficult for her.

Working from an intrinsically motivated place makes an individual more resilient. It is not entirely clear if Kathleen's intention to care for her mother was a purely intrinsic goal. It seems that she has an underlying concern for ontological security and was somewhat anxious about the unknown. Kathleen thus provides us with some ontological insight from the perspective of an older carer. She is aware of the fragility of life and the unpredictability of the future ('*But you know we don't know what is in front of us do we?*'). It would seem therefore that she is perhaps extrinsically motivated – by providing the necessary care for her mother she will be rewarded later on if she is faced with her own failing health. In addition to this, it is not completely clear if she was doing it entirely out of her own free will, or if it was because she felt she was the only person who was in the position to take responsibility for her mother because her siblings '*have their own families*'. If it was the case that she felt obligated to take on her mother's care it would have had a significant impact on her eudaimonic wellbeing. However, Kathleen has no regrets, and would do it all again, so this would suggest she was working predominantly from a position of intrinsic motivation. With Terry it is more clear that he was acting from a place of intrinsic motivation. As with Terry, Kathleen needed to have access to external GRRs to ensure she was not over expended in pursuing inherent values, and to make life more manageable, yet in having access to these external GRRs she still put other areas of her eudaimonic life '*on the long finger*'.

Ageing-in-place: a relational process?

There are a number of commonalities between Terry and Kathleen's experiences of providing care to their loved ones, however most fundamental to these commonalities is their motivation to support their loved one to 'age-in-place', and to form a sort of continuity of place i.e. a continuation of home as a place of intimacy, familiarity and care. Ageing-in-place has attracted a lot of attention from the policy, practice and academic communities (Andrews, 2009; Wiles, *et al*. 2012a; Wiles, *et al*. 2012b). Theoretically, geographers have used different perspectives to try to develop an understanding of ageing-in-place. Cutchin (2003:1078) for example outlines ageing-in-place as an 'ongoing process of place integration', or the ongoing 'continuity of person and place' where changes associated with ageing and later life experiences pose a significant problem for person-place integration. Cutchin (2003) is thus alluding to a persistent and *resilient* person-place relationship. In order to restore or maintain the place-person integration the (resilient) individual or group

reacts creatively to these changes and their motivation is derived from 'local, place-based values and morals' (Cutchin, 2003:1078).

Relational geographies of age are additional frameworks proposed to develop our understanding of ageing-in-place (Ziegler, 2012; Lager, *et al*., 2013; Hopkins and Pain, 2007). It is through this relational geography of age framework that the SOC can be effectively applied to understanding the relationship between health, wellbeing, place and age. A relational approach to ageing and place helps us understand the complexity of individual's interaction with the social and physical world, and how this reaction is made complex by patterns of continuity and change. This approach requires that we consider the affective bonds people have with place. It is through these bonds, or attachments to place that people often establish their sense of identity and maintain identity continuity (Ziegler, 2012). Therefore ageing-in-place may be understood as a continuation of attachment to place, as well as the continuation of the social relationships associated with those places. Importantly, relational geography applied to ageing research is not about the older person's fit or adaptation to place, but rather it is about understanding how people and places are produced in relation to each other. It is about how people give meaning to and negotiate place and its changes through social interaction, and also intersectionality with the characteristics of place and the characteristics of the individual (Lager, *et al*., 2013).

According to Findlay and McLaughlin (2005) an older person's ability to deal with the discontinuities of place is a great deal dependent on their personal characteristics, their experiences, and their histories. Here the salutogenic language of adversity and resilience can be assumed. The discontinuities of place can be recognised in salutogenic terms as a form of adversity the older person is confronted with. The personal characteristics mentioned by Findlay and McLaughlin (2005) can be attributed with the older person's SOC, shaped and developed by their personal histories and experiences intricately bound to place, and distinguished as a set of GRRs that are internally present, and externally available to them. The intersectionality between person and place is commonly focused on age, gender and class for example, but by introducing the SOC components to relational geography as points of person-place intersection further insight is provided on the affectivity of this relationship. To understand the older person's negotiation of place and its changes this relational process is recognised as dependent on the intersectionality of meaningfulness, manageability and comprehensibility. Because the person's interaction with place is in constant flux, and requires ongoing negotiation to maintain a sense of

continuity and belonging (Cutchin, 2003) the older person must consistently draw on their SOC, their understanding of the world and their place in it. Interactions with place thus become an ongoing process of meaning making. Antonovsky (1987) claimed that the SOC is both a stable psychological disposition and one that is intimately bound to the person's environment, however in appreciating relational geography's understanding of the person-place relationship, as something that undergoes continuous negotiation, it is very possible that the person's SOC is also altered by the discontinuities of place. For the resilient person change might not weaken their SOC but it might require them to re-evaluate how they view the world and their place in it. For the less resilient person however the discontinuities of place might act to undermine their internal resources such as self-esteem, deprive them of external resources, and make the world appear to be a less manageable place. It seems that while the SOC offers valuable insight on the person-place relationship to health and wellbeing, the geographic discipline, and in particular relational geography, provides salutogenic theory with some valuable theoretical insights that positively challenges some of its viewpoints.

Further to the relational geographies of age as a valuable theoretical approach for ageing research, Horschelmann (2011) provides a geographical perspective for the theorising of the unfolding of life transitions and the significance of place. It is argued that life course research privileges order and continuity rather than uncertainty and discontinuity. The latter is particularly pertinent because in later life sudden events are common such as the death of a loved one, the sudden onset of serious illness, or the need to adapt to change imposed on the older person such as having a driving licence revoked. These uncertainties are always present and such events have a profound impact on daily life and the negotiation of place. Changes to the older person's environment cannot be taken into account when life course research applies 'pathways' and 'trajectories' to understanding the person-place relationship because they imply a well-ordered, deterministic transition from one life stage to the next. This does not take into account disruptions, obstacles and uncertainties of the older person's life world experience. The notion of 'transition' in the life course needs to be revised 'to capture the complexity and non-linearity of situated lives that are always in a process of becoming' (Horschelmann, 2011:379). This complexity and non-linearity of life is evident in the empirical evidence presented in this thesis, in particular what Horschelmann (2011) refers to as 'linked lives', that is the degree to which people make decisions on their activities in relation to the 'life trajectories, needs and understandings of

others who lead their lives in connection to ours' (Horschelmann, 2011:379). This sharing of lives and its relevance to the SOC is apparent in both Kathleen and Terry's accounts, and will arise in other empirical accounts. While resilience is not mentioned in Horschelmann's (2011) discussion on life transitions, it is suggested that a biographical approach can be applied to understand why some people celebrate change, while for others change can be costly in terms of quality of life. Subsequently, a biographical approach 'can contribute significant insights to critical work on social inequality and difference (Horschelmann, 2011: 380). These observations put forward by Horschelmann (2011) have considerable relevance for the empirical data presented in this chapter, and again provides a theoretical and conceptual lead for SOC and salutogenic research into both geographies of health and ageing.

Ageing-in-place: a process of 'place identity' continuity?

Mancini and Bananno (2009) found that resilient older people used 'identity continuity' as a coping mechanism following bereavement. Identity continuity is an underlying, continued, and steadfast sense of self, or view of oneself, when experiencing significant change. Resilient older people carry their identities with them from earlier life, and this often involves bringing with them the activities or source from which they derive these identities into later life. Most likely these activities are something that older people gain self-esteem from. In Terry and Kathleen's cases identity continuity is evident and associated with the internal resource of self-esteem possibly derived from carrying out duties of care. The care they provided can be understood as a relational practice, and as a practice shaped by expectations derived from the biographical experiences of place - to provide care when in the position to do so within the intimate context of the home environment. Relational practices are subject to both continuity and change (Ziegler, 2012). With Terry and Kathleen the continuity is the maintenance of a caring relationship within the home environment, while the change refers to the role reversal of who is caring for whom. However, continuity of such activities is not always a positive thing, particularly if these activities require the individual to be heavily invested in them at the expense of seeking fulfilment from something less demanding. Resilience in later life is about being able to adapt and move onto the next developmental stage of life. This may be hindered by continuity especially if the person has unrealistic expectations of themselves and their abilities. Later in this chapter Kay, Mag and Doug will be introduced and their activities will be explored as positive

sources of identity continuity, crucial in positioning them within family and community life, and providing them with status and purpose, all of which are essential to psychological wellbeing.

SOC and continuity appear to be closely related, because they both pertain to the individual and both the SOC and continuity are affected by context or place. Moving onto the next developmental stage of life will often take place in the same spaces of earlier life, such as the home, the neighbourhood and the community, where relational practices are understood in terms of the biographical experience of place. Therefore, to understand identity continuity, and its relationship to health and wellbeing, adequate attention must be paid to place. Relph for example (1976) recognised that identity is generated through an individual's relationship with place. Later Buttimer (1980) expanded on this suggesting that identity is often bound up in the activities that take place in and around the home for example, or other meaningful sites, and it is through this that 'place identity' is formed. Place she argues is essential to the formation of personal identity and wellbeing through the activities performed there. Like geographers, environmental psychologists also agree that personal identity is often based on the individual's cognition of the physical world in which they conduct their lives. At the core of this is the view that individual's 'environmental past' influences cognitive elements such as memory, feeling, attitude, and behaviour. Through autobiographical memory emotional bonds with place contributes to both sense of self and identity (Addis and Tippett, 2008; Damasio, 1999). This autobiographical memory has biopsychosocial relevance because it relates to subjective coherence and continuity (Markowitsch and Welzer, 2009). In bringing together the individual's experience of place, their environmental past, and how these shape identity, sense of self and continuity, and by exploring it using the SOC, some progress can be made in linking together these elements to produce an understanding of the person-world relationship, health and wellbeing.

Ageing-in-place after death – continuity versus finality

With Terry and Kathleen the continuity of place and its relationships are dependent on their ability and willingness to support their loved ones to continue to live at home despite their declining health. For others however this form of continuity is not possible because of the deaths of loved ones. Indeed, rather than a discontinuity of place, there is an exact finality to the tangibility of the phenomenal place, and such places subsequently become peopled by memories, and gain a sort of spiritual significance. This spiritual significance can be

beneficial for the older person as they negotiate the home environment following the deaths of those they once shared the intimacy of that environment with. Taking comfort from positive memories of deceased loved ones is recognised as an important resilience factor (Bonanno *et al.*, 2002; Bonanno *et al.*, 2004; Mancini and Bonannno, 2009). Internalised representation (attachment theory) of the deceased is an adaptive process that contributes to resiliency (Mancini and Bonannno, 2009). For some death is followed by a complete absence, while for others death is not an end of their presence, or their disappearance, but rather their incarnation in states and forms other than living flesh (Derrida, 1994, cited in Wylie, 2009), where these states and forms are present in, and experienced through, the landscape. For Rose (2006) the individual interacts with the landscape through their inclinations, sensations, and responses to what is present, or what they imagine to be present. Through contact, immersion and immediacy of experiences the self and landscape become one, representing a phenomenological collapse of the self and the world they experience (Rose, 2006; Wylie, 2009). In his work on the memorial benches at Mullion Cove, Wylie (2009) considers how absence and presence of the deceased can co-exist in the same landscape. The accounts used here also demonstrate this 'absent yet present' (Wylie, 2009: 282) tension in trying to comprehend the landscape of the home environment and how it is experienced.

This notion of 'absent yet present' in the landscape is an important lens through which to consider the older person's experiences of home as a health-buffering environment. The home can become a place of both remembered and imagined relationships with absent people. These relationships, which were once real but take the form of memory and imagination, can be understood in terms of the SOC. Through memory and imagination the absent person is made present, and this restores the home environment. In terms of the SOC, and in particular the comprehensibility component, this blurring of absence and presence in the landscape of the home acts to re-order the home and its environs and to emotionally un-do the death or absence of the loved one. Comprehensibility is about being able to put order on to the chaos of life. The death of a loved one, especially someone so central to daily life, brings instability. Through an ongoing relationship with place, however it is imagined or perceived, life can once again be ordered. For older people life can become unstable very quickly because of failing health and loss, however through the familiarity of affective places they might find a sense of continuity and stability.

The meaning attached to place is often shared. For instance Kay and her husband Jimmy bought their home after retirement (like Terry and Cathy), but her husband Jimmy died soon afterwards. Sadly for Kay and Jimmy their new home was the beginning of a new phase of their life, but a phase that they did not experience together for very long. Kay's life became disordered after her husband's unexpected death, and the meaning she attached to her new home was bound up in a life she and her husband had planned together. Following the death of her husband Kay continued to feel Jimmy's presence in their home, and often behaved as if he was still physically present. This gave Kay some sense of continuity:

Int: Do you find it lonely living on your own?
Kay: Sometimes you would yes, especially in the winter. I don't like to be out of my own house though. I haven't been up to Margaret in Dublin in years. She got tired asking me. I would have to come home again. After [my husband] died I would come back here, and nobody here, and still, now this is airy fairy, I used to feel a presence in the house. That is the way I felt that there was a presence here and so once I got in and shut the door after me I was happy. Now that might be airy fairy, and I don't know if anybody would ever feel that but that is the way I felt. I thought that Jimmy was there when I came back, in a good way, in a happy way. That is my experience now.

By continuing to feel the presence of her husband Kay controlled the feelings of loneliness. Indeed when she left the house for a number of days she missed his presence. Coming home to the familiarity of her house and to her husband's presence was comforting. Similarly Alf felt his wife's continued presence in his home, and in some ways he continued to relate to the spaces of the home as if she was still physically present.

Alf: 'She is everywhere I look. I don't mean physically, [laughs].

Alf: 'She was very healthy. She had two of the babies here in the house. The first baby was born in Holles Street. So this house has been very important to me. No one ever lived in this house other than us. The lads said to me to move out, live with them, but I will live here until I die. All the family lived and grew up here. They all got married out of here. I am not leaving it. I will stay here until I die. When I broke my leg I couldn't do anything and they got a home help for me for a couple of years and they were very good but I got tired of it. I wanted to be independent. I didn't know how to cook when Bridie died. Well, I learned when she got sick. I cook a fairly nice meal for myself. I have sirloin steak for today.'

The 'absent yet present' experience, or the co-presence of death and life, as described by Wiley (2009: 282) is evident in Kay and Alf's accounts. This can be understood as a desire for continuity, in order to buffer against the risks posed by substantial change in later life.

The home is a space where an individual's identity and sense of belonging intersects, and these elements of affective spaces often have an important interrelational component. This is particularly the case with older people who have ordered their lives relative to the intimate meaningful relationships experienced in the family home. According to Blunt and Varley (2004:3) 'the home is invested with meanings, emotions, experiences and relationships that lie at the heart of human life'. While these are evident in Alf's account the true meaning of the home environment is articulated through the memories it holds of his wife. The home is infused with meaning and this meaning comes from the belief that she is still present with him. Because Alf believes that his wife is still present he maintains his identity as the husband and she his wife, and thus maintaining his understanding of his place in the world. Through his wife's continued memory he does not see the world or his place in it entirely differently than before her death. Her absence is not experienced as loneliness as such, and is quite similar to Kay's account of experiencing the home environment following her husband's death.

Kay and Alf's relationship with their home environments, as a place where they find comfort, solace and familiarity, and becomes subsequently bound up in their wellbeing, may be understood as a sort of imaginative therapeutic landscape of the mind (DeVerteuil and Andrews, 2007; Gestaldo *et al.,* 2004). But rather then retreating into their minds, Kay and Alf are projecting onto their homes, through the use of imagination and memory, a sort of continuity in how they relate to the space. This continuity is formed from a sense of familiarity imbued by resurrecting their dead loved ones mentally and re-placing them where they deem them to belong, in the home they shared. Willis (2009) expressed concern that places conceptualised as therapeutic landscapes were used to palliate rather than to heal, this is evident in both Kay and Alf's case. While they know their partners have died they are not fully letting go, and they attempt to manage their emotions through their relationships with place, by holding onto a version of home that was familiar and comfortable to them. Gestaldo *et al.* (2004: 157) proposed that the therapeutic landscapes concept can be extended to include the personalised mental strategies that people use to cope in times of change, and that 'everyday and personalised place-related memories' should be included in its conceptualisation. Kay and Alf's accounts certainly compound this proposal. The SOC can be applied to consider how holding onto the presence of a deceased loved one, and building an imaginative therapeutic landscape peopled by the deceased, represents a coping mechanism to achieve a health buffering effect. If this notion of an imaginative therapeutic

landscape of the mind is considered through the lens of the SOC components it is possible to make sense of such a strategy. The home is a place where an individual can exert considerable control and agency, it is also where they can put order on their lives, a place they can identify exclusively with and be identified by, these attributes of the home may intensify with time. In other words we achieve to some extent a sense of comprehension through engaging with the spaces of the home. Importantly the people the home is shared with are significant to this comprehension and in their absence the order of the life world is interrupted. Thus by maintaining their presence imaginatively, or through 'everyday and personalised place-related memories' the individual's SOC is protected to some extent.

Ageing-in-Place: Home as a place of activity continuity and self-determination

According to Blunt and Varley (2004:3) the home lies at the heart of human life. It is for this reason that the transitions associated with later life and the related uncertainty of being able to remain living at homes intensifies the older person's relationship with that space. For example some older people's immobility might mean that the scale of their entire world is reduced to the immediacy of the physical spaces of their home. For other older people the threat of having to leave their home because of failing health is a difficult prospect to think about, yet remember Kathleen's statement *'But you know we don't know what is in front of us do we.'* Millie reiterated many times during our meeting that she dreaded the thoughts of possibly one day not being able to live at home any longer:

> *Millie: If it came to it, and I couldn't look after myself I wouldn't have much choice but to go into a nursing home.* […]
> *Millie: I think I would have to be pretty bad to leave my home. I find that people go down hill once they go in.* […]
> *Int: Do you think that place, or more specifically your home is important then?*
> *Millie: Well of course it is. It really is really important, because if you are in a place that you are not happy in, it takes the good out of you. And some places are more peaceful than others.*

Home is a central site for promoting and maintaining older people's sense of continuity and self-determination, that is the continuity of having access to a shared family space through which emotional needs such as belonging and intimacy are met. As well as this the home provides the older person (indeed people of all ages) with opportunities for self-determinism through the freedom, autonomy and independence that can be found there (Blunt and Dowling, 2006). When older people are no longer able to continue to live at home,

continuity and self-determinacy is interrupted, and it is perhaps this that leads people to '*go down hill*'. Matt has similar feelings about the home environment as place for wellbeing maintenance:

> Matt: '*I know my son-in-law's mother is ten years older than me but what is life in a nursing home? I hope I never go into one. My brother was in one in Carlow and he was fairly well looked after. But you are only sitting there marking time until they give you the shout [God]. What else is it? I know I could say the same here now, but that's the way from the day we are born.*'

For Matt the life that is absent from the nursing home is that afforded to those who are able to be in the middle of the activities and energies of the family space, peopled by younger generations of sons, daughters and grandchildren, and having access to wider community life. Being part of family life is a significant part of Matt's identity, and it is through family life he gains considerable self-esteem, he is both needed and active in contributing to the activities of the family. However, Matt is speaking as someone who describes his health as '*apart from a few aches and pains, excellent*', for other older people who are experiencing serious illness and disability remaining in the family space of the home is often not possible and a nursing home is their only option. For others they might not have access to an intergenerational family life for numerous reasons.

This state of displacement from home can be likened to domicide. Domicide was proposed by Porteous and Smith (2001) to describe the discontinuation, or destruction, of home as a phenomenal place, and an important site offering sense of place identity and sense of self by experiencing the spaces of home in terms of attachment, rootedness, memory and nostalgia. These same feelings for home are also experienced by the older person if they feel they have no other choice but to move out of their home due to failing health. Institutionalisation of older people can be understood in salutogenic terms as the outcome of resistance deficits, such as physical or mental impairment, an unsafe environment or isolation, exceeding adequate resistance resources to aid the older person to age in place, such as access to practical care and a supportive environment. The positive effects of the home environment, when sufficient resistance resources are available, appears to meet the requirements of the SOC – meaningful relationships are established there, as is a sense of self in the world, and self-esteem. Arguably when an individual has to leave their home out of necessity rather than choice their SOC may be undermined because their

attachment to place is dismantled (meaningfulness), their sense of security and ownership is removed, as is their freedom to engage in the activities of the spaces of home (manageability – access to both internal and external resources), and also their sense of identity and the ability to locate themselves within a social network of family and community life bounded by place is eroded (comprehensibility) (Porteous and Smith, 2001). The elements of eudaimonic wellbeing is present in this understanding of the affective power of home, and when Millie claims that people '*go down hill once they go in*' she is referring to a form of domicide that can be interpreted as a process that destabilises the SOC and weakens it ('*it takes the good out of you*').

According to Rowles (1983), older people's identity and place are bound by 'autobiographical insidedness', and through ageing-in-place the older person can sustain their personal sense of self, and this helps them to adapt to old age. The home he considers to be an extension of the personality, a site of social integration and also a site of multigenerational social order. In the following account we meet Kay. Kay lives on her own but her adult children and grandchildren regularly drop into her and she makes them dinner. There has been an on-going arrangement that her teenage grandchildren who attend the secondary school close to her home will go to their grandmother's house until their parents return from work, and Kay makes them all dinner. This practice has been the case for a number of years and represents a continuation of her role in the family structure. It is a role Kay values a lot because she was a housewife throughout her adult life and was responsible for daily home-making practices such as cooking, cleaning and childrearing. Now in later life she has continued to participate in these same roles:

> *Kay: I make cakes at Christmas and I say to the lads I'm not making them cakes and then it comes to November and no body is making a stir to do anything and I think how would you face Christmas with no cakes or no puddings. So I start then and once I make the first one I am on my way to Christmas. It is stupid I would say they wouldn't care if they never saw a cake either way.*
> *Int: But it is nice to keep the tradition up*
> *Kay: Well I will always make them anyway. You know on a really cold day I love a dinner. Nothing fancy, just a stew or something, and I would have the lads coming in from school and I make the dinner for them, they might not even want it but it keeps my brain going.*

Again, the elements of eudaimonic wellbeing are evident here, Kay is working volitionally to sustain purpose in life and to carry forward meaningful goals and values into later life.

According to continuity theory (Atchley, 1999) people need mental frameworks to organise and interpret the world and their experiences of it. Possibly one of Kay's central mental frameworks that she applies in organising her world is her identity as first and foremost a homemaker, and subsequent to this identity as wife (but now widowed), mother, and grandmother. It is through this identity she can establish her sense of self, and personal goals, and these are grounded in the environment of the home. It is also through this identity that she maintains a sort of status within the family unit and her role in the family is valued. The evidence of this is found not in how she has articulated this identity but rather by her actions, maintaining her role as homemaker. People spend time investing in their conceptions of themselves, the world around them, and their place in it. It is through self-awareness that this investment is guided and directed – the individual will continue to invest in activities that are meaningful and valued. In relation to salutogenic theory when an individual's role is valued, and through this role they achieve status, the world is more comprehensible to them (Atchley, 1999). People respond to life experiences and actively develop individualised personal constructs (Atchley, 1999). These personal constructs shape how the person thinks of themselves in the world, their relationship with others and their personal lifestyle. Personal constructs can also be understood in terms of autobiographical insidedness (Rowles, 1983). Atchley (1999) found that if the desire for continuity is not fulfilled, for example because of ill health associated with ageing, mental health may also deteriorate, potentially resulting in depressive disorders.

Ageing-in-place: Self-determinism, attitude and the SOC

For the resilient older person the ability to adapt to changes often requires a positive attitude, and it is here that the stoicism of salutogenic theory becomes apparent. In Chapter Four individualism of salutogenic theory was explored, concluding that the SOC emphasised the role of individual attitude and personality as a strong predictor of resilience and subsequently health, wellbeing and quality of life. The next three accounts provide some insight on attitudinal resilience and its contribution to healthy ageing. Mag is almost 91 and lives with her adult children and grandchildren. She plays a very active role in contributing to family life, and from this role she believes she maintains her wellbeing. Alf is almost 96 and has experienced many serious illnesses but pulled through each time and managed to continue to live an independent and fulfilled life and has continued to achieve the goals he has set for himself. Doug is 93 and has been registered blind for 30 years, yet despite this has continued to live at home, pursue his interests and lead a productive life as a horticulturist.

Mag is extremely active and independent. She recently travelled alone to America for a holiday and to visit relations. She was recommended for the research project during an interview with a community development worker as someone who had an incredibly positive attitude towards life, and great confidence in her ability to do anything:

> *Jack: 'The level of trust and the confidence she had in herself* [to travel alone to America] *says a lot. People like that would inspire you to take on more, not to be afraid. She is a very good example. The level of courage that she has, and the level of trust that she have in herself and her own ability and the level of faith that she has would be absolutely excellent. A very very strong lady.'*

Mag is a very good example of an older person who has carried forward a resilient personality into later life. She demonstrates this resilience as self-belief and having a get-up-and-go attitude:

> *Mag: 'Well I never thought of it* [getting older] *for a long time, you would never think of it, just keep going, eventually you know yourself you're slowing down. You won't do things this year as easily as you did last year. You feel you're going down. But I never thought much about it I just kept going* (laughing)*. I keep going. I keep going. I do what I can* […] *But then if I wasn't well, I would go as much as I could but I would try not to over do it now. If I did feel tired or anything I wouldn't, and as they say keep going as long as you can. Sure I would do it out of spite if nothing else* [laughs]*.'*

Int: 'Nothing will hold you back.'

Mag: 'Not at all. I would chance anything. There are four of us here now and we play cards every Wednesday night going back for a number of years, maybe 30 years. There are four of us, so four different houses, here one week and then three others, we rotate around every Wednesday night. I would always be looking forward to that. Now when the weather was so bad we haven't had it. We will leave it for another couple of weeks before we try it again between the roads and the weather and everything. But things like that keep you going. I have friends up the road and I call up there usually once a week […] Yes keeping out, and keeping going. I go up and down the avenue everyday, as far as the road, a couple of times a day for a walk. You have to keep going, and keep in contact with what is going on. Don't pass up what is going on today. Join in. Be there if they want you. If you think they [the younger generations] *are going off the rails altogether call them back. They wont listen to you* [laughing] *but sure say something and maybe they will think of it sometime […] Well I have been told that that is what it is* [keeping her active and healthy]. *I was down in Wexford with my sister and we were talking about what I do be doing, and the youngsters were here still going to school and I would be bringing them home from school and I would be here with them, and sometimes they would be in different schools and picking them up at different times and I would be on the road along, like that, a kind of taxi service I think I am running, only I don't get paid for it. And my sister said you know that is what is keeping you the way you are because if you were at home doing nothing you wouldn't be half as well.'*

Int: 'And do you think it is true?'

Mag: 'I do think it is. I see people and they would be at home and they wouldn't be half as well. I even see [daughter-in-law's] *mother here and she is in town and she has nothing to do, and she is there, herself and the father and they have nothing to do only look at one another all day long. She didn't keep out, she didn't keep going, and she was active. If you don't keep out and keep going, if you're any length at all in you hate going out.'*

Int: 'You would kind of go into yourself?'

Mag: 'You would yes. It's important to keep out and keep going as well as you can. You wouldn't be a whole lot of use to anybody but still you're there. I would be no good to organise something but if there was anyone to do it I would help and I would like to be doing them things […] well you see I have the time to do anything that is wanted. If it's wanted I could go anytime any day any hour, well most anyway.'

Int: 'Do you like being asked to do things?'

Mag: 'I would, I would like to be asked. If I could at all whatever it would be I would do it. Well I would try it anyway, and if I failed sure what harm (laughs) […] *They tell me I am like the battery, ever ready.'*

For Mag being able to continue to situate herself in the collective as both a purposeful and engaged participant of family life appears to be a significant motivation for her ('*I would like to be asked. If I could at all whatever it would be I would do it. Well I would try it anyway, and if I failed sure what harm* [laughs] *They tell me I am like the battery, ever*

ready'). While the activities of family life are meaningful to her and indeed she appears to make a significant contribution to family life, Mag also maintains her own network of friends outside of the family. Her weekly card games, attending prayer meetings and adoration services in local parish churches, and also attending the local social club are all important social outlets for Mag (*'Don't pass up what is going on today. Join in'.)* Being motivated to stay active, as Mag has demonstrated, is a good example of a resilient personality, and is an indication of a high SOC. She has constructed her lifeworld so that she can see the range of potential it has to offer, and has determined how she can continue to engage with it (Antonovsky, 1987: 144), and locate herself socially and instrumentally. Mag is determined to maintain her engagement with the lifeworld (*'I would chance anything'*) while at the same time she is aware of her limitations *('But then if I wasn't well, I would go as much as I could but I would try not to over do it now').* The elements are present for each of the SOC components. The activities she engages in are meaningful and make sense emotionally to her in that they are contributing to her overall health and wellbeing (*'I see people and they would be at home* [doing nothing] *and they wouldn't be half as well').* Her activities, even though she is kept very busy (*'a kind of taxi service I think I am running')*, are central parts of family life because much of her energies are focused on rearing grandchildren, bringing them to and from school and preparing their meals. Mag's level of physical health is certainly an advantage to maintaining her activity levels. Further to her personal (internal) resources of physical and mental resilience, her positive attitude, confidence and ability to cope with the changes of later life largely reflect her external environment. She is afforded with the opportunities to play cards for instance because she has an established network of friends going back 30 years with whom she plays. She has a family that both need and want her input into family life (*'Be there if they want you')*. She also lives in a local community that makes a considerable effort to provide social outlets for its older members, and she actively participates in many of these.

According to Antonovsky (1987) the confidence that one establishes is a reflection of the quality of the external environment, which can be understood as the quality of immediate family life and relationships (respectful and loving), the home environment (comfortable and adequate), or the focus extended more broadly to incorporate community and societal environments (older people are both respected and valued). The theory of salutogenesis argues that the person with the stronger SOC can transform potential reality into actuality by making use of accessible resources (Antonovsky, 1987). The SOC can be

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understood therefore as a behavioural response that has both a history and a future that strongly reflects the quality of the external environment. The history refers to the development of the SOC in response to the individual's experiences of the lifeworld, and its quality. The future refers to the individual's behavioural response to challenges and the ability to adapt or cope. Arguably Mag's positive attitude has developed gradually over the life course knowing that she has a supportive family, and a respectful community that can be relied on in a crisis:

> Mag: '*You know you have a back up, you are not on your own, you have a back up if you wanted anything* […] *It is very important* [to be able to rely on the community for help]'.

From this she has gained an ontological security that has positively contributed to her wellbeing. This reading of an empirical case through the analytical lens of the SOC recognises the importance of context in shaping behaviour and attitudinal development. Theoretically the SOC is socio-structural in nature, recognising that each individual is born and raised in a socio-cultural context. This context provides both opportunities for 'successful ontogenetic development', but it can also impede it (Wiesmann and Hannich, 2014: 340). Experiencing life within a socio-structural context means that the individual will be continuously bombarded with experiences of generalised resistance deficits ranging from poverty and inequality to crime to pollution. These threats to wellbeing may be buffered by experiences of generalised resistance resources ranging from feelings of belonging and having access to supportive relationships, to a clean and safe neighbourhood environment. These experiences shape the SOC over the life course. If the individual experiences more deficits than resources the result is a weakened SOC, ineffective coping and adaptation skills, including attitude formation, and the result will likely be poorer health and wellbeing (Antonovsky, 1987; 1996). For Mag, while she has had her share of difficulties losing both her husband and a son to sudden illness, and of course the various stressors that naturally occur daily throughout life, her positive attitude may be attributed to a life that has had more resources than deficits. Throughout the life review Mag seemed content with the life she has had. In particular the quality of her relationships and community life:

> Mag: '*[It is good] that people would stay in contact with each other, and look out for each other, that they would notice and give help if they could. Visit people, call on people or ring people or some way communicate with them, and*

any little bit of help that you could give them. Some of them [younger generation] *would be very good. Some of them would be very thoughtful, more of them couldn't care less. I see all the little ones up there in the primary school they would be all there ready to talk to ya. Say a cheery word to ya. There is a great youth club up here now and they are very good to the older people.'*

While Mag demonstrates a resilient personality, an indicator of her internal environment, the role of the external environment and the quality of family and community cannot be ignored.

Both Alf and Doug have experienced serious illness and disability during the last few decades. Despite the adversity they faced they both believe that it is because of their positive attitude and self-determination that their quality of life has not suffered. The following is an extract from Alf's interview. Alf lives alone in south inner city Dublin. Two aspects of Alf's character emerge from his interview, firstly, Alf is a very determined individual and secondly, this determination may have contributed to his recovery from several episodes of serious illness.

Alf: We got married and the children came along, We had three kids. We are a very happy family. We had a happy marriage, we had our ups and downs. We were married over 50 years when Bridie died […] *All the rest of my family are dead. My brothers died from the cigarettes. I was a heavy pipe-smoker until the 1980s. Bridie said you'd never give up the smoking, and I said I would, so the next day I put the pipe down and didn't pick it up again. I wanted to prove to my wife I could do it. I smoked for 30 years, and just like that I stopped. I am very determined to do anything. I started smoking when I was about 18.*
Int: Did it affect your health?
Alf: It did. I gave up the smoking in the 80s and in the 90s I got cancer of the throat and mouth. Even though I had stopped I said it was the pipe that had done it. My own doctor in Guinness', they have a health department, said there is something wrong with your throat and that he would send me up to James'[9], so they did a biopsy and said it was cancer in the mouth and there was a big ring and he said you would end up with a hole in your mouth, and I went to St. Lukes'[10] and had radiotherapy, 25 sessions, it's very hard on your body it burns you. I didn't get the hole it was sealed off. I always had a bit of trouble with my mouth. Four years later it broke out again, this time on my nose and the back of my eye on the left-hand side. The doctor in Guinness' said they thought I had a growth in my nose because I couldn't breathe, and sent me to hospital and there they told me I was a cancer patient, so they said they couldn't operate on my cancer. So I had another session. [Having the cancer twice] *was very hard on me, oh they are very good in the hospital. I got over that and in the meanwhile I*

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[9] Local acute hospital
[10] Dublin hospital specialising in cancer treatment

had a heart attack and I was carted off to the hospital and they thought I was going to die. I got over that again anyway.

Int: You have overcome three serious health problems, how did you do it?

Alf: In my mind I knew I was going to get better, I didn't see myself dying or anything. I got a bad dose of pneumonia in 2004 and I was carted off to St James' Hospital and I was very bad again and a nurse came into me to say she had bad news that I had got the superbug MRSA. So I probably got it there, and I had to go off and be put into an isolation ward by myself, so I nearly died with that. I was a long time there. I didn't know at the time, but my family were told it was touch and go. My eldest daughter asked me did I mind dying, and I didn't, you have to die sometime and I didn't mind going. A surgeon came in one day, and I asked him what is wrong with me and he said you are very sick, you have Septicaemia, and they had given me a lot of drugs, and I asked him am I going to get better and he said to me I don't know I am not a prophet. I said to him you might not be a prophet but you are a very clever man, a professor and you have a class standing around you listening to you, you must have some idea. Well he said to me there are four drugs, we will try the two first, if they don't work we will try the others, and that's it. So it worked.

Int: Do you think that because you thought at the time you were not going to die...

Alf: I think it has a lot to do with the mind, I think it has a lot to do with your mind. I think in life if you set yourself to do anything, you can do anything. I always say to myself if nobody else can do it I can do it. If you put your mind to it you will get what you want. You might not be able to get the direct road but you might have to go around to get on the road. Well, I didn't think I was going to die anyway, or I didn't mind if I did die. I was in a bad way when I came out of it. I was only getting over all that when I fell in the street and broke my hip, so I was back into hospital and I am on a stick ever since, but I am well able to get around, I still drive. I learned to walk on crutches and then I was down to only one crutch.

Int: So who was taking care of you through all this?

Alf: The social worker had a hand in it. But other than that no one. The family might drop in but, sometimes they would and sometime they wouldn't, and sometimes I would tell them to go on home. I have to come at it on my own you know. The district nurse was very good, they used to come in to me. I got on grand here myself. I used to drive up and down the street until I got going. And I am still driving and I am nearly 96.'

Physical decline is a common aspect of normal ageing, whereby the older person experiences several episodes of ill health in different measures of severity during their later years. Such challenges are however very often experienced in terms of inner strength, growth and personal development, and signify a coexistence of gains and losses (Nygren, Nyberg and Lundman, 2007). The coexistence of gains and losses may provide the older person with the opportunity to transcend the physical decline and limitations of later life, and continue on a path of self-development (Tornstam, 2005). In order to recognise self-

development as a potentiality in later life it is necessary to consider both the continuities and discontinuities of ageing as a type of developmental process that requires the older person to respond (Tornstam, 2005; Horschelmann, 2011). According to salutogenic theory how people will respond to such challenges will be determined by the strength of their SOC relative to the appropriate component and how they view the stressor (Antonovsky, 1987). Alf demonstrates a resilient response to the challenges of ill health, and is perhaps a personification of the definitional successful ager (Wiles *et al.*, 2012b), demonstrating endurance, perseverance, personality characteristics that support and encourage adaptation, and has positively moved through the ageing process despite significant adversity (Wagnild, 2003). He demonstrates endurance and perseverance in terms of the number of serious illnesses he faced and overcame ('*had radiotherapy, 25 sessions, it's very hard on your body it burns you [...] (having the cancer twice) was very hard on me, oh they are very good in the hospital. I got over that and in the meanwhile I had a heart attack and I was carted off to the hospital and they thought I was going to die. I got over that again anyway [...] a bad dose of pneumonia [...] had got the superbug MRSA [...] so I nearly died with that [...] he said you are very sick, you have Septicaemia [...] I was in a bad way when I came out of it. I was only getting over all that when I fell in the street and broke my hip'*). The ability to endure serious illness and recover, is in Alf's opinion, largely down to his attitude ('*I am very determined to do anything [...] In my mind I knew I was going to get better, I didn't see myself dying or anything [...] daughter asked me did I mind dying, and I didn't, you have to die sometime and I didn't mind going [...] I think it has a lot to do with the mind, I think it has a lot to do with your mind. I think in life if you set yourself to do anything, you can do anything. I always say to myself if nobody else can do it I can do it. If you put your mind to it you will get what you want. You might not be able to get the direct road but you might have to go around to get on the road).*

Studies on health outcomes have indeed found that a resilient personality such as Alf's is a strong predictor of a positive patient outcome with serious illness (Reich and Schotzberg, 2012). Self-reliance was also important to Alf and he was very determined to get on with his life with as little support as possible after his set backs ('*The family might drop in but, sometimes they would and sometime they wouldn't, and sometimes I would tell them to go on home. I have to come at it on my own you know').* Alf had a strong perception of his capacity and personal effectiveness to make things happen, and this was an important factor in terms of personal continuity, and personal development and adaptation to change

in later life. This was also a reflection of the strength of his SOC and the positive outcomes that resulted. It is through his perception of the world, the belief that anything is possible if you put your mind to it, and his personal appraisal of being able to do things that others cannot, that Alf has responded to his experiences of ill health positively. Alf has articulated very well 'the global orientation' of salutogenic theory and the SOC whereby he expresses confidence in both his internal and external environments in terms of having access to the resources that are required to meet the demands posed by his physical health. Additionally, these demands are 'worthy of investment' (Antonovsky, 1987: 19). It is evident from Alf's account that his return to self-reliance and to reinstate his personal agency and independence is worthy of investment, and it is from this that he takes his motivation. Unlike Mag Alf is much more inward looking and looks to his internal environment for the strength he needs to face his challenges.

Alf makes several references to the health care system and its effectiveness as an external GRR in supporting his recovery ('*The district nurse was very good, they used to come in to me*') so his account is not void of the institutional structures that have contributed to his recovery, thus providing a structural context that is often missing in the other participants' accounts. Indeed references to the health care system across the other participants' life reviews was not significant, mainly because their contact with the system was for the treatment of acute illnesses and injuries, or for preventative care, in particular preventative medications for cardiovascular health.

Antonovsky (1987) refers to the predictability of the outcome of the stressor. For the doctors treating Alf it was not always certain that he was going to recover from his illnesses; his doctor claimed not to be a prophet when asked about a prognosis. Antonovsky uses 'predictability' (Antonovsky, 1987: 19) as a factor of the SOC. It could be argued however that life is not predictable enough for predictability to qualify as an indicator of the strength of an individual's SOC, but rather the belief that whatever the outcome the individual can deal with it, thereby expressing neutrality or even optimism. Expressing neutrality or optimism about something as final as death for example is a form of resilience and indicates the interrelatedness of spirituality and psychosocial wellbeing (Nakashima and Canda, 2005). Alf was optimistic about the future even if that future was ultimately his death. This resilience can be attributed to his spirituality, something that is very important to him throughout his life. He didn't mind dying because he had faith in God and through Him the promise of the next life:

> *Alf: 'Oh it's* [religion] *very important I think. I go to mass in the mornings, and that is the most important thing I have done for the day. That's my insurance for the next life, this life is not important. It is only a forerunner to the next life.'*

To use the notion of predictability here to describe Alf's resilience, the unpredictability of this life is offset by his perceived predictability of the next life. In this way Alf experiences his life in a meaningful way and it is also made comprehensible because it is organised and understood in relation to a higher power. Nygren, Norberg and Lundman (2007) recognise the feeling of connection, or being in someway part of a bigger whole, including a relationship with God, as an important source of inner strength in resilient older people. Spirituality as a predictor of resilience and wellbeing, and its significance for the SOC is discussed in more detail in Chapter Nine.

Ageing-in-place with disability: positive attitude and family support

Doug also demonstrates the resilient characteristics of having a positive attitude, self-determination, and desire for personal agency such as those evident in Alf's account. While Alf demonstrated these characteristics when faced with serious illness, Doug demonstrated resilience in coping with disability. Much like Mag, Doug's strong SOC evident in his account can perhaps be explained by the quality of his social environment. In particular the quality of relationships in the family home, and the opportunities for continued engagement with the activities he valued in earlier life afforded to him by his adult children. Doug had been blind for almost 30 years, yet continued to live an active life with the support of his family. Doug was 93-years-old when the interview took place. He lived in the rural countryside in the South East of Ireland with his then 82-year-old wife Maeve. Maeve was also interviewed and her account provided a good deal of additional insight on Doug's attitude to life, and its effect on her. Indeed, much of Maeve's account refers to Doug specifically, and even when asked about herself she answered using Doug as her main point of reference. For example in asking about her social networks in the local community, she replied:

> *Maeve: 'Oh yes, but again Doug would be very lonely at times, and at the drop of a hat he is back in Africa, he can get, I don't know, when the weather was so bad, I suppose you couldn't call it depression but he would be kind of lonely and as I say a lot of the people of his age there are not many of them around. A lot of the people that worked* [with him] *would appear up occasionally. But most of them are all dead. It is hard. It is hard.'*

Answering the questions using Doug's experiences made it difficult to find out about Maeve's own life as an individual. However her account provided good detail on Doug's daily life, his activities, his character and living with his disability. In conducting the life review with Doug he was keener to share his stories of living with his family in Africa than answer the questions of the life review. According to Maeve '*at the drop of a hat he is back in Africa*'. The reflective diary entry also proved useful here to provide insight on Doug's resilience.

After studying Agricultural Science at university he moved with his wife to Africa, where their children were born. The time they spent in Africa was a defining period in Doug's life, he remarked '*probably if I were still a bachelor I would still be in Africa*'. A lasting influence of this period in Doug's life is how it has shaped his attitude, particularly his appreciation for what he has in life and his optimism. It is this attitude he believes that has been a significant factor in contributing to his wellbeing at 93. Maeve describes Doug as being '*quite happy in himself*' despite his disability:

> Maeve: '*Doug propagates plants outside and he can see very little really, but he knows by the feel. I could come in and sit there and he wouldn't know that I did. He wouldn't know that it was me. He would know my hair now. He doesn't like being helped at times you know. He would go up to Communion and he would come down and turn into the wrong seat. He is quite happy in himself he is not the worrying type, whereas I am*'.

Doug confirmed that worrying was not in his nature:

> Doug: '*I have always had a very casual attitude towards worrying about things I can do nothing about. If you can't do anything about it what the hell is the point worrying about it, and so many people worry about things.*'

Even when their home was burgled and many of their belongings stolen Doug was not fazed:

> Maeve: '*It was frightening. I don't think it worried Doug.*'

Doug believed his optimism was a significant factor influencing his health and wellbeing throughout his life, an observation that has been verified by much research in positive psychology (Seligman, 2011). Worrying in his opinion was not worth investing energy in. There was however an interesting dynamic in Maeve and Doug's relationship shaped by Doug's optimism and carefree mentality also emerged. For Doug his optimism and his '*casual attitude towards worrying*' represented, in salutogenic terms, an internal resistance

resource. Doug believed it was a strong factor in determining his health and wellbeing, however for Maeve her husband's optimism acted in some ways as a stressor for her.

> *Maeve: You heard my husband say, you know I don't think he worried about anything very much.*
> *Int: Do you think it was to his advantage then?*
> *Maeve: it was I suppose but I did a lot of worrying then.*
> *Int: So you took on the worrying then?*
> *Maeve: Yes I suppose in ways. He didn't worry about money even. If the money was there he spent it. Oh he had insurance taken out and that, but he was happy go lucky about money.*

Maeve considered herself to be a natural worrier, and she attributed this to being a woman, according to her '*women worry more than men*'. However Maeve's cousin Mary, like Doug, was not a worrier despite knowing the uncertainties of life having experienced serious illness when she contracted TB in her youth. Maeve attributed Mary's positive attitude to her health:

> *Maeve: 'She* [her cousin] *was happy go lucky, not a thing in the world worried her, not a thing. She is 80 now, not a thing worries her, she takes no tablets for anything, and her hair is the colour of yours* [brown]*, no grey, and she is as happy as Larry, no worries, not a bit in the world'.*

Much of Maeve's life was planned around Doug's career, and the needs of their children. Now in later life Maeve's primary concern was for Doug's health, happiness and comfort. Doug gradually became blind due to macular degeneration in his early 60s, and was registered blind for over 30 years at the time of the interview. Again a version of the caring relationship discussed earlier in Terry and Kathleen's accounts emerges, although different in many respects. For example Doug had expectations of Maeve that she did not feel she could fulfil, and Doug did not seem to realise why somethings were problematic. For example Maeve still drove her car but restricted herself to short familiar journeys and did not drive at night. This did not make sense to Doug. Maeve's cautious nature and Doug's 'can do' attitude are apparent here:

> *Maeve: 'I have to drive, I still drive but I have arthritis in my shoulders and I don't like driving long journeys and you need to have your wits about you so much now. I would drive down to Wexford at a pinch maybe but I am not happy doing it. But Doug… I will go into the towns but I avoid going if I can… Doug sees no… in the past few months my brother's wife died and I went over of course I got the local taxi man to drive me over, and Doug doesn't see any trouble in driving to places, he has forgotten. But it was very funny one day* [my friend] *and myself were in town and going down by the Protestant church and*

we turned down a one-way street and the next thing there was the blind fellow in the backseat and he said 'you know you are going the wrong way' [laughing]. *He would know certain things you know.'*

Doug was a very determined individual and did not allow his disability to hinder his daily life. Aside from the blindness he was physically and mentally very healthy. Maeve and the rest of the family did however play a significant role in supporting Doug in his activities, or as he called it '*pottering around*':

Int: You retired in 1986? That is before I was even born!
Doug: Well, as the nurse in the village says I am the trouble with the pension funds [laughs]. *She is quite right. There is a lot of people living very long.*
Int: You retired 25 years ago. That is a long time ago.
Doug: It is a long time ago
Int: How did you spend your time?
Doug: Well most of the time I was pottering around. I am fairly lucky in that my family bought me a very nice plastic house and I potter around in the plastic house, propagating plants, which my sons use in Dublin, and elsewhere planting up gardens. So what I say is I potter around. So now unfortunately my biggest hardship was my eyesight. I suffer from something called macular degeneration. It means in effect I am registered blind. Reading is a problem, the letters seem to run into one another, but there is radio and there is talking books and all sorts of things you know… there are all sorts of ones [talking books] *out there, but the most recent one* [my daughter] *has brought me is extraordinary* The Blind Traveller *the 1780s to 18 something. This extraordinary man was blind and was travelling all over the world and his activities were published and then they disappeared. My other daughter bought me three talking books one time, she said you need educating, one on Darwin, which was okay, the next one was on Newton, bit of a battle, the third one was on Einstein now that got my goose. Einstein you know* [laughs]*… I will take you up to the plastic house. I have been lucky in so many ways, particularly with the family, and having this house where I propagate plants. I like to go down with my sons to the garden centre. I was down there yesterday. We were buying stuff. It is quite sizable, oh it is well worth the visit, particularly if you can see properly* [laughs].

Maeve: 'Luckily he is very keen on classical music and he is very knowledgeable on it, and that is from having been reared in Dublin and being able to go to operas and concerts and everything. I know from his Mam's side he would be interested in music. In the bad weather he would sit in here and play classical music all day […] *I think having lost his sight was the biggest thing, the biggest draw back from him* [in doing things] […] *Everything changed for Doug when his sight went. When we went up to Dublin previously he could do anything, I could go off anywhere and he could spend his day over in the music centre or in the library or some place else, and went to concerts as well. But once his sight went there was a sudden change.'*

Research Diary Extract

After we had finished the interview Doug insisted he bring me outside to his garden and show me around. The plastic house was where he cultivated the plants that his son later used in the gardens he designed in his landscaping business. I wondered if the customers knew that the plants in their beautiful newly landscaped gardens were nurtured for months by a 93-year-old blind man. Probably not. I was very hesitant to go outside with Doug but he was insistent. I was concerned that he might trip over the uneven surfaces of the garden. Funnily Doug had similar concerns though not that he himself might fall over, but that I would. All the while as we were walking through the garden he would say to me 'mind that step now', or 'be careful there is a hose crossing the path', 'watch your head, the doorway is low'. When we were inside the plastic house he showed me, with considerable pride, the plants growing there. Going from plant to plant he gave me a detailed run down on each of the plants needs and his work in growing them. Doug was clearly very busy. He had referred to his work as 'pottering around' but really he was very productive. Every day there was something that he needed to do. When we came back inside after looking at the plants in the plastic house Doug jokingly asked his wife for a piece of chocolate for me. Maeve scolded him 'he does not really want to share his chocolate with you, that is not why he is asking, but in giving you some he will get some more and he already had his daily allowance'. Doug jokingly replied to this laughing 'isn't that terrible Sandra a man living to my age and I can't even have a square of chocolate?' We didn't get any chocolate in the end, but he did insist that I take home some blueberries that he had grown in his garden. They were beautiful.

Doug had always been very academic and as a young man growing up he read a great deal, particularly on subjects such as genetics and horticulture, and frequented the libraries in Dublin.

Doug: 'There was a bloody fine library, and I don't think Carnegie is thanked enough. Dun Laoghaire Library was a godsend when I was living in Dalkey, they would have over 100,000 books in the library. And of course there was a reading room there too. Then you had Pearse Street Library and of course the National Library. If you were not a resident of the city you had to get somebody to sponsor you to use the library. Especially during the war the library was a godsend because it was warm, of every place the library was warm, and when we went out of it, it was cold. One thing, if on occasion you wanted specialist books as I did, on genetics, the local library wouldn't have it, so they would get onto the students library in Mount Street, they didn't do medical books, but everything else, yes. They would go to untold trouble to get the book for you and you had it for three weeks, which you could renew. It was free.'

After he received his education, he had a very successful research career in horticulture both in Ireland and abroad. Now in later life with help from his family he was able to maintain his interests and continue to pursue the activities he had always enjoyed in so far as

possible. For example it was difficult for him to go to concerts now, but he had a good collection of music gathered over the years and given to him by his family. Their daughter, described by Maeve as '*a typical teacher*', provided him with 'talking books' to keep him interested. This provided him with a sense of continuity of self despite his disability. The support provided by their family has been essential in contributing to their quality of life:

> Maeve: *'My family are keeping an eye on us all the time, bossing us [laughs].'*

The notion of stability when applied to older people refers to the continuity of sense of self whereby the older person still feels, behaves and maintains the same interests as they did when they were younger. This is recognised as an inner strength (Nygren, Norberg and Lundman, 2007) and salutogenically it can be identified with the manageability component's internal resources. The stability of sense of self is evident in Doug's case in terms of his optimistic attitude and his activities. In maintaining this stability, or inner strength, it is believed that older people can adjust more easily to new realities (Nygren, Norberg and Lundman, 2007), also by recognising the inner strengths of older people it is possible to provide them with a meaningful role, however big or small within the collective. For Doug the willingness of his sons to give him a role in their landscaping business, thereby recognising the knowledge he has and his potential to contribute to their work, was an important source of self-esteem for Doug, and acted to promote his positive self-concept. Doug was very proud of his work in the plastic house, and his adjustment to the new reality of his blindness was made much easier by the input of his family who recognised his capacity to stay engaged and active despite limitations. The supportive environment provided by his family was significant in shaping Doug's perception of the world and his place in it.

> *Side note:*
> *After lunch one day in February 2013 as part of his daily routine Doug turned on his favourite classical music and sat in his reclining chair for an afternoon nap. He sadly passed away.*

Resilient ageing-in-place relationally

In order to understand healthy ageing using a resilience framework it is necessary to untangle the complexity of the person-place relationship to gain insight on how the older person's life world is shaped by their values, expectations and needs. Of significance to the relational geographies of ageing and place are the complex patterns of continuity and

change, and the affective bonds people have with place and the people in it. The participants now better known as Terry, Kathleen, Millie, Mag, Kay, Matt, Alf, Doug and Maeve all demonstrate the complexity of the ageing process and its relationship to a biographical attachment to place. For each of these people the continuity of themselves, their identity and their activities in place (ageing-in-place) was considered a valuable and worthwhile goal for different reasons. For Terry the idyllic life in the countryside was to mark a retirement hard earned and longed for, but interrupted by the normal processes of ageing, and consequently a desire to maintain a close and caring bond with his wife Cathy. For Kathleen it was the continuity of intimate family life and the desire to maintain the familiarity of the home environment as she cared for her frail mother. For the others the home was the centre of their activities and provided them with the opportunity to maintain their sense of self, status and independence through these activities. With the exception of Alf it was through the continuation of social relationships associated with those places that provided an important source of resilience. For all the participants the importance of the intersectionality of the characteristics of place and the characteristics of the individual emerged to suggest that people and places are produced in relation to each other. As a result the continuity of place, and the continuity of individual identity, activity and self-concept are closely related, and it is through this intersectionality that the SOC, and subsequently wellbeing, influences resilience in later life.

Resilient older people ageing-in-place: some cautions and conceptual limitations

Within the healthy ageing paradigm, as applied to ageing research and policy, there is considerable concern that the concept is both exclusionary and unrealistic (Martinson and Berridge, 2014; Angus and Reeve, 2006). It emphasises that healthy ageing is predominantly within the control of the individual and is dependent on behaviour and attitude without giving sufficient credit to the socio-structural contexts within which people's life course unfolds (Clarke and Griffin, 2008; Dillaway and Byrnes, 2009; Leibing, 2005). The empirical results presented in this chapter and analysed according to the SOC components, while drawing on other relevant thinking, demonstrates the explanatory value of salutogenic theory in attempting to understand later life experiences, the life world of older people, resilience and wellbeing. However, it does reinforce the individualism of the healthy ageing concept, and provides little room to take into account the broader socio-structural contexts to move the healthy ageing concept away from individualism. This is

because the focus is on the individual's attitude, behaviour and ability to adapt to or transcend challenges, demonstrating resilience. This is a fundamental problem with the application of salutogenic theory to understanding health and wellbeing flagged in the critical analysis on Antonovsky's theory in Chapter Four. Even though the SOC can be described as a socio-structural concept, because it is about the individual's reaction to their environment in terms of their behaviour, when applied to empirical data the balance of agency and structure in determining outcomes is not all that clear. Conceptually the SOC appears to favour the person who can overcome adversity as someone who is naturally predisposed to resilient behaviours and positive affect, recognising the freedom of the individual to create their internal environment while situated in an external environment, or socio-economic and cultural context. Dillaway and Byrnes (2009) describe successful ageing (a slight variant of healthy ageing) as a game that can be won or lost, and unfortunately the SOC when applied to further develop understandings of ageing has a similar impact. This is because it forces the researcher to question how well the older person has adapted to the changes associated with later life. The participants discussed in this chapter all demonstrate a great deal of resilience and appear to have coped well with adversity, however the salutogenic question as argued already is interested in the 'deviant' – the healthy ager – and so the salutogenic framework further compounds Dillaway and Byrnes (2009) concern. Furthermore, all of the participants that contributed to this research were from a working class background. None were found to be experiencing poverty, or serious social exclusion in the definitional sense[11]. This might be due to the purposive sampling used in identifying the research participants i.e. they had to be over 75 years old, in subjective good health, and living independent and active lives. The use of such purposive sampling does not provide for the 'missing voices' of marginalised groups in ageing research (Martinson and Berridge, 2014). Yet despite these shortcomings the application of the SOC here contributes to wider discussions on healthy ageing, providing a useful framework for understanding older people's (emplaced) motivations, and provides the health geographer with a useful analytical tool to further extend the person-place and person-context relationship.

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[11] Whereby social exclusion is understood as 'a multidimensional process of progressive social rupture, detaching groups and individuals from social relations and institutions and preventing them from full participation in the normal, normatively prescribed activities of the society within which they live' (Silver, 2007:15)

Chapter 8

The Sense of Coherence and close personal relationships

"Friendship is unnecessary like philosophy, like art… It has no survival value; rather it is one of those things which give value to survival"
C.S. Lewis

The Sense of Coherence and its relationship with health, stress and coping

The Sense of Coherence has been identified as an influencing factor on health and wellbeing. Having a high, or increasing, Sense of Coherence measurement has been linked to recovery from episodes of major depression (Skarsater *et al.,* 2009), subjective physical wellbeing and high efficacy (Zirke *et al.*, 2007), physical and psychological wellbeing and the use of adaptive coping strategies (Pallant and Lae, 2002), psychological integrity and as a mediator in the relationship between wellbeing and resources among older people (Wiesmann and Hannich, 2008), perceived health related quality of life among nursing home residents (Drageset *et al.,* 2008) the prediction of psychological health (Wiesman, Niehorster and Hannich, 2009), determining quality of life following a serious illness (Norekval, *et al.,* 2010). It should be noted that all of these studies employed the SOC quantitatively using the Orientation to Life questionnaire.

The theory of salutogenesis and the SOC as an analytical construct is presented by Antonovsky (1987) as a framework for understanding how the brain and the immune system operate at a molecular level within a given social, physical, cultural, political, context or environment. For the social scientist, or in this case the geographer, Antonovsky has provided a framework for interrogating the health-place relationship for older people. The SOC has mainly been used as a tool to measure, using Antonovsky's terms, their global orientation, and establish an association between their SOC score and some other objective measure of health, wellbeing, coping, quality of life and life satisfaction. Such applications of the SOC as a measurement tool do little to explain these associations either qualitatively or subjectively. Wiesmann and Hannich (2013) for example, suggest that the SOC acts as a mediator between the resistance resources available to an individual, and life satisfaction, and satisfaction with health, among older people. Subsequently, they identify the SOC as a superordinate concept because it pools resistance influences. However, according to Frys and Debates (2010) much still needs to be learned about the origins and source of human

strengths, and how the older individual draws on these resources to preserve and promote health and wellbeing. There thus appears to be two important tasks at hand, the first to identify the origins and source of human strengths, and the second to examine these resources using the SOC components as conceptual tools of analysis. In doing so one can develop a fuller understanding and explanation of the processes underlying the relationship between the SOC and wellbeing among older people. These processes may also be spatialised.

It is problematic that the vast majority of empirical studies on the SOC and health have shied away from the qualitative application of the SOC, and in doing so overlook subjectivity in health experiences. Antonovsky's original motivation in developing the theory of salutogenesis was to introduce a perspective on health that did not reduce the person to a set of tidy and objective medical problems that existed at the cellular level, but rather to view the person holistically, as self-creating and self-determining. Antonovsky was also calling for a closer examination of the person-environment relationship in determining health, resilience and ability to cope. The person-environment relationship is chaotic and multilayered, where both protective and risk factors co-exist, and each of these factors exert a force on the individual moving them along the health-ease-dis-ease continuum. The accounts presented in this study of the healthy oldest old individuals offers a valuable exploration of health and place in later life, and should add to the understanding of the processes that link health and the SOC in place. The person-environment relationship is relevant and important throughout every life stage, however given the intensification of the negative forces on health in later life, the role of coping mechanisms are heightened. According to Wiesmann and Hannich (2008: 57)

> *'ageing is understood as the individual time dimension on which negative and unavoidable changes take place. With advancing age the individual is losing his or her capability to produce bio-psycho-social integrity, and this increasing insufficiency will finally result in the individual's death'.*

In this study the participants, through their participation in the life review interviews, provide insight on the challenges to and the maintenance of bio-psycho-social integrity, i.e. as living systems maintaining health by coping with adversity, by drawing on resistance resources located in their internal and external environments. The affective potential of place as represented by the home and the immediate social environment in terms of its relational geography provides a spatial focus for the concept of bio-psycho-social integrity.

This chapter will explore the role of the relational social environment as a determinant of health, influencing bio-psycho-social integrity, with the SOC components providing the analytical lens. For the older person there are significant and ongoing changes to their immediate social environment, or their close personal relationship network. These changes pose a significant threat to their health and wellbeing, and this threat can be examined using the SOC to interpret and make sense of the significance of the health buffering effects of close personal relationships. The accounts provided here demonstrate the experiences of shrinking social networks among the oldest old, and the challenges these pose.

Before exploring some of the empirical data it is useful to first set out what is already known about social networks, loneliness, friendships and later life in the research literature.

Belongingness as a fundamental human need essential to health and healing

According to Baumeister and Leary's (1995) work on the common need to belong, human beings are naturally concerned with establishing and sustaining a sense of belonging, in the form of 'lasting, positive, and significant interpersonal relationships' (Baumeister and Leary, 1995: 499). He argues that belonging can be regarded as a fundamental motivation, whereby such motivations are only fundamental if they have negative implications for health and wellbeing when they are not satisfied. Further to this, motivations can be divided into needs and wants. Needs and wants differ in that unsatisfied needs result in pathological consequences, whereas wants do not. If belongingness is a need, and it is not satisfied, pathological consequences in terms of health and wellbeing will result. Baumeister and Leary (1995) outlines the meta-theoretical criterion of fundamental motivation. Firstly, fundamental motivations can operate in any contexts and are therefore not necessarily subject to favourable circumstances, and reflect subjective importance and concerns. If fundamental motivations are not satisfied there are pathological consequences, such as ill health. Fundamental motivations have no restrictive circumstances and thus exist regardless of situation or conditions. They are also universal and thus transcend cultural boundaries. Fundamental motivations are very powerful in that they impact on a range of behaviours and human activities. Baumeister and Leary (1995) argue that the only way belonging, as a fundamental motivation, could be falsified is to prove that an individual can live a happy and healthy life in complete social isolation, or to show that an individual will experience no

significant cognitive or emotional effects following a change in belongingness status. Threats to social relationships and the dissolution of interpersonal bonds result in negative affect; the loss of important relationships result in depression, grief, anxiety and loneliness. Feelings of aloneness may be harmful, giving rise to feelings of helplessness in a seemingly hostile world.

The importance of belonging is recognised in the literature on positive ageing. Sustaining and engaging in close relationships with family and friends throughout the life course is considered an important aspect of growing old successfully. Rowe and Kahn (1998: 46) suggest that the very task of successful ageing is to develop relationships and activities that bring people together to provide closeness and meaningfulness. Social support can be understood relative to two broad categories - 'socio-emotional' and 'instrumental'. Relationships that offer socio-emotional support are important to feeling a sense of belonging or connection with another person, or group of people. Relationships that are based on providing instrumental support are focused on meeting the practical needs of an individual. The engagement with the life aspect of successful ageing is identified in two forms. The first is maintaining relationships with other people, and the second is in the form of productive activities. This latter form reflects what is considered to be productive in contemporary society, and refers to the contribution an individual makes to community life.

Rowe and Kahn (1998) outline three chiefly important aspects of social connectedness with relation to their health buffering effects. First, isolation and loneliness are a 'powerful risk factor for poor health' (Rowe and Kahn, 1998: 153). Secondly, social support in its many forms has direct positive health effects. Thirdly, social support can buffer the negative effects of ageing. Yet social support does not work in the same manner for everyone, and sometimes such support can have a negative effect on the health and wellbeing of older people, this is because it may create dependency, or reduce older people's self esteem if the support is not needed. It is important to note that it is more than social contact that determines if an individual is experiencing loneliness.; Baumeister and Leary (1995) claim that there is a stronger absence of belongingness associated with loneliness than merely the quality of social contact. Social contact is thus not a sufficient buffer against loneliness. In addition loneliness is more than simply the size of an individual's social network in an objective sense, it is more so about an individual's sense of aloneness and belonging. It is thus important to ask what types of relationships influence aloneness and belonging. In particular because of the focus of policy and practice on

combating social isolation the experiential and conceptual distinctions between loneliness and social isolation are significant. Weis (1975) provides two conceptual categories for understanding loneliness. The first is emotional loneliness and refers to the individual's personal satisfaction with their existing social networks. The second category is social loneliness and refers to the individual's feeling that they do not have access to wider networks of social support during times of adversity.

There is much (biomedical) evidence to support Rowe and Kahn's (1998) claims. For older people loneliness, as a form of psychosocial stress, is one of the most common causes of suffering, posing a significant challenge to their quality of life. This is perhaps because the importance of emotional closeness in relationships increases with age (Cartensens *et al.,* 2000; Fung *et al.,* 2001). Indeed, continued social relationships are considered vital in reducing the risk of illness and disease throughout life. According to Cacioppo, Christakis and Fowler (2009) humans require consistent and regular contact with others to survive and prosper, perhaps because they are meaning-making species, and meaning making is often carried out relative to another individual or group of individuals.

Loneliness has significant implications for the maintenance of mental, physical and social health across the life course, and has been associated with increased morbidity and mortality (Harvey and Cacioppo, 2010; Luo *et al.,* 2012). Given the evolutionary history of humans as social species this should not be surprising; we as humans have always relied on groups for protection and safety. The impact on health of persistent loneliness versus having continued meaningful relationships is equal to the difference between smoking and not smoking, because of its influence on the production of stress hormones, and its impact on immune and cardiovascular functioning (Cacioppo and Hawkley, 2007). The physiological impacts of experiencing loneliness represent the physical manifestations of an unfulfilled fundamental human need for survival as described by Baumeister and Leary (1995). As with a vitamin deficiency, for example, the body will respond to this deficiency by manifesting symptoms. In recent decades considerable empirical evidence has emerged on the relationship between loneliness and health. Perrissinotto *et al.* (2012) for example found that loneliness, that is the subjective feeling of being left out, feeling isolated or lacking companionship, is a common predictor of functional decline, and was found to be associated with an increased risk of death, even after controlling for serious illness. Research conducted by La Grow *et al.* (2012) found in a sample of older community-dwelling New Zealanders that those who were either moderately or severely lonely had poorer physical

and mental health than those not experiencing loneliness. Walker and Beauchene (1991) found loneliness to be related to dietary inadequacies, which would have significant effects on both mental and physical health. Loneliness has also been linked specifically to cardiovascular ill health among women, with those experiencing loneliness having an increased risk of incident coronary heart disease (Thurston and Kubzansky, 2009; Booker, 2012). Boden-Albala *et al.* (2005) found that socially isolated first time stroke patients are 40% more likely to suffer a second stroke within 5 years than socially connected stroke patients. They identify depression, stress and poor adherence to medication guidelines as common factors across the socially isolated participants. According to McCall (2009) the traditional factors associated with the occurrence of a stroke, such as high blood pressure, lack of exercise or being genetically predisposed to coronary heart disease only account for between 10% and 30% of the risk, thus suggesting that something in the external environment such as access to social support has a significant role in buffering against stroke. According to Kiecolt-Glaser *et al.* (2010) close personal relationships are strongly linked to the body's inflammatory responses, which are responsible for healing the body following viral and bacterial infections. The authors conclude that there is still considerable research to be carried out in order to detail the relationship between social integration and support and its effects on health. Some research on loneliness and health in Ireland produced important findings. Molloy *et al.* (2010) found that loneliness was a factor in 42% of emergency hospitalisations in the Republic of Ireland and Northern Ireland. Similarly loneliness was found to be a factor contributing to physician utilisation among older women who are generally in good health (Sheung-Tak, 1992). Golden *et al.* (2009) found that sense of wellbeing, depression and hopelessness among older people living in Dublin was directly related to feelings of loneliness and having non-integrated social networks.

The mechanisms through which the social world impacts on health are elusive. Even though the social environment has regularly and consistently been linked to measures of mortality and morbidity it is difficult to find exact causations linking aspects of the environment directly with a specific disease. Despite this, possible pathways to ill health caused by loneliness have been identified. However it must be noted that the effects of social relationships on health, or the lack of such relationships in the case of loneliness, takes several years to unfold as an influencing factor on health. It is also difficult to map the processes operating between the social epidemiological level (where isolation and loneliness can be found) and the physiological level (at which symptoms manifest). Some research on

these pathways have found that for example loneliness may lead to self-destructive habits, and influence unhealthy behaviours for example leading people to search for instant gratification in the form of binge eating, alcohol or drug use. This might be because social relationships are necessary for behavioural adjustment, and cognitive functioning. Further, people in middle age are more likely to report feeling stressed if they report feeling lonely (Cacioppo *et al.*, 2008; Hawkley and Cacioppo, 2003).

It has been hypothesised that loneliness is an example of an emotional contagion. A person who is experiencing loneliness will appear to be closed off to the possibility of meaningful engagement with others. This is thought to have the effect of a contagion because the facial expressions, posture and movements may lead to a convergence of emotions (Hatfield, Cacioppo and Rapson, 1994; Berscheid and Reis, 1998; Cacioppo *et al.,* 2006). For example Person A encounters Person B in a social situation, Person A hopes to befriend them, however Person B's posture, lack of eye contact and tone indicate that they are not interested in engaging in conversation. To Person A the stranger appears to be dismissive and unfriendly, however Person B may have low self esteem, feel anxious, shy, or awkward in social situations, all traits associated with loneliness, and thus making it difficult for Person B to engage in meaningful interaction. As a result Person A may feel isolated and potentially lonely because what they expect or desire from their social relationships is not met in this situation, and Person B continues to be lonely. This is referred to as the induction hypothesis and suggests that if one person is experiencing loneliness this may contribute to another person's feelings of loneliness. This places loneliness within a given social network, and a shared environment, and indeed the non-lonely individual is at risk of becoming lonely if they spend time together. This also means that loneliness can have a specific geography, based on proximity (Cacioppo, Fowler and Christakis, 2009). Loneliness as an emotional contagion is evident in some of the accounts presented later in this chapter. It is suggested that isolates are often rejected from social networks. This is of particular significance for older people, because it has been found that older people reduce the size of their networks by removing those that they have less meaningful relationships with (Carstensen, 2001). The isolates that exist on the periphery of a social network following earlier rejections are also at risk of being rejected by their remaining friends. To appropriately target those most at risk of loneliness it is perhaps best to set in motion a strategy to help them repair their social network and create a protective barrier to prevent loneliness (Cacioppo, Fowler and Christakis, 2009).

Perception is an important variable in determining the effects on health of social isolation and loneliness. Perceived social support rather than objective social support is more strongly associated with lower resting blood pressure, better immunosurveillance and lower levels of stress hormones (Cacioppo and Kiecolt-Glaser, 1996). Similarly perceived low levels of social support and evidence of hostility in the social environment have been linked to increased risk of carotid artery lesions even when age, education, BMI, lifestyle and metabolic rate are controlled for (Knox *et al.,* 2000). According to Price *et al.* (2001) women experiencing stress with insufficient intimate emotional support were nine times more likely to develop breast cancer. This supports earlier research by Fox *et al.* (1994), which found that in women stating that they felt lonely before their mammogram were more likely to be diagnosed with breast cancer. In terms of survival following breast cancer diagnosis, Kraenke *et al.* (2006) found that women diagnosed with breast cancer and who were socially isolated were at a greater risk of mortality following the diagnosis than those who had access to informal supportive relationships. Socially isolated women were four times more likely to die than those with a network of 10 close friends. The study concluded that having friends was protective, even against the effects of cancer.

Loneliness was identified by Walsh and Harvey (2011) as one of the biggest problems facing older people living alone in Ireland today, and subsequently loneliness is exacerbated by widowhood, low levels of education, poor health, low income, rurality, and infrequent contact with family (Drennan *et al.,* 2008). As discussed already, loneliness and social disconnectedness is not the same thing. Giles *et al.* (2005) in their study on a large group of older people, aged 70 years and older, found that having a network of close friends was protective against mortality. Interestingly there was no difference in the effect of the network whether it was made up of relatives or friends. Designing policy approaches to promote the social inclusion of older people is more straightforward than tackling the issue of loneliness. This is because loneliness is a subjective state. While policy can address the variables identified as exacerbating loneliness, for example by providing opportunities for older people to volunteer, to remain in the workforce after retirement age, or by ensuring they have access to transport and other services (Hole, 2011), the subjective nature of loneliness means that it is perhaps outside of the remit of policy. Targeting that relational space between two people, or one person and a group, where subjective experiences and emotions are generated is difficult. No matter how successful social inclusion policies are in encouraging older people to engage more fully with their wider community and to help

them develop a wider social network, addressing the challenge of emotional loneliness is perhaps beyond policy efforts. Just because an older person is active in community life and surrounded by family and friends does not necessarily mean that they have meaningful or fulfilling relationships with those that make up their social network. Similarly, results of the TILDA[12] project found that 60% of those who were socially isolated according to the objective measures used in the research did not report feeling lonely (TILDA, 2011). However, for the health research community it is important to continue to develop our understanding of loneliness and its relationship with health, and this can be done through the application of the SOC framework.

Given the review of research literature on the effects of friendships on health outcomes, it is reasonable to argue that friendship does have survival value, as well as value in and of itself, as suggested by C.S. Lewis.

Belonging and place

Geographers have addressed the concept of belonging as a notion that relates people to their social worlds in multiple ways and at multiple scales (Wood and Waite, 2006). It is recognised as an inherently geographical concept (Mee and Wright, 2009) and as being at once emotional, political, personal and societal (Wright, 2014). Belonging is something that has significant emotional relevance linking individuals relationally to the world in experiential, performative, embodied and affective ways (Wright, 2014). Ho (2009) argued that the notion of sense of belonging has been regarded superficially in geography as a taken-for-granted ontological condition. It is not a concept that has been sufficiently explored as an emotional affiliation within geography, and it has not been asked often enough what belonging actually feels like, and the significance of the emotions that accompany feelings of belonging and not belonging (Wood and Waite, 2011). However, belonging, as an antonym for loneliness, is not something to be taken for granted considering the extent of the health effects of loneliness already outlined. Furthermore, the application of the SOC to understanding the individual's experience of the self in relation to the collective can open up the concept of belonging to the health geographer. Applying the SOC to studying the concept of belonging geographically will expand the geographical gerontology idea of ageing-in-place and identify aspects of emotional and health relevance.

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[12] TILDA is a large scale longitudinal research project on ageing in Ireland

In this section empirical data from the life review interviews is presented to explore the experience of being a much older person ageing-in-place and negotiating the relational geographies of belonging and not belonging. Following on from the previous chapter's discussion on the relational geographies of age the environmental aspect of Antonovsky's thinking will be developed further.

Mag was introduced in the previous chapter. She is very active and always eager to get involved with family and community life. However, being one of only a few nonagenarians in her local community, and having witnessed most of her age-peers pass away, her sense of belonging has been considerably challenged:

> *Int: Do you have very strong ties with* [the area] *then?*
> *Mag: Well* [I am] *90 years in it now*
> *Int: Tell me about your friends?*
> *Mag: Well they are nearly all gone now, that's one thing, it's lonely when you come to that, in a sense, everybody is nearly gone, those that you grew up with. There is a couple more in the parish a little older than me, but Mrs. […] up here now doesn't know whether it's night or day, she's 99, she will be 100 this year if she lives to September. Mrs. […] up the back road she's 96. Then there is two more up in […] they are around the 90 mark too. The rest of them are nearly all gone. And you find if there is something you are thinking of and you're not really sure, you have nobody to ask. And you go anywhere and you're kind of on your own, your own crowd is gone. I had a sister in law up until two years ago and we used to go everywhere together and she died […] and the first time I went out to anything after that was to a birthday party of one of her grandchildren, it was the first time that I was out that she wasn't there and when I came home I said I would never go out to anything again. And even months after there was another 21st and I couldn't go to that but then the girl's other granny was there and that was different. You would feel a little out of place in one sense, they would all be old but you would feel just that… I don't know what way to explain it.* [Mag becomes emotional at this point, and the topic of friendship is changed].

Being aware of feeling a sense of either belonging or not belonging, as Mag demonstrates here, has required her to pay attention to the ontological, relational and emotional significance of being 'immersed in the middle of things' (Stewart, 2008: 77). Mag recalls her subjective emotions within the collective context of an extended family birthday party when she considered herself to be '*a little out of place in one sense'* and detached from those around her, even though she knew many of the people at the party ('*you go anywhere and you're kind of on your own, your own crowd is gone'*). We know from the previous chapter that Mag enjoys being at the centre of life and activity, and enjoys getting involved

whenever she can, so it is somewhat unexpected to learn that Mag still experiences loneliness in her relational world despite her eagerness to participate. Because of what we know about Mag's enthusiasm for life the significance of the relational geographies of the older person in influencing their disengagement from the world emerges. The absence of her best friend resulted in Mag reappraising her sense of belonging, arguably because of Mag's SOC she eventually found the courage to re-establish herself in the social world in the absence of her close friends and peers. According to geographical thought on belonging, in order to understand subjective emotions within the context of the collective a relational view of the self and the world is required. This is because emotions are not generated from within the individual, but rather emotions are generated and mediated through the interactions between the individual and the collective. It is through this interaction that feelings of otherness, or Mag's experience of feeling '*a little out of place*' are determined (Ahmed, 2004). In the more ordinary spaces of community life Mag also identifies feelings of otherness even with other older people.

The loss of friends and age-peers represents a potential threat to the stability of Mag's internal environment because it alters her understanding of the relational world and her place in it. Comprehensibility, as a SOC component, is about making cognitive sense of the internal and external (relational) environment. Comprehensibility derived from a relational view of the self and neighbourhood is perhaps dependent on the attachments to place that people often use in establishing their sense of identity and in order to maintain identity continuity (Ziegler, 2012). Relationships with other older people might for instance remind and reinforce the older person's identity, effectively reminding them of who they are and their individual and collective histories. For example Mag's age-peers and friends had a role to play in ordering, structuring and explaining the information presented to her both internally and externally ('*you find if there is something you are thinking of and you're not really sure, you have nobody to ask*'). In their absence Mag's perception of the world is more chaotic and unpredictable because she does not feel that those of a different demographic are the same as her or that they have similar experiences or shared histories. Mag's life review has been produced in relation to her peers and through a continuity of attachment to the people of her past she experiences a continuity of this identity. This continuity of identity is however challenged and this might explain Mag feeling, at times, detached from her social world, and leave her prone to feelings of loneliness. This represents a challenge to the older person's 'ongoing process of place integration' as they

age-in-place (Cutchin, 2003: 1078). Additionally the death of Mag's close friend meant a loss of a meaningful relationship, which was a primary motivator encouraging her to socialise ('*we used to go everywhere together*'). Mag frequently attends a local social club for '*somewhere to go*' on a Wednesday afternoon. The age distribution of this social club was considerable, Mag was the oldest member, and the youngest members were a couple in their mid-60s. Mag's opinion that qualitative differences exist across the age groups in later life raises questions about the meaningfulness of the relationships established within these groups. While the social contact such groups offer is important to prevent isolation, it might not totally address the issue of loneliness among older people. Indeed it should also be noted that older people are not all the same.

Long established friendships are important for sustaining self and identity; this is particularly important for older people who are vulnerable to significant changes in their life circumstances (Hess, 1972). Such friendships are also important for sharing experiences and interpretations of life events (Hartup and Stevens, 1997) and are closely linked with self-esteem (Lee and Sheehan, 1989; Peters and Kaiser, 1985). According to Carstensen (1991) being able to sustain friendships is very important for older people. In the Orientation to Life Questionnaire (OLQ) the first question asks the respondent 'When you talk to people, do you have the feeling that they don't understand you?' [Comprehensibility]. If the respondent feels that they are understood this is positively correlated with their SOC, and subsequently health. The loss of close personal relationships within the peer-group thus undermines the individual's SOC, in particular the feeling that someone else in the world can relate to their experiences, both past and present. The individual feeling that they are not understood may leave them feeling isolated in the world and alone. Mag's explicit use of the word lonely, her observation that '*everybody is nearly gone*', and the feeling that she is not the same as other people in the local community is significant. The otherness expressed by Mag is both an embodied relationality because Mag is in very good health, and also a relationality that is grounded in having a shared biographical identity and shared history. The loss of her close interpersonal social network could potentially pose a threat to Mag's wellbeing and mental health. However, as was discussed in the previous chapter Mag is a very determined person and while such losses are without a doubt significant to her she has been able to recover from these and carry on.

It is evident that Mag's friends have in the past provided help and resources when needed. At the time of the interview Mag had been widowed for seven years, yet the loss of

close friendships outside of the home emerged as most significant during our conversation. Indeed she focused on the support she received from a wider network of friends following her husband's death as one of the most important factors in helping her to cope:

> *Mag: 'They are very much inclined to help. They are there. Definitely if you want help or want anything there is no problem. There is plenty for that. Oh the neighbours would be very good now and friends in the parish they would be ready to do anything for you anytime, no problem getting help. The best of them around here, sure you know Mrs. [...] is up here at the top of the hill, sure you can see the house from here, the like of her, there are a lot of people like her... You know you have a back up, you're not on your own, you have a back up if you wanted anything.'*

> *Mag: 'The neighbours drop in occasionally, they would yes. And if they weren't around they would ring or contact you in some way. Or [my daughter-in-law] would be in the shop and she'd say such and such a person was asking for you, and that they hadn't seen you in mass, and were wondering if you weren't well'.*

Earlier in this chapter the ideas of socio-emotional support and instrumental support were introduced. In Mag's account here we have considerable evidence of instrumental support, but overall Mag seems to lack socio-emotional support. And it is here that the risk of loneliness lies. However the instrumental support evident should not be demeaned because it is very important in offering a sense of security to the older person as they age-in-place. Instrumental support, like socio-emotional support, is reciprocal in nature. Mag, although one of the oldest people in the community, is conscious of the wellbeing of others and takes on a similar role of providing social support.

> *Mag: 'I was talking about going up to see Mrs. [...] up the back road, she is 96, to see what end of her [13] because she wasn't at mass either. You would miss the regular ones [when they don't attend]... we were just saying at the dinner table she is gone very small and angish[14] looking.'*

> *Mag: 'Well some of the younger people would look out for the older people, but I don't know if the older people appreciate it, some wouldn't. They would say mind your own business, there would be the few. But then I can't imagine that anyone that you would get help off that you wouldn't appreciate it. I wouldn't see it myself [...] But, I don't know, some of the younger people don't seem to want to share a lot. The older people seem to be more close knit'*

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[13] Colloquial term meaning how the person is
[14] Angish is a colloquial word meaning frail

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Based on the SOC component of manageability, the OLQ asks about feelings of confidence in receiving adequate help from others, or having access to external resistance resources to make life manageable. Such resources are considered necessary for health promotion and maintenance because they support the individual during times of stress. Manageability is determined by both internal and external resources, so for example knowing that people exist in the community and are close by if needed, is not the same as having the confidence in them actually providing adequate support. Mag for example has had a very positive experience of community life following the death of her husband, and she feels confident in the support she has received and potentially will receive if it is needed again. She does however make an interesting observation that not everyone in the community is as open to giving and receiving support through a wider network of friends, perhaps such exchanges of support are not considered meaningful, or that accepting help from the younger generations is a sensitive issue for older people. According to Mag this might be an issue of pride. Additionally, Mag observed that there were many older people in the community that did not wish to take part in the social club she was a member of. While she felt it provided her with a beneficial social outlet and improved her quality of life she acknowledged that some people were *'just not into that sort of thing'*. Earlier in this chapter findings were included from the TILDA project that pointed to the difference between objective measures of social isolation and subjective experiences of loneliness demonstrating that the two were not entirely related. Mag provides us with a development of why this might be so. People, old and young, will experience their social environment differently, and most probably in accordance with their values and attitudes, motivations and goals. An individual's reading of his or her social environment in the face of adversity will reflect their level of self-understanding, alluding to Antonovsky's SOC component of comprehensibility. Yi Fu Tuan, similarly, regards self-understanding as necessary in solving problems, this is because 'no two persons see the same reality. No two social groups make precisely the same evaluation of the environment' (Tuan, 1990: 5). This is an important insight from Geography supporting salutogenic theory and the SOC construct, in understanding the subjectivity of how we experience and perceive the world in which we live. An environment that one individual might find positive another might experience it negatively, and these experiences are translated through the SOC components of meaningfulness and comprehensibility.

Like Mag, Kay's husband has also died and her wider social circle has reduced significantly over the previous few years.

> *Kay: As I said my husband passed away and most of my friends are gone now too. I had three really nice friends and they are dead, two of them were younger than me. So you would be lucky to be alive. We wont talk about that, we live until we die* [laughing].
> *Int: It is very difficult to see your friends go…*
> *Kay: It is yes, especially when they are nice friends*
> *Int: Was that recently?*
> *Kay: Well one of them, it was two years ago. Another was a good bit back. The other was about three or four years ago, now she was really full of life. She would come over with her dog sometimes and she was lovely. It's lovely to have friends like that they do make a difference*
> *Int: Do you have close friends now?*
> *Kay: Well I would have friends but it's kind of different, they were really close friends. It's lovely to have people like that, that you can talk to and you won't hear it back.*
> *Int: And who fills that gap now?*
> *Kay: Well I would have my nieces, my own children of course, four of them. They are here in a minute if you want them, really good now. The nieces and nephews are marvellous, really good now.*
> *Int: You are from a family of nine?*
> *Kay: Yes, now I have one brother alive… The whole place has died, the neighbour across the road and her husband has died, and then there was another woman there in another house, and all up along they have all died out of the houses. And on this side as well, there was four houses as you came up the road there, there was two elderly ladies and two men, they are all gone. There was a lovely little woman there beside us as well and her son. Every one of them. It is surprising now. And now there are new people coming in.*

When discussing their respective social networks, Kay and Mag focus significantly on two variables determining these networks, firstly, those living within the immediate vicinity of their home in terms of their presence and reliability, and secondly, age-peer specific. The proximity of the neighbours and the relationships with them are important in terms of giving and receiving social support, as can be determined from Kay and Mag's accounts, however these supportive networks significantly change with time, either as the result of death, or cognitive or physical decline. Kay and Mag, who have not experienced the same decline in health as their peers, are left to cope with and adapt to their changing social networks. Thus, where the older person's social networks are age-peer specific there is a substantial risk of isolation and loneliness. Yet place-based social support networks appear to offer a wider sense of security. While Mag and Kay's reduced age-peer support network represents a

challenge to their SOC, in particular comprehensibility, they feel confident that they have the necessary instrumental support. The availability of such support, and feeling that people are close at hand if they need them, thus making life more manageable, will impact on feelings of social isolation, but might only have limited influence on feelings of loneliness. The conceptual distinction between social isolation and loneliness is important for social policy and practice. Interpersonal relationships may be intrinsically motivated or functionally motivated, following the deaths of close friends, or confidantes, the number of emotionally meaningful relationships are reduced, and at the same time wider social networks become necessary in providing functional support. The loss of close personal relationships represents a loss of relationships that make emotional sense to the individual. The meaningful aspect of the individual's SOC is undermined, and comprehensibility is challenged. Considering the results of the empirical literature reviewed earlier and the necessity of feeling a sense of belonging what is emerging here is a potential connection between the experiences of place and social environment mediated through the SOC and a pathway potentially linking the SOC to physical health.

Experiencing the loss of a close friend, or witnessing their deteriorating health represents significant adversity in a person's life, regardless of age. Antonovsky hypothesises that the SOC components are protective of health, however these components are to some extent developed and maintained through ongoing meaningful interpersonal relationships. When these relationships are threatened by one of the friends failing health, the individual left behind faces a double trauma, in the first instance they are witnessing the deterioration of their friend, and secondly, they no longer have access to a primary source of support. Similar to Kay's account, Maimie also shared her experience of witnessing her close friend's deteriorating health

> Maimie: 'One of my friends is very ill at the moment, and I am killed about her. We were like sisters. She's a friend for years. She was the healthiest woman in the parish, and the most Christian, and she got Motor Neuron Disease. She's only struggling now. She's a lot younger than me you know. But I have lots of friends around the Parish, many of them are dead and gone now, but that's the way it is. It's hard to see them pass away, a lot of very good friends […] I am not a good person at talking through my problems or the bits and pieces that go through my mind. Now my friend that is not well at the moment she would tell me her problems and I would tell her mine […] Ah, ask me about something else…' [Maimie becomes upset and the subject is changed].

One further observation relating to Kay, Mag and Maimie's continuing good health relative to their age-peers is their active role in looking out for, and visiting with friends and acquaintances who are confined to their homes or are residing in nursing homes, representing the emotional work of friendship. Kay had a weekly routine that included at least one visit to a local nursing home where she visited the wards. Mag frequently dropped by to check on older people in their homes she felt were in some way vulnerable. Maimie brought the Eucharist to her friend because she could not go to mass and there was no permanent priest in the parish. Visiting peers as Kay, Mag and Maimie frequently do, is an expression of friendship, and in particular alludes to the affectivity of friendships, whereby affecting and being affected represents emotional labour that requires 'mutual trust, reciprocal care and fondness' (Bunnell *et al.,* 2012: 499). These activities can also be understood as processes, practices and performances of belonging (Curtis and Mee, 2012; Veninga, 2009). It is through such active and caring interactions with neighbours and friends that belonging is created (Mee, 2009). Through ongoing performances of friendship such as those demonstrated by Kay, Mag and Maimie that the sense of belonging is produced and re-produced across time and space. With increasing age the shape and form of these processes and practices change, but such processes are about the continuous nurturing of people's sense of belonging. For example Maimie's friend belonged to the same Church as her and when her health deteriorated Maimie ensure that her friend could still perform the rituals of her religion and maintain her connection with the Church. This represents the more-than-human aspects of belonging, whereby the material aspects of institutions are incorporated into feelings, activities and performances of belonging (Curtis and Mee, 2012; Barad, 2008).

The affectivity of friendships is located between the personal spaces of the home, and the more public spaces of community and parish life where the wellbeing of others is closely monitored and observed. Indeed, the home is a particularly important site for producing and contesting belonging, because it is where an intense interaction between place and feeling unfolds (Blunt and Dowling, 2006). The notion of 'dropping by to say hello' or to 'quickly check on' someone were common activities of daily life for many of the older people interviewed, though some of the participants did not have access to such omnipresent support. Terry for example moved from the city to the countryside with his wife to retire. They participated in many of the social clubs and made an effort to get involved with the wider community, yet in his account it was evident that he did not have

access to the mutually supportive bonds, or at least did not perceive such bonds to exist, as those described by Mag for example. Treating Terry's life review holistically, as it was in the previous chapter, it is perhaps possible to deduce from it, Mag's hypothesis, that some people might not actually want to receive support in such a casual manner. Some people might perceive 'dropping by to say hello' as an intrusion. Martha discussed the erosion of such support in recent decades within her local community, and the changing nature of the home environment:

Int: Do you think people consider their homes to be more private now?
Martha: Yes, I do. You go to a lot of houses now and let you be known no matter, you are met on the doorstep. I remember in years gone by there wouldn't be a day that would go by that we wouldn't see two or three of the neighbours. You would definitely see one of them in the run of the day. The week would never go by that you wouldn't see every one of them. That time the door would be open and there was an open fire and the kettle would be perpetually boiling. And you would have to have a cup of tea now before you go, and that was on everybody's house. You could have ten cups of tea in the one day. And 'oh God I made an apple tart yesterday or a currant cake and come on you will have a cup of tea and a bit of that before you go' and you know you would get none of that now. There is only one old lady out the country now, lived beside where I was born and reared and I would go out regularly to see her, and she is the only one that has kept it. They are all new neighbours that have moved in around her and she is really lost. She was 90 there before Christmas. She is really lost because as she said more neighbours now than what we had when we were out there, twice as many houses now, surround her. She don't know any of them, nor none of them would ever go near her to see did she want anything in the shop. She has a home help and all that but you know you think neighbours… That wouldn't be like years ago when I was growing up, they used to go by to the village on push bikes and they wouldn't go by without shouting in to know did you want something from the village. But I notice even now up by where I am, I was there in the bed nearly a fortnight with the flu and there was not one ever called in to find out how I was or to find out did I want anything from the shop, now that's not to say they knew I was in the bed but that's the way they are. Mary now she missed me for two or three days, she lives next door to me, and she would be the only one, and I would call into her if I knew she was sick to see did she want anything. But that would be all. The others would pass up and down by the gate… you see there is no neighbourly… well everybody to their own, let them do what they want, and thank God I am able to get out and do what I need to, that I am not in the bed. But you know there is no sort of neighbourliness now with people, you know they are friendly and they bid you the time of day, but don't trouble me, sort of way. Yyou get that feeling. Now maybe that is only me I don't know. I have heard several people say the same. You know if there is not somebody to call in and out you are left there. I would say television done away with an awful lot of it. I have noticed a big difference since television came in. Almost everybody have cars, I don't drive but most people will now have a car, maybe two cars, and they are

just hopping into cars and driving off. That time everybody had pushbikes, pony and trap or you walked. I suppose when you look at it that way things have improved.

According to Martha's account of community life in a small rural village the openness and willingness to share support she had once known is no longer present within her local neighbourhood. Such gradual changes to her social environment seem to have left Martha feeling insecure. In terms of her health and wellbeing this poses a significant challenge because it may result in feelings of isolation and insecurity. Martha lives alone and as a result having access to social networks outside of the home is essential to her wellbeing. While in very good health at the moment, she is able to join the active retirement group and is able to get out and socialise with them. However, when she was ill for a short period of time it became apparent to her that she does not have access to a wide social support network. People did not call into her home to visit her, with the exception of her neighbour, who is a close friend of Martha's. Martha recognises the importance of sociability within the community for wellbeing, and is herself open to getting to know those living close by, however to her it seems that the difficulties in establishing a wide supportive network of neighbours and friends is the result of an independent culture where dependence and mutual reciprocity are discouraged.

One effect of this is a change in how the space of the home environment is used. According to Waitt and Gorman-Murray (2007) home is a key site for establishing and producing the connections that support one's sense of belonging. However, it can also become a site of contradiction when subjective emotion and experiences of belonging and not belonging co-exist. It is this contradiction in belonging that is emerging from Martha's account. For instance at one time the neighbourhood was an extension of the home environment (*That time the door would be open and there was an open fire and the kettle would be perpetually boiling [...] You could have ten cups of tea in the one day*) but there is '*none of that now'*. According to Martha's experience home has now become an intensively private space where people are met at the front door ('*You go to a lot of houses now and let you be known no matter, you are met on the doorstep'*) and not invited in, and to Martha the neighbourhood lacks the sense of attachment and inclusivity it once had. There is now a disconnection between the home and the neighbourhood as an extension of the home. Home, once a place open for socialising, is now more private, intimate and closed to the wider community and this according to Martha erodes the connections that encourage a

sense belonging (*You know if there is not somebody to call in and out you are left there*). Interestingly when Martha agreed to take part in the interview she was given two options for the location of the interview, the first option was for it to take place in her home, and the second option was for the interview to take place in the local Family Resource Centre. She chose the latter.

Within place people engage in various 'practices of boundary making' that can act to include or exclude people from a collective sense of belonging (Mee and Wright, 2009: 772). Such practices of boundary making are evident in Martha's account. For example her statement '*there is no sort of neighbourliness now with people, you know they are friendly and they bid you the time of day, but don't trouble me, sort of way, you get that feeling*' provides a qualitative insight on how loneliness can become an emotional contagion (Hatfield, Cacioppo and Rapson, 1994; Berscheid and Reis, 1998; Cacioppo *et al.,* 2006). Martha is not living in a remote area but rather she is surrounded by the activities of village life, thus the issue of proximity as an emotional rather than distal concept emerges (Cacioppo, Fowler and Christakis, 2009). Martha presents us with a picture of a fluid contemporary world defined by mobility, transitions and people who are '*are just hopping into cars and driving off'*, in contrast to the slower pace of those who used to '*go by to the village on push bikes*'.

Like Mag and Kay there are new people settling into Martha's village. Martha's encounters with the new people in her neighbourhood can be understood in terms of 'elective belonging', where identities and belonging are subject to mobility and one's choice of place to set down roots, as opposed to communal roots, place-based shared histories and nostalgia (Savage, *et al.* 2005). This idea of elective belonging is at odds with Martha's experience of, and most importantly her expectations of, what home and community life should be like. Elective belonging is also at odds with social participation in the context of the neighbourhood, where social participation is understood as a continuum of social interactions that are based on 'life-long spatially situated social relationships' (Ziegler, 2012: 1297). There is thus both spatiality and a temporality to these relationships, and expectations of them. The accumulation of Martha's experience of community life has provided her with an idea of what community relationships, as a form of social participation should be like. The difference between expectations and reality of these embedded relationalities requires a strong SOC to adjust (Antonovsky, 1987) and to prevent feelings of disconnection and loneliness. Indeed because neighbourhoods change over time and

meaningful social relationships have to be continuously renewed (Ziegler, 2012), one's SOC could be strongly implicated in adjusting to these changes (Antonovsky, 1987), and also in determining the formation of new meaningful friendships (Bauminger *et al.*, 2008). People want different things from their social networks, some people are more introverted and are happy to be removed from wider community relations and instead have just a few close confidants. For the older person however having a few close friends, specifically age-peers, can leave them susceptible to isolation if or when these close friends pass away as already discussed. This potentially undermines their SOC.

The changing use of the home, in particular its shift from an open and transient space to a bounded space of privacy may have implications for health and wellbeing because it might act to promote social isolation. The home as a space for establishing meaningful relationships with the wider community, as a place for developing and accessing internal and external resources, and as a site for ordering the spaces of the local community, was once a natural focal point for social networks and supportive relationships. Anne reiterates the importance of the home as a positive affective place. The 'door is always open' mentality was according to Anne important to her quality of life.

> *Int: How would you describe your quality of life?*
> *Anne: Good, yes, very good. I have nothing to complain about.*
> *Int: What do you think makes it good?*
> *Anne: Well I think it's up to yourself to be as active as much as you can, participate in whatever you can. Have all your neighbours. The neighbours come in and we would have a chat, they all seem to come, the door is always open and I always seem to have someone. That makes my day, as the saying is.* [The neighbours across the road] *all I have to do is give a ring if I want anything. It is a security, very much so.*

Anne lives in a rural area, with only a small number of houses on her road. The neighbours she is referring to are a married couple in their late thirties with two teenage daughters. They are not related to Anne but she regards them as close to her as her own family, and has developed a strong bond with the family since they arrived. With the changing nature of the home environment from an open and welcoming space to a more private and intimate space the maintenance of close interpersonal relationships is made more difficult, as is giving and receiving informal care and support. For Anne quality of life is determined by close and continuous contact with neighbours within the personal space of her home. The quality of supportive relationships for older people appears to be determined by access to such

personal spaces, and to be a process of 'letting people in' both emotionally and spatially. Where access to the home environment is denied the quality of meaningful interpersonal relationships might be reduced.

For some older people the relationships already within the home provide the sense of belonging and socio-emotional support they need. Julia, for example, is immersed in the middle of family life. In 1978 she retired from farming and moved into an apartment attached to the family home, her son took over the running of the farm, married and raised his family next door. In reviewing her life since her retirement from farming she felt that being in the middle of family life and surrounded by her grandchildren as they grew up was a significant and important factor in promoting her health and wellbeing. Indeed she felt that having plenty of family around her meant that her involvement in the wider community, in particular the active retirement group, was not necessary because she was *'seldom ever alone'* and had enough meaningful relationships within the family unit, buffering her against the loneliness often associated with later life. Her grandchildren have played a significant role in her life:

> *Julia: And of course the young crowd coming up, keeps me interested in life. I know about each one, what they are doing in school and all. I am interested in the schools, with my own having gone through. It's very important for me to know what each one is doing, it keeps me interested.*
> *Int: Do you go out much?*
> *Julia: Ah not really, I played bridge during the summer, actually for years, but then I broke my arm… The parish is very important. But, no I don't go out much, everyone is here.*
>
> *Reflective Journal*
> [Julia's] *home was full of activity, while I was there four of her family members dropped by to say hello to her. This was a typical day she said, 'they never forget me, always calling in to check how I am and if I need something'.*

The 'door is always open' mentality was also present in Julia's account, but this was limited to family. She felt that because she regularly had company she had access to the necessary close and meaningful personal relationships within her family and these relationships were acted out in the home environment, and as a result she did not feel the need to look for them in the wider community. A home environment where the 'door is always open' might not always however result in emotionally fulfilling friendships. Meaningful friendships tend to have considerable longevity, or a history, as with Kay, Maimie and Mag, and are established

as bonds between individuals rather than relationships dependent on places of interaction as Martha is suggesting. Martha is keen to form friendships that have a strong instrumental aspect so she can derive a sense of security from them, and such relationships might have a particular spatiality to them. However, it might also be the case that emotionally close relationships are not as spatially contingent, and that the 'door is always open' policy might not always foster a sense of closeness. For Matt, whose account is given next, this appears to be the case. Meaningful relationships are not just dependent on the fluid nature of the home as a social space, but the inter-subjective nature of friendships are also dependent on time. This is because the relational view of the self can be established over time, in terms of long and short-term relationships. From the previous discussion on the relationship between belonging and place, context, specifically the home environment, seems to have some influence on the form and intensity of friendships. However, friendship itself can act as a relational space in which emotions are made (Cronin, 2014) because emotions arise at the interface between the self and the (social) world (Hubbard, 2005). The discussion so far suggests the importance of home as an important site for bringing people of different generations together to foster relationships and bonds. However, this might not always be the case because relationships experienced within and through the home do not always bring with them a sense of closeness.

Matt's wife died several years ago. Being widowed was a very definitive time in Matt's life, and every day Matt laments her loss. The loss of an intimate bond and companionship following the death of a spouse can leave people, both young and old, very vulnerable to loneliness (Cattan, *et al*., 2005). This is certainly the case for Matt. At the time of her death Matt was living alone and his adult children were dispersed throughout the country. At the time of the interview he was living next door to his daughter and her young family.

> *Matt: 'Now the day is long here, sometimes you would be sitting here and you wouldn't see anyone all day* [...] *I am used to it. I am nearly used to my own company now. But sure I was at home when* [my wife] *died. Mary might be home, Marian wouldn't, except I went up and brought her home, and that was to Sligo, I would bring her home Friday evening and drive back Sunday with her. Now after dinner, drive to Sligo turn around and come back again, get a cup of tea maybe, go home again to an empty house, so you had the house to yourself from then until Friday evening. And the funny thing about it the people that used to come in and out never came in anymore. Only two women ever came into chat to me and I didn't know them that well at all...* [eventually they

stopped calling in] ... *I have buried my wife, and I married again and buried my second wife. So as the lads say you couldn't say my life was a joy. It was a hard rough and tumble the whole way. Anyway the only way I look at it is... now there was times, when my wife died, of course, it is the hardest thing, you have no idea. I have buried my mother and my father, and my brother, but you have no idea what it is like until you bury your wife, you know it is a different game altogether. You know like you come home in the evening from a day's work or whatever it is, you sit down and have a chat with her, and it won't always be rosy, but thanks be to God we did have a good life. Maybe I am thinking it was better than it was, but we were not inclined to argue. Now we won't talk much about the second wife because I wouldn't advise anyone to get married a second time. Now if you get one keep them forever if you can. But you see I was unfortunate my* [first] *wife died.* […] *You had a whole week to sit at home and brood and wonder. But the only thing is I had three good girls, the best in the world, and with that I said there was something to live for. Which I did.'*

Friendships can often help people to negotiate challenges and adversity, such as during a time of grieving. After Matt's wife died, her friends continued to visit him perhaps out of a sense of obligation to their friend, and to look out for Matt after his wife's passing. What is not mentioned in Matt's account here, is that much of his working life was spent away from home, and this may have meant that the habit of his friends calling to his house was not established by the time his wife died. While his wife's friends called to visit, and although it was appreciated, these were not established and meaningful relationships. They lacked the longevity of the bonds of meaningful relationships. This perhaps represents a gendered dimension to the presence of social networks within the spaces of the home. Because of the nature of his work he would spend long periods of time away from home, and as a result did not often socialise in the local community. Now in later life, and left widowed, Matt's social circle consists mainly of family members. He has a very good relationship with his grandchildren, and plays an active role in their lives. Apart from going to watch his grandchildren participate in sports and going to the church he does not interact very much with people outside of the family. But his family has kept him going, kept him motivated and engaged in life ('*the only thing is I had three good girls, the best in the world, and with that I said there was something to live for. Which I did.'*)

It was apparent throughout our meeting that the death of Matt's first wife was a traumatic experience for him. He loved his wife deeply and struggled to find meaning in his life. He found comfort in prayer but the reality of her passing was difficult for him to come to terms with. He did eventually meet someone and got married again, but Matt believed this to be a mistake, and saw it perhaps as almost a betrayal to his first wife. But his second

marriage was to find that feeling of belonging and closeness that human's crave, that is fundamental to our nature. Matt's second wife also passed away. He was not willing to discuss their relationship.

Remarks on belonging, place and the SOC

Belonging in the geography literature might also be interpreted with relation to the idea of 'knowing', where knowing refers to relationships that have an ontological depth accrued over time. Knowing another person or a place, or people in places, is not just about being familiar with, or having knowledge of them, it is about what matters in terms of the relationship or connection. Knowing is the multiple practices that position people in multiple ways with relation to other people, and place, and with relation to memory, change and the past (Degnen, 2013: 555). What matters about the relationship is what binds it, whether it is the shared history and biography such as that expressed by Mag, the feeling of familial bonds as with Julia, the deep affection one feels for their best friend such as Kay had for her friends, or the love a husband has for his wife, such as Matt's. What matters is the motivational component, or the meaning that one attaches to these relationships, and this meaning provides the ontological depth that differentiates a sense of belonging from feelings of detachment, and loneliness from social isolation. Of significance is the subjective nature of feeling a bond or a sense of belonging. Feelings about other people, and about the places that daily life is immersed in will determine to some degrees one's sense of wellbeing. The processes that operate in that relational space between friends, loved ones or neighbours have implications for mental and social wellbeing, and given the review of the research literature at the beginning of this chapter perhaps for physical health also. This is because it is in this space that emotions are generated (Cronin, 2014; Hubbard, 2005).

The SOC as an analytical framework can to some degree make sense of these processes and the emotions that arise. Taken in their abstract terms meaningfulness, manageability and comprehensibility can be used to examine this space, but as an explanatory tool much interpretation of the theory is still required. The relational space between an older person and their environment is negotiated in terms of their SOC, while at the same time the SOC is a product of the processes that occur in this space. For example meaning can be established through relationships (meaningfulness), while character traits such as self-esteem and self-worth, recognised as internal resources for manageability are very often derived from relational encounters with the external world, as are external

resources to support an older person to age-in-place. It is perhaps the comprehensibility component that can provide a new perspective on how older people experience the world relationally. One aspect of the comprehensibility component is how well people feel they know those that they are in contact with daily. Knowing them very well increases one's SOC. Being able to predict other people's behaviour, for example knowing that someone will be supportive during a challenging time, is also associated with a higher SOC. Comprehensibility is about putting order onto chaos, and so 'knowing' the people in your relational space, and feeling a sense of belonging, is part of ordering the lifeworld, and buffers against stress during change. Thus for older people such as the participants who have outlived their husbands, wives, friends and siblings, their comprehensibility is challenged, and this poses a challenge to their health and wellbeing. The discussion presented in this chapter is too tentative to provide a conclusion on the link between the SOC and health in later life, however what it does do is provide the qualitative link between the components of the SOC, and the lived experience of ageing-in-place. It also points to the extent of the impact of subjectivity in determining bio-psychosocial integrity.

Chapter 9

Spirituality as a resource for health

Antonovsky (1987) suggested that individuals experience their worlds as bounded spheres, where the boundaries are negotiable and fluid. One of the crucial spheres of life identified is the existential sphere, and this sphere was easily identifiable across the research participants because they all had an active spiritual life, that they recognised as important in contributing to their ability to cope, and also their wellbeing. This chapter will consider the spirituality within the framework of the SOC, and in particular looks to the content of individual questions in the Orientation to Life questionnaire to locate the SOC cognitively in the participants' global orientation i.e. how they view the world and understand their place in the world.

On a global scale spirituality, understood as a single humanity or oneness (Hornborg, 2013) has been identified as an important aspect of life that has made a positive contribution to people's health and happiness. As a result the World Health Organisation was eager to incorporate spirituality as a fourth dimension of health, alongside the physical, social and mental dimensions (Dhar, Chaturvedi and Nandan, 2011). Importantly, contemporary discourses on the role of spirituality, as the oneness or unifying essence of humanity, should not be confused with religious dogmas, orthodoxy and fanaticism, that separates humanity in accordance with the details of a given belief system (Hornborg, 2013). Indeed the link between health, religion and spirituality has been largely avoided within policy because it is subject that many may regard as too irrational, emotional or political (Rhi, 2001; Levin, 1996). However, in recognising the emerging evidence that religiosity and spirituality does in fact appear to have an influence on health and wellbeing it does need to be addressed in the health literature (Koenig, 2013). This requires the focus on spirituality to concentrate on the day-to-day spiritual and religious practices that positively contribute to individual and collective wellbeing (Dhar, Chaturvedi and Nandan, 2011). While religiosity and spirituality are recognised as important determinants of physical and psychological wellbeing, and quality of life (WHOQOL, 1998), it appears to be particularly relevant in helping to cope with the changes experienced in later life (Atchley, 1999). The purpose of this chapter is to situate spirituality and religiosity, as reflected on in later life and expressed in the qualitative life review data, within the salutogenic framework of the SOC. In particular the role of spirituality and religiosity will be examined as a way of

finding meaning and comprehension in life, and as a source of some of the necessary generalised resistance resources (GRRs).

Unlike the pathogenically oriented model of illness, the salutogenic model recognises that even the terminal patient can still move towards health and experience healing despite the deterioration of the physical body, or disturbance of the homeostasis of the biological organism (Antonovsky, 1987). This is because the salutogenic model recognises that health is multidimensional, and so for an individual to be healthy and to experience wellbeing, holistic healing is required. Holistic healing as such requires attending to psychological, social and spiritual wellbeing and represents a movement towards a biopsychosocial-spiritual model of health (Sulmasy, 2002). In recognising people as existential beings in resilience research, the role of religious beliefs and spiritual values supporting wellbeing and providing life strengths are accounted for (Fry and Keyes, 2010). The salutogenic orientation provides scope for taking seriously the role of spirituality in promoting and maintaining positive health and (inner) resilience when faced with the symptoms of physical and mental decline associated with normal ageing. Indeed towards the end of life older people tend to become acutely aware of the finite nature of life and may seek answers to existential questions such as the meaning of life (Atchley, 1999). The older person asking and finding satisfactory answers to existential questions represents a final act of healing (Sulmasy, 2002). This might be one of the routes through which the older person who is experiencing physical and mental decline can move along the health-ease-dis-ease continuum as described by Antonovsky (1987). The movement towards the healthy end of the continuum through positive engagement with spirituality could be described as later life spiritual development and recognises it as part of a continuous process of self-development (Atchley, 1999). The notion of continuity is important here because it recognises that spirituality can be an ongoing relational process between the individual and the transcendent. However, for some people the conditions of later life might intensify the awareness of spiritual needs and this might lead to a more intensified engagement with spiritual life. Such engagement will reflect the older person's religious background and the extent of their engagement throughout their life. For those who have always valued a religious or spiritual belief system there is often a continuity of the inner resources associated with that spiritual life (Atchley, 1999). This continuity of accessing the inner resources of spiritual life for resilience in later life is present in the life review accounts presented later in this chapter. As discussed in previous chapters interpersonal relationships

are vital in shaping health and wellbeing, and within the biopsychosocial-spiritual model of health the individual's relationship with the transcendent appears to be similarly influential on health and wellbeing. As a person approaches later life they might experience changes to their relationships with family and friends, and in a similar manner they may also experience a changing relationship with the transcendent. Such changes are significant to wellbeing (Sulmasy, 2002). The role of ongoing relationships with the transcendent has attracted considerable attention from health researchers (George, *et al.*, 2013).

The SOC as a relationship with God: finding meaning and comprehension to manage adversity

Antonovsky does not make reference to spirituality, religion or God as significant determinants influencing an individual's ability to cope and maintain resilience in the face of adversity. Despite this the definition and components of the Sense of Coherence provide scope for its inclusion into the salutogenic framework to understand resilience. Taking the terms of the SOC it is possible to merge the SOC with an existential framework of religiosity and spirituality to explore resilience. The definition of the SOC refers to a

> *'pervasive, enduring though dynamic feeling of confidence that […] the course of living are structured, predictable and explicable […] the resources are available to one to meet the demands […] these demands are challenges worthy of investment and engagement' (Antonovsky, 1987:19).*

Using this definition the SOC can be applied in exploring the role of faith or having confidence in a higher power, namely God, to promote wellbeing and health. Faith in God leads to feelings of confidence that the necessary support and strength to overcome adversity will be provided, and engagement with spiritual teachings will provide guidance on living a good life, and secure immortality in the afterlife. Having faith in the presence of the divine makes it seem more achievable to overcome adversity (George, *et al.*, 2013). For example when an individual is suffering from serious illness, and does not have the confidence in himself or herself to recover, having trust in God may replace confidence in the self (Strang and Strang, 2001). This might compensate for feelings of not being in control. The 'structured, predictable and explicable' nature of life (Antonovsky, 1987: 19) can be understood as the life God has planned for each person and the blessings and challenges He has presented them with. In terms of 'resources', GRRs may take the form of having an innate confidence in God and trust that He will provide support during times of

crisis, and give the strength required to recognise and draw on the available resources during adversity (Perschbacher, 2002). The individual seeks out this support by communicating with God through prayer, asking Him for help, guidance, and to provide divine inspiration. Seeking connection with God acts as a coping behaviour when confronted with adversity, and is found to be a positive influence on mental health and quality of life (Maltby, *et al.*, 1999; Koenig, 1995). Celebrating the existence of God as a collective provides feelings of closeness with the divine, and feelings of belonging to a community. This extrinsic dimension of spirituality is positively correlated with anxiety, a threat to psychological wellbeing (Maltby, *et al.,* 1999). Rote *et al.,* (2013) for example found that religious attendance is associated with high levels of social support and social integration and lower levels of loneliness. Religiosity can therefore be regarded as a source of relational resilience. The religious community offers opportunities for socialising and a medium through which to find social support. Religious discourses tend to be strongly associated with and promote interpersonal connectedness, and the creation of social bonds (Cummings and Pargament, 2010). In addition to this the individual can, through prayer, be in constant conversation and communication to someone they believe is both listening and present:

> *'Even though I walk through the valley of the shadow of death, I will fear no evil for you are with me; your rod and your staff, they comfort me.' Psalm 23:3*

The challenges that life presents to the individual are considered 'worthy of investment and engagement' if these are challenges are considered as sent by God, thus making them meaningful. While illnesses and other difficulties are not desirable, spirituality might make them comprehensible[15], and this may aid in accepting the situation and it is through this acceptance that mental health might be buffered (Strang and Strang, 2001). Under some interpretations such challenges might also act as a test and requires the individual to look to spiritual teachings for guidance, and by putting into practice these teachings a place is earned in Heaven. This also makes the challenges meaningful and provides the motivation to invest in overcoming them.

Meaningfulness is recognised by Antonovsky as the most important component of the SOC, because without it the components of comprehensibility and manageability are redundant. The person with a high SOC asks how they can find meaning in a difficult situation and the person who can find meaning are said to be demonstrating a profound SOC

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[15] 'For God is not a God of confusion but of peace' Corinthians 14:33

(Antonovsky, 1987). Through finding meaning in terms of a relationship with a higher power the individual can interpret the world and their place, and arguably it is through this interpretation that the SOC and spirituality can be linked to health and wellbeing. The meaning and reason that people find in their religion might provide some relief for people when they are experiencing stress or suffering. This is meaning-related resilience (Cummings and Pargament, 2010). Krause (2003) found a relationship between older people believing that God had a plan for their lives, and life satisfaction and optimism. For people who draw on their religion to find meaning when confronted with a stressor, when they experience suffering, or when they are confronted with personal hardships, they may see such realities as having a purpose, which has been devised by God. For example, following tragedy families may find meaning through their religion and use this meaning to cope. Murphy, Johnson and Lohan (2003) found that parents who had lost children in tragic circumstances and turned to religion following their death had been able to find some meaning in their circumstance during the 5 years that followed their child's death. Dalal and Pande (1988) found that Indian patients left permanently disabled after an accident and who believed that the reason of their accident was to be found through God or karma were more likely to expect to recover, and were more likely to make plans for the future. Krause *et al.'s* (2002) research on older Japanese people provides further support for the existence of a positive relationship between religion, meaning and health. They found that older people who held religious beliefs were less likely to suffer from hypertension 3 years after the loss of a loved one, than those who did not believe. The researchers suggested that perhaps the anticipation of meeting the loved one in the after-life might have buffered their suffering. Considering these research examples it seems that drawing from religious beliefs may make it easier to respond and adapt to suffering.

In breaking down the SOC to look at its elements more closely it is possible to explore the connection between having an ongoing positive relationship with a higher power and spiritual wellbeing and resilience. The construction of the SOC integrates a stress/coping model of comprehension and manageability with the meaningfulness of spirituality (Strang and Strang, 2001). For instance in attempting to measure the SOC, the Orientation to Life questionnaire asks the participants if they have a defined purpose in life (question 8; meaningfulness); if they suffer from existential angst (question 14; meaningfulness); if they find it difficult to find a solution to a problem (question 15; comprehensibility); if they have someone they can count on in the future (question 23;

manageability); if they feel that they can overcome difficulties (question 27; manageability); if they feel that they can find meaning in the activities of daily life (question 28; meaningfulness); and if they feel that their life is under control (question 29; manageability) (Antonovsky, 1987: 190-194). Each of these questions relate to the individual's perceptions of the world and their place in it, and specifically how they relate to the people that make up the social and institutional environments they encounter. For many people this relationality also incorporates a relationship with the intangible and immeasurable spiritual world (Sulmasy, 2002). The construct of the SOC provides considerable scope to include the individual's spirituality and their relationship to a higher power or spiritual entity as a source of resilience. Importantly this scope provides further qualitative understanding of the SOC components and their relationship to resilience, health and wellbeing. The answers to the questionnaire might be framed cognitively by the participants according to their belief systems, for example the existential understanding gained from biblical teaching might buffer against existential angst (question 14), being able to turn to God and prayer during times of crisis, or to express gratitude when life has been kind, may help the individual cope and maintain feelings of control over a given situation (questions 15, 23, 27, 29), and the meaning provided by spiritual life may provide the motivation for the activities of daily life (question 28).

In analysing the life review data these were the sorts of themes that emerged on spirituality and subsequently located themselves in accordance with the SOC components. The value of questioning the SOC qualitatively rather than relying on the quantitative measure is that this level of insight cannot be gained from such measurements. How can the researcher tell the source of purpose or meaning that is registered by the participant on the survey? Without qualitative insight the SOC is void of reality because it is not grounded in the every day experience, or contextualised in biographical detail. Subsequently, the route to promoting health using the salutogenic orientation is inaccessible until the SOC is understood qualitatively. The SOC is socio-structural in nature, but was designed so that it can be applied accurately as a measurement tool across cultural contexts and here lies its merit, but also its limitations. The SOC as a measurement is comparable across cultures (Antonovsky, 1987), but its interpretation requires attention to cultural values and societal norms, because these can and do impact on wellbeing (Gatrell, 2009). For instance, several of the research participants expressed their resilience and coping styles in relation to their religiosity and spirituality. These accounts are heavily situated in biographical detail laden

with references to an early to mid 20th century Irish society compelled by Catholic Church teaching and dogma (Inglis, 1998). Yet, despite the parochial nature of the society they grew up in, the participants express sincere trust in their own independent spiritual beliefs in strengthening their resilience and in contributing to their health and wellbeing. In analysing the data through the SOC framework it was important to keep this in mind, and to consider the findings exploratory rather than conclusive, and using the data primarily as a means to locate the SOC in the activities of daily life, and a value system informed by Catholicism.

Spirituality, health and wellbeing

The incorporation of religiosity and spirituality into health research, care and practice represents yet a further shift in our understanding of the mind-body relationship. It represents a movement even further from the biomedical model, to expand the social model, so that it becomes a biopsychosocial-spiritual model of health and wellbeing. This forces the health research community to move into a paradigm that acknowledges the human as an intrinsically spiritual being and where spirituality can influence health (Sulmasy, 2002). Many quantitative and qualitative studies have been conducted to examine the relationship between spirituality, religiosity and health (Koenig, 2013). The evidence presented by many of these scientific studies indicate that spirituality and religiosity can have a beneficial impact on physical health, including cardiovascular and neuroendocrine health as well as immune system functioning (Tartaro, Luecken and Gunn, 2005). Spirituality is also found to be an important buffer against mental illness (Strang and Strang, 2002). One of the greatest challenges for the scientific study of spirituality, religiosity and health is the difficulty in measuring spirituality and religiosity because they are intangible, subjective and multidimensional concepts (George, *et al.* 2013).

Spirituality has been recognised as an essential component of successful ageing, but something that is often forgotten about in models of ageing (Crowther, Parker and Achenbaum, 2002). Of significance for healthy ageing are the health relevant aspects of spirituality and religion, and these health benefits can be understood in terms of positive spirituality. Positive spirituality is defined as

> *'developing and internalising personal relations with the sacred or transcendent that is not bound by race, ethnicity, economics or class and promotes the wellness and welfare of self and others'* (Crowther, Parker and Achenbaum, 2002: 613).

Through positive spirituality older people are provided with a sense of control and reduces the sense of helplessness that accompanies illness. It also provides a cognitive framework that reduces stress and gives meaning. Activities associated with the practice of spirituality, such as praying and being prayed for by another person may act to reduce the feelings of isolation and contribute to feelings of control (Close, 2002). Similarly participating in public rituals, such as attending church services, and receiving visits from church representatives all act to combat loneliness and isolation and provide a sense of belonging (Close, 2002). Participating in organised religious life also promotes older people's engagement with life and supports them to stay active. Religious beliefs also provide guidelines on lifestyle and behaviour that are positive for physical and mental health, and people who participate in religious life tend to have better health behaviours (Masters and Knestal, 2011). A belief system that regards life as a gift from God requires self-restraint with regard to unhealthy and hedonic vices. Studies have found that people who regard themselves as spiritual are more likely to engage with self-care and to be assertive with regard to health concerns (Freidman *et al.,* 2006; Prado et al., 2004; Canada *et al.*, 2006). Given the extent of influence spirituality and religion has on the determinants of health its role in health promotion is recognisable (Crowther, Parker and Achenbaum, 2002).

Prayer: Resilience through belief in God

'When difficulty falls upon you, remember that God, like a trainer of wrestlers, has matched you with a rough young man 'for what purpose?' you may say. Why, that you may become an Olympic conqueror.'
Epictetus

Examining the SOC qualitatively from the philosophical perspectives of stoicism and spirituality provides further insight on the role of the SOC in coping with adversity. The stoicism of the SOC provides an optimistic worldview, because it argues that people can flourish in any circumstance and under any condition. Of significance here is the role of inner freedom (stoicism) and the soul (spirituality) as something that is unreachable except by the Divine. According to stoic philosophy nothing can harm the soul unless it is allowed to (Frankl, 2006). This stoic principle underpins cognitive behavioural therapy used in contemporary psychiatry and counselling to overcome mental illness (Robertson, 2010). When faced with stressful circumstances, such as those associated with the normal process of ageing, the older person may enter into a process of spiritual development, where the

matters of the soul are attended to and cared for (Atchley, 1999). Indeed when faced with adversity some people might regard their difficult circumstances as opportunistic and a good time to consider the condition of their spiritual life and for spiritual growth. Alternatively they might also consider such adversity as punishment from God (Koenig *et al*., 2001). The process of spiritual development may take on many forms, but ultimately it is about achieving a kind of inner freedom that will buffer the soul against the insults to the body and mind. This inner freedom might be understood in salutogenic terms as forming an ultimate Sense of Coherence or understanding of one's place in the world (Antonovsky, 1987) in relation to the Divine, and understanding the meaning of the life they led and of the life they still have to lead. To draw on Epictetus and place stoic philosophy into the SOC framework informed by spirituality, God issues the challenge but also provides the resources required to overcome the challenge (manageability), and He has a reason or purpose for setting the challenge in the first place (meaningfulness).

One route of spiritual development during stressful times is through prayer. Prayer acts as a resource that can be used to overcome adversity (Koenig *et al*., 2001). For example using prayer to communicate with the Divine and ask for guidance might provide strength and initiative to access other inner resources when faced with a crisis (Perschbaker-Melia, 2002). According to Wachholtz and Samhamthoori (2013) in their application of the transactional theory of stress and coping, prayer can be understood as a cognitive act that can reframe pain in a more positive way. They found that prayer as a coping resource acts to buffer mental and physical health. Through prayer the individual experiencing pain may find a

> *'demarcated 'place' both in time and space where one can actively re-appraise his situation based on the framework of his meaning system. This cognitive processing can stimulate a healthy adaptation to the pain of the situation' (Wachholtz and Samhamthoori, 2013: 543).*

Communicating with the transcendent through prayer is a means by which to find support during crisis, and a sense of belonging or connection with something outside of oneself (Wachholtz and Samhamthoori, 2013). At the same time the meaning system provides some order to the chaos of life as it unfolds, making it appear more comprehensible. In the previous chapter on close personal relationships the significance of loneliness and belonging to health and wellbeing was examined. The themes of loneliness and belonging emerge yet

again here, this time as an important aspect of spirituality. In the previous chapter loneliness was described in terms of the discontinuity of places and the discontinuity of place-based relationships. In exploring the data to determine the possible role of spirituality in enhancing the SOC existential loneliness (Ettema and Derksen, 2010) emerges as something that is offset by an ongoing relationship with the transcendent. In the previous chapter close relationships were considered with relation to the SOC as a source of meaning, comprehension and manageability. Likewise here an ongoing and continuous relationship with the divine appears to have a similar role in supporting the SOC components when faced with adversity.

Existential loneliness and religious coping

In the following account Matt discusses the significant role faith played in helping him cope with the many crises he has faced in life. In particular the importance of an ever present, close and intimate relationship with the Divine when other relationships were inaccessible resulting in feelings of isolation and alienation. An awareness of existential loneliness due to an absence of relatedness (Ettema and Derksen, 2010) strongly emerges from Matt's account. This absence of relatedness follows the death of his first wife and the feeling that she is irreplaceable. Further to the emotional pain of mourning his first wife Matt also experienced an absence of relatedness when he experienced physical pain. Rather than seeking comfort in others he sought it from the transcendent through prayer because he felt others were burdened with their own problems, and he could find more understanding through communicating with God. It is important to note that Matt is aware of the threat of existential loneliness but actively uses his spirituality and belief in the transcendent to buffer against it. This emerges as a feeling that he is fundamentally alone in the physical world when experiencing a crisis:

> Matt: 'Religion is very important if you are in a hospital bed and you are sick and sore. I was in Kilkenny hospital for three weeks and I suffered martyrdom before my foot was amputated, and who would I turn to?'
> Int: Would you turn to prayer as a way of coping?
> Matt: 'Yes sure what else have you? You are there in the hospital and your sick and sore what do you turn to? You don't start cursing, there is no use talking about the devil. I don't know whether there is either, but I firmly believe in something. There must be something. No matter what religion they are they all have something. I do I believe in religion and I believe it helps you get through […] Well you see what option have you? What do you do? Finish yourself off or continue on? And that's a thing [suicide] that has never entered my mind […]'

Int: 'You mentioned the next generation might not believe in it, do you think that would be a major loss?'

Matt: 'A mighty loss. Well what have you if you haven't God? You are young and you are probably on a crossroads and where do you go if you don't? Tell me now you are young?'

Int: 'Personally I never had much attachment to religion. If I was in trouble I wouldn't turn to religion or prayer.'

Matt: 'And who would you turn to?'

Int: 'I think I turn to myself.'

Matt: 'Well isn't it nice to have a shoulder to rest on at times? Something to help you through? You see the trouble is in my time when you were young suicide wasn't on. You never heard of it because we were told that God put us on this earth for a purpose and he would take us off it in his own time and anyone that took their own life were really spitting in His face, and you were doomed. I never heard tell of a suicide when I was young, and I can also say very few murders. […] Well when you're young do you ever think you are going to be killed? Do you ever think you are going to die? You think you are indestructible. But you don't know what could be around the corner, but when you come to my age if I get another 5 years I would say I am doing mighty well […] What else is it? I know I could say the same here now, but that's the way from the day we are born. There is only one thing you are sure of or I am sure of the day we are born, is that we are going to die and whether it come in ten, fifty, or one hundred years you can't do anything about it. You depend on the call [from God]. It's like a neighbour here used to say when the man above opens your page that's it! Another lad was very sick and he nearly died, he was fairly well on in years 'God you got over it John, you got over it well and you came out of it' they said to him and he said 'Ah sure they had enough of scrap up there they didn't want me" [Laughs]. And my [late first wife] God be good to her used to say only the good die young. And she went young. She was only 49.

Int: That was very young. Was it long afterwards that you got married again?

Matt: Oh it was ten years nearly, maybe more. I wouldn't advise anyone a second time. Unless you are very young. Because they will never be the same to you. Your first love is number one. Now I went with another few girls but never for very long, I dated a couple for a short while, a few months. I did one night stands and this and that but there is something different about… and you will never repeat it.

Int: I suppose your heart is broken the first time and you had to mend it.

Matt: It is ya.

Int: Did prayer get you through that? You didn't think why has God done this?

Matt: I asked that question umpteen times. Why did he, why did he make life so hard, so rough on me?

Int: But yet you didn't abandon religion or your faith?

Matt: Well who was I going to go to? Now that's a simple question for you to ask yourself. Who are you going to go to? Who are you going to talk to when there is no one left? Well if you hadn't a bit of divine inspiration to turn to, what else have you? […] You know divine inspiration is always with us […] Well the way I look at it is that every day you are able to get out of the bed and stand upright is a blessing. And you know when you look back we do get our

knocks, but then I would be half thankful enough when I see what others endure. You see other people sitting in a wheelchair, for the short life they get and when you look at things like that, when you are young you don't see them things then like you do when you go on in years. And when you look at that now would you say you should thank God for as I am even though I may be suffering, even though I may be in pain. But is it ever bad enough to say 'enough is enough'? That's the way I see it. If you are middling at all there is no point loading others with your problems because they have their own problems.'
Int: Do you think that gives life meaning?
Matt: Of course it does. If there is nothing [God or an afterlife] we only go down like the animal […] Well you say to yourself what is it all about? Why do I ever bother? You might say feck it what's the use of praying no one ever listens to me. What's the use of talking, whispering with no listening?

Quality of life is not just down to the quality of health care received during illness for example, it is also dependent on the quality of inner emotional life (Mayers and Svartberg, 2001). For Matt faith and prayer has provided a means through which to maintain, in salutogenic terms, a stable internal environment (Antonovsky, 1987). Several times Matt felt he was being pushed too far in life. His first wife, his first and only true love, died young and this was a terrible 'blow' to Matt. When his second wife died he was still mourning the first wife, and during these significant life events he also experienced considerable ill health, notably here he talks about suffering 'martyrdom' with the pain in his foot when it became infected with gangrene. At times Matt questioned God's role in bringing him to this place in life having suffered a difficult fate. Matt never lost his faith in the Divine because it seems if he lost faith in God he would be putting himself in a position of existential loneliness (Ettema and Derksen, 2010). There are numerous risk factors evident in Matt's account that placed him many times at a critical turning points in life. According to salutogenic theory the person that can rise above such adversity is demonstrating a strong SOC (Antonovsky, 1987). In Matt's case there is evidence that this strong SOC and the desire to continue to plough through adversity is attributable to his faith.

The three characteristics of existential loneliness are offset by Matt's persistent belief in divine inspiration. Firstly, existential loneliness results from the fundamental separation from others (Ettema and Derksen, 2010). For Matt this fundamental separation was most obvious during times of ill health when he was *' in a hospital bed […] sick and sore'.* This experience could have been both frightening and isolating, and perhaps it was, but he found solace through prayer, and accessed inner strength to recover through his beliefs and religious practices. Giving up was not an option ('*God put us on this earth for a*

purpose and he would take us off it in his own time and anyone that took there own life were really spitting in His face, and you were doomed'). The second characteristic of existential loneliness also present in Matt's account is the absence of relatedness (Ettema and Derksen, 2010). Relatedness and feelings of being understood are recognised as an important element shaping one's SOC (Antonovsky, 1987). The absence of relatedness is evident in two ways in Matt's account. The experience of undergoing an amputation is not something that many people can empathise with, but because it was somehow part of God's plan for Matt, there was sense of understanding on the transcendent's part as to what Matt was going through. This relatedness was not available from those in Matt's support network. When Matt's first wife died he sought out other relationships to fill the void she had left but was unsuccessful. Again Matt anticipated understanding from the transcendent because it was also part of His plan ('*And my* [late first wife] *God be good to her used to say only the good die young. And she went young. She was only 49')*. The third characteristic of existential loneliness is that it is a process through which a negative experience can be transformed into a positive one, resulting in a renewed search for meaning and understanding. These are both aspects of spiritual development and inner growth (Ettema and Derksen, 2010). For Matt the difficulties he experienced over the course of his life reaffirmed for him the role of prayer and spirituality in his life as a source of strength and inspiration. Without it he felt he had nobody to turn to.

For the older person there are many aspects of later life that can and do act to induce existential loneliness, most notably ill health, the prospect of dying, and the death of loved ones. As a result death anxiety becomes an important topic of spiritual contemplation. Existential loneliness and death anxiety are thus closely related. According to Baumeister and Leary (1995: 23) death anxiety can be understood in terms of both friendship and religiosity. In particular death anxiety is closely related to the understanding that belongingness is a fundamental motivation, and when a person's sense of belonging is undermined existential loneliness might result. Death anxiety represents a fear of loneliness and isolation, where death is a threat to belongingness and social inclusion. Death anxiety may be soothed by religious beliefs, in particular the belief in an after life that promises the continuation of belongingness and close relationships, or at the very least a continuation of the relationship with the transcendent. Of the three types of loneliness (social, emotional and existential), existential loneliness is the most difficult to solve, this is because when the person closest to us dies, i.e. the person that makes us forget that we are fundamentally

alone, existential loneliness is likely to result (Tillich, 1980; Mayers and Svartberg, 2001). According to Tillich (1980) not even God can change this destiny of feeling alone in the world when an individual outlives a loved one. For Matt this is perhaps the case. Alf is not afraid of dying, partly because he has full trust in God, and partly because he could potentially be reunited with his wife:

> Alf: 'Yes, you put your trust in God. When you say a prayer you have to believe in the prayer, it's not just a matter of saying the words, you have to believe in the words. You have to say the prayer right. If it's for your own good you will get it, it if is not for your own good you will not get it. It's a great gift to have, a religious belief, because you always have something there, and when you get old too it's very important. If you believe in God, you know that there is something in the next life, other wise you are missing something because this life is very short. The next life is eternity. Everyone has to look after themselves. They say you meet people that you knew in this life, you might meet a different person altogether, a different situation. It's only your soul, your spirit that goes.'

Matt's belief that his spirituality sustains him during adversity, and additionally the importance of faith in providing inner strength on a daily basis is echoed in Alf, Julia, Kay, Helen and Mick's accounts, they too hold similar beliefs:

> Int: 'Can you find a connection between your wellness and health and your religious belief?'
> Alf: 'I always say Our Lady help me otherwise if He wanted me I would be gone. The doctor can't cure you. The doctor can only do so much. I think if you have strong spiritual belief you can overcome anything.'

Alf considers the agency of spiritual life as on par with the medical profession to promote recovery and healing, and this reflects Mayer and Svartber's (2001) suggestion that the quality of the inner emotional life, and this would include spiritual life, is necessary for overall quality of life. Daily prayer and attending mass is important to both Anne and Kay as well. They both use it as a coping strategy and as way of meditating. For Anne, knowing that the priest is checking on her welfare is also important:

> Anne: Well I go to mass, to the exposition, and any other worship that is on. The Fatima rosary that does be on the 13th of every month.
> Int: Is religion important to you?
> Anne: It is, and always was. Not saying I am a Holy Ghost or anything. But I always believed in prayer, it has always got what I wanted, even when I was younger. Although the way religion has gone it's not great either, but I wouldn't waiver. I still have my beliefs. When you think back to the way priests treated people, they didn't treat them nicely in by-gone days, they were very

superior. You felt very low. I remember a priest at home in our own parish, there were three houses, big, big houses, well off farmers, and the priest would only visit those. But the ordinary working people, he never bothered with them. Our priest is very good, now I am not saying they are all like that either. I don't know. He would drop in especially in the winter and if I wasn't at mass and he noticed, he would come with Holy Communion. He is very good that way. Without having to ask. It means a lot. It means that he is keeping an eye.
Int: Tell me about the exposition
Anne: I have been going to that since it started. I love that. You go down there and you pray away in silence. You have no interruptions. It's nice. You can sit back relax. Do some reading, praying, even just to think. It's meditation. I am sure it is important for my health, I would think so, at least I think it is, maybe others might not. I think anything like that is important for your wellbeing. It's a personal thing. I always believed in prayer. I try to get in the rosary every day. If I had a problem I would pray more then [laughs]. *I always thought it worked. Well if you didn't get what you were praying for something else turned up.*

Kay, like Anne, values her prayer as a factor contributing to her wellbeing:

Int: When you were talking to me about your daily life you mentioned that you go to mass everyday. Do you think that religion is important to your wellbeing?
Kay: Absolutely.
Int: Why?
Kay: Why? Well because I just couldn't imagine myself living without it. It's absolutely brilliant for you. To realise the closeness of God, we really can't realise the way he is watching over us all the time. I don't think I would exist without. I couldn't see what my life would be like without prayer. I am sure there are people ten times better than I am and they might not be going to mass but they would be very good people. But that is what it means to me […] *I really do think that it is wonderful for you, your faith.*
Int: Why is it good?
Kay: Why is it good, because… well this is a selfish answer. When you are in trouble or you want help where do you turn? But then you're kind of using it. That's not a good answer. Really that is a selfish answer. It's my understanding of faith anyway.
Int: Does it give life meaning?
Kay: Oh yes. Definitely. It makes life worthwhile and that's why I think people don't think enough about mass. In mass everything is just pouring out of you there […] *Oh I love my religion. I don't think I would be here as well as I am without prayer in my life* […] *I have no doubts in the world* […]
Int: So your daily masses are important to your routine?
Kay: Didn't I tell you I was bragging. My age group would find religion important. Oh but it is great to have your faith it will get you through a lot of things. Bad things happen, but God doesn't send them, God loves everybody and you keep trusting. I think that prayer Footsteps, you know when they are really in a bad way there are no footsteps because that is the time that he is carrying you. There were double footsteps before and I thought that was lovely […] *Well you see God is present in the Church, but I think myself you can pray*

at home as well but I think now it's lovely to visit the Church, just to drop in if you're passing to say a prayer. And it's lovely for adoration. It's marvellous.

The importance of place to spirituality and in particular the location of prayer is not all that clear from these accounts. While Kay and Alf believed that they could pray anywhere, being present in the physical space of the church was also considered important. Millie for example felt that there was something special about being present in the church and that feeling could not be replicated elsewhere. For Mick and Matt prayer took place in the bed when they had an opportunity to be alone with their thoughts for mindful reflection (Close, 2012). There is a sense of intimacy and vulnerability here. Opening up and confiding in God (or anyone) and asking for guidance and support places the individual in a vulnerable position, and this sense of vulnerability and intimacy is heightened when such communication with God take place in the intimate and private spaces of the bed and bedroom. For Mick the physical spaces of the church was a site of 'social entertainment', as well as a place for acting out the rituals of his spirituality:

> Mick: 'I go to mass as often as I can, I say my prayers, say most of them in bed. I am not a model Catholic. I get a lot of distractions and temptations as well, sexual temptations, temptations of the flesh. At mass as well my mind would be wandering.'

Likewise for the other participants who choose to pray alone in the church during adoration services, or by dropping in at different points during the day they experienced the spaces of the church more intimately and felt alone with God. The church was also a key site for socialising, and provided an opportunity to meet with people and offered a means to survey the wellbeing of others. If somebody did not attend morning mass for example they would be missed and subsequently checked on to make sure they were ok.

Healing at a distance

The sense of control or agency prayer provides does not only relate to the needs of the self. Some of the participants also prayed with the intention of offering support to others that might be in need, and this provided a sense of relevancy of the self to the wider world:

> Phillis: 'And one thing I have felt, I know I am only praying about it now, but a thing that has come to me very strongly recently is the number of suicides that are happening especially happening in and around Wexford now. Now I don't

know in a practical way what I might be able to do but I am praying very, very much that, I pray every now and again during the day that maybe there is somebody out there that at this moment might be tempted to commit suicide and I just pray that somebody would intervene, something would happen to stop it. So that is just an initial little thing. And I suppose why I have become interested in that is because I had three serious nervous breakdowns in my own life, for which I can thank God now because it has given me an insight into what people are suffering when they are depressed, or whatever.'

In recent years there has been much interest in 'spooky actions at a distance' (Leader, 2005: 923) that is having the ability to influence activities, including the health, wellbeing and quality of life of others across distances (Wiesendanger *et al*., 2001; Sicher, Targ, Moor and Smith, 1998; Zachariae *et al*., 2005). The effectiveness of prayer, as understood by Phillis, has the ability to transcend the geographical boundaries of distance and defy the limitations of space and time. Phillis is hoping that her prayers will be heard and will result in some form of divine intervention. Phillis's intercessory prayers are aspatial, and reflect what Dossey calls the 'non-local mind'. While the 'local mind' is fixed and isolated, the 'non-local mind' is part of the collective and is concerned with the interconnectedness of people and the interdependence of life. The non-local mind allows an individual to be present spiritually and provides them with the opportunity to participate spiritually across distances (Dossey, 1982; 2003). For instance, the effects of praying for an individual from a distance might reach the individual as a healing agent impacting on the body through emotions. Knowing that someone is thinking of you and praying for good intentions might act to combat the sense of loneliness and isolation at a difficult time, and heighten the emotional bond between two people because it allows for a transpersonal connection between minds (Close, 2002). This might be understood in terms of distant healing defined as

'involving acts in which one or more individuals consciously will, intend, or ask for the improved wellbeing of another, insofar as such wishes are not primarily mediated and effected by direct physical or social contact with the receiver' (Leader, 2005: 924).

For the physically frail older person who is confined by their immobility the 'non-local mind' may provide them with a sense of purpose and give them a valuable and relevant role within society when praying for the intentions of others and participating in distant healing (Close, 2002). For Phillis intercessory prayers provides her with the means to maintain a sense of relatedness in the world ('*I don't know in a practical way what I might be able to do but I am praying very, very much*'). For Phillis her history of mental illness has meant

that she has a strong sense of relatedness to others experiencing such difficulties and through her spirituality she has found a way to relate to the world around her, participate in the world, and locate herself spiritually and purposefully in both the local and the non-local.

Seeking guidance and direction through religion and prayer

Julia used prayer to sustain her during the difficulties she faced in life, most notably in coping after being widowed early. She sought guidance from her faith, and she looked to the parish, to prayer and to the priest to help her through difficult times. She describes the experience of losing her husband early in their marital life as the beginning of a new and different life, one completely unanticipated, and a time during which her spirituality was central to her ability to cope:

> *Julia: '[I had] just an ordinary life. It was tough going being widowed at 38. Seven children and the youngest wasn't even a year. I could have lived or died then, whichever I liked. A farm and a family to look after. That is where I started really […] My faith is very important. Well it is the meaning of life to me. Without it I would have no focus, no meaning, or no reason, I think it all makes a lot of sense. To do the right thing, try and be upright. It is not a problem the things we are suppose to do, they just come to me. The parish is very important.'*

In a conversation with Julia's daughter[16] she elaborates on Julia's faith:

> *Julia's daughter: 'Having to manage all those years after dad died that I think faith was very important to her, and prayer was very important... That would be my revelation.'*

Julia's reference to having had an *'ordinary life'* is significant here. In recent decades resilience research has developed a focus on 'ordinary magic' and positive outcomes. Such research recognises that resilience comes out of ordinary rather than extraordinary processes (Masten, 2001). This contrasts with Antonovsky's focus on the 'deviant' and extreme cases of suffering. While Matt talks about relying on faith during times of hardship, Julia reflects on its application in the context of ordinary daily life. In particular the meaning she finds through her faith. The importance of prayer in daily life emerged across the participants. For Alf attending church and praying gave him a sense of purpose in his daily life and

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[16] At Julia's request, her daughter sat in on the interview.

contributed to the meaningfulness of his life. He also credits his faith to the success he has had in life:

> *Alf: 'When I go to mass in the morning I am happy for the day, and on a day that I don't go I wonder what am I doing here, I am wasting my time. What I am doing here is not important. If I go down to mass and I believe God is there and you can receive God. Money can't buy that [...] My happy marriage was a success for me, my family and my management position in Guinness' too. They are my successes. I always said God looked after me.'*

Like Julia, Alf also took guidance in his daily life from his religion, and through it found a sort of moral code by which to live a good life by. In following this code he believes he has been awarded with success in this life, and also the promise of the next life. He believes, and subsequently lives his life accordingly, that this life is only preparation for the next, and if he follows a moral code of conduct the rewards will justify any suffering experienced now:

> *Alf: '[you] have rules and you live by them and you say a prayer everyday. Make a good life, obey the rules of the Church, don't have a wife and a mistress around the corner.'*

Matt similarly finds guidance in religion on living a good life:

> *Matt: 'And well what harm has it done us? If you have religion it helps you keep on the straight and narrow to a certain extent too it helps you to be fair and deal better with your business and your studies and friends. Because we learn in the catechism don't do to others what you wouldn't like done to yourself, and be honest and fair in all your dealings. Well now they all come from religion.'*

While Mick considers his spiritual life to be important to his mental health, ironically it was also associated with fear:

> *Mick: 'I consider my mental health and my spiritual health to be the one thing. [...] I always felt very enlightened through my prayer life. And the effects of holy water, it keeps us strengthened against evil spirits [...] I would say I had an innate fear of committing sin, I might of cursed when I shouldn't have, use a small bit of bad language. I deplore bad language.'*

Mick's '*innate fear of committing sin*' might reflect the heavy-handed approach taken by the Catholic Church in instructing its followers on how to live a good and moral life. Reflecting on his younger years as a man trying to meet a wife in Catholic Ireland Mick considers the

difficulty in reconciling the natural urges for intimacy with what was considered appropriate behaviour in the eyes of the Church:

> *Mick: 'In my time boy meets girl and the priest would come along with a big black stick and hunt you out of the ditch and you might be only holding the girls hand, you might be even afraid to kiss the girl which is only natural human instinct, I don't know how you could stop doing it. God made man. The physiology and chemistry of a man and woman are made to attract each other so the natural instinct if you like the girl is to kiss her. Other activities, more intimate activities, social intercourse rather than sexual intercourse complimenting the woman on her manners or whatever... I believe in my time if you were brought up in a strong Catholic faith as I was you wouldn't want to think about it or go there. Thought, word or interactions were regarded as sinful in them times. A lot of people I think most people in that era, did respect the girls and had a high sense of morality.'*

Similarly, Matt experienced reminders that God was present and watching, or at least the priest was, when moral judgements were being compromised, and temptation was heightened:

> *Matt: 'Well I was at a dance one night* […] *At about half one the priest would be in and out, it was the parish hall and Tommy O' Neill from Wexford was playing and* […] *He was just after calling a Samba and we were all eyeing up someone for the Samba. Now I had no particular girl there that night, nothing only the talent. He* [the priest] *went up and took the microphone and he said now the next item on the programme is the Rosary and if anyone feel they don't want to get involved would they please walk outside. Every one of us was down on our knees and he gave out the Rosary in the middle of a dance. We had a good night and after prayers and all left the place empty handed, walked home alone.'*

Challenges to faith and its significance for wellbeing

In recent years the Catholic Church has come under considerable scrutiny for its abuse of power, and as a result there has been a considerable breakdown in the relationship between the Church and Irish society (Inglis, 1998). For older Irish people in particular, such as those included in this research, who were brought up to respect the Church, it's representatives and it's moral codes, learning about the extent of the corruption posed a considerable challenge to their faith. According to Phillis, who has spent much of her later life dedicated to pastoral work:

Phillis: 'The way the Church is at the moment and it is very dodgy after all the abuse and that kind of thing, and people are very very fragile and very hurt by the Church.'

For Maeve society is also to blame for how much power it gave to the Catholic Church:

Maeve: 'Oh it [religion] *is of course* [important to wellbeing]. *I am very saddened by what has happened. It is terrible for young people isn't it? It is sad what has happened and it shouldn't have happened. We as a people are responsible as well, very much so. Where a girl got pregnant the fathers would throw them out of their home. The government, where kids were skipping school or weren't looked after properly they were put into these schools. Society was the problem, very much so. The Church had too much power, a terrible power, and they got away with it. When I went to school the nuns had all power, they really had and there were some of them who were never cut out to be nuns they were thwarted with life.'*

Helen is much less invested in her religious and prayer life than the other participants mentioned here, yet she will draw on it when she feels she needs to. She is also critical of the Catholic Church, and cuts out the 'middle man' when she seeks support through prayer. For Helen the Church has proved itself inadequate and relies on her spirituality rather than her religiosity when faced with difficulties. However, despite the shortcomings she recognises in organised religion she values her beliefs:

Helen: 'I wouldn't go overboard [with praying] but I have my beliefs [...] I would incorporate my religion [into daily life] but as I said I don't go overboard. I wouldn't be going to mass every morning, but then you see I don't drive. I have a neighbour who brings me. I wouldn't go overboard but it's lovely to know that it's there. I think it works, I mean, when you are in trouble and you are awful worried about something you automatically say a prayer for help. I mean even if you lose something 'Saint Anthony help me'. I mean that's it [laughs]. *I cut out the middleman and stick to the main ones* [God, Our Lady, the Sacred Heart] [laughs]. *My mother was a great woman for St. Anthony. These latter years I think Our Lady and the Sacred Heart is enough for me, as I said cut out the middleman* [laughs]. *Our priest is a peculiar man. He could come out with anything. You wouldn't want to die during the Cheltenham races. He is going to the races and to hell with you. That's the kind of man he is, oh very much so. And he would let you know it to. There is a lot of young people going to mass in our parish, I think they are going to see him because they don't know what he is going to come out with. He could say anything. A bit of a character, but you know we only have mass for 20 minutes. When someone got on to him about how short mass was the priest asked him what did he leave out* [laughs]. *I could say he left out half of it.'*

There were some mixed feelings across the participants about the Catholic Church as an institution. Helen and Maeve were not the only participants to feel the representatives of the Church were inadequate and even disdainful. Matt also had off-putting encounters with the Church and felt let down by its representatives when he was at his most vulnerable:

> Matt: 'Yes, I always [go to mass]. There was a time once when I had a difference with a priest and I was going to quit it and I said to myself he is only one.'

These experiences however did not deter them from their faith rather they considered their faith and beliefs to be separate from the Church as an institution. According to Helen the middleman is not necessary in order to apply faith in daily life. Mick felt for many years that he had a vocation to become a priest but felt he did not have the right socio-economic status to do so. Consequently he recognises the institution of the Church as something that is constructed out of power and hierarchy, and is essentially a man made entity. This for him however has little or no relevance to his relationship with God:

> Mick: 'I say if a minority let you down well I think it's not important. Your faith shouldn't depend on how good you think the priest is, you have to think of the next world and believe in the next world, God didn't let us down there will always be lapses. Popes fathered children […] The Church is only an institution, it is only bricks and mortar, […] inevitably we have to save our own soul, we are not bringing the bishop or the Pope with us. When we are growing up our parents teach us morality, they couldn't bring us around in their pockets we have to live on our own and follow the morality we are taught. That's up to us. Some people would say I am conservative but I think I am calling it as it is.'

Reflections on the role of spirituality in promoting resilience

According to salutogenic theory one's SOC is established in early adulthood and remains constant throughout the life course (Antonovsky, 1987), therefore the coping strategies adopted from belief systems may also be established in early life. Certainly for the participants discussed here drawing on their spirituality for strength was not something new to them. Rather their spiritual life was an ongoing self-development process throughout their life course, and represented a continuation, maintenance, and enhancement of the inner resources (Atchley, 1999). The role of spirituality in supporting their cognitive resilience framework as demonstrated by the participants is something that was set down in early life, and persisted throughout, perhaps in some cases intensifying when faced with the challenges

of later life. Many of the participants expressed concern that the younger generations were detached from their spirituality, and believed that this was a considerable disadvantage to their wellbeing. This raises questions about the role of spirituality in supporting mental health across the life course, and especially in promoting resilience among younger generations. While it must be acknowledged that the participant's experiences are heavily contextualised in a staunchly Catholic society, they did separate their spirituality from their religiosity, and felt certain that they benefitted from their spiritual life.

In terms of the SOC, spirituality fits neatly into its components, and provides some indication of the cognitive and behavioural processes that link the SOC and spirituality with health and wellbeing. From the qualitative data presented here spiritual beliefs may provide the individual with meaning, and subsequently motivation, when faced with the challenges of daily life, it may also provide a sense of stability to the internal emotional life, and put order on a world that may otherwise be experienced as chaotic.

The SOC as a conceptual lens for geographical gerontology

In the basic description provided by Antonovsky (1987) there was a reasonable suggestion that the SOC might have some value for the Health Geographer. As a measurement alone however its value to explain the person-place-health relationship was limited. As has been demonstrated using the empirical data presented, a qualitative description of the SOC components generates a new analytical lens for understanding what it means to live and experience life in place, and the implications of this for health and wellbeing.

The SOC lends itself very well to framing the affective power of place, and this was evident in applying it to the home and community as key sites of ageing-in-place, and also as affective places that are known intimately through deep emotional experiences, attachment, and identity. Using the empirical data the concept of the home in later life was developed beyond the ideas presented earlier. Taking the relational geographies of age perspective (Ziegler, 2012; Lager *et al.*, 2013; Hopkins and Pain, 2007) and Cutchin's (2003) process of place integration, the SOC expanded on these to tell us more about what these concepts mean experientially, in particular the cognitive processes that underpin meaning making at the site of person-place interaction. The meaning making process as found in the empirical data spoke to the broad geographical gerontology literature quite well, but its interrogation using the SOC components provided some real added depth. For example places are always in the process of becoming, and for the older person who has an

autobiographical affinity with a place (Rowles and Ravdal, 2002) the effects of such changes might undermine their resilience depending on how or if they impact on the SOC components.

The unfolding of life in place is not a solitary process, but rather a relative process that is subject to the needs and understandings of those people with whom life is shared (Horschelmann, 2011). The empirical data reinforced this, in particular the significance of relationships in forming attachments with place through the activities and performances that go on there, whether these are intimate performances of family life, or the familiar gestures of neighbours. Such activities are also used to demonstrate a continued sense of self and self-determinism in front of an audience. That is continuing to engage with tasks and to perform the role of the younger self, much like the (bodily) integrity Twigg (2000) referred to. The desire for continuity, when provided for by the body's ability to meet the desire, has important health buffering effects because it can be psychologically and emotionally fulfilling when continuity is possible in later life (Atchley, 1999). The relational self is preserved.

Context is identified as a factor determining resilience. According to Antonovsky (1987) the self confidence one establishes is a reflection of the quality of the external environment, that is the quality of immediate family relationships and the broader social or community environment. This also refers to opportunity structures available to enhance quality of life. According to salutogenic theory the person with the strong SOC can transform potential reality into actuality if the resources are made available. In a hypothetical situation where an individual has experienced disadvantage and poverty during their formative years they are said to have experienced more deficits than resources, most likely resulting in a low SOC, and are thus potentially less likely to transform potential into reality. In terms of the upstream efforts of the community and voluntary sector, having a clear understanding of the SOC components might prove valuable to identify meaningful resources to invest in. While functional supports might be necessary the net effect of meaningful resources could have a significant effect on health, wellbeing and quality of life. Using the SOC to identify meaningful resources and supports for the C&V sector is one area that could be explored in the future from a geographical perspective.

Wiles *et al*. (2012) research on resilience recognised the co-existence of vulnerability and resilience. The application of the SOC to the empirical data as has been done in this thesis demonstrates this co-existence also. Not only does it demonstrate it, but

the SOC also provides some insight on how two opposing characteristics can be present together. The multitude of ways a person can move through the ageing process despite significant adversity can be uncovered with the SOC, because the components can access the coping strategies employed. This is because the qualitative application of the SOC is asking the necessary questions to locate the strategies in their context, and brings together internal and external resources, as well as the individual's relational view of the world.

While this research has created a fresh dialogue between Health Geography and salutogenic theory, there is considerable room and opportunity to continue it. Geographical Gerontology was a good place to begin the discussion, particularly using a sample of healthy older people and working retrospectively with life review data to make sense of the SOC qualitatively. Now that the dialogue is in place, and the theoretical and conceptual relationships have been established, it is should be possible to continue it into other areas of the discipline.

Chapter 10

Conclusion and discussion

Relational spaces and fluid boundaries around the crucial spheres of later life

Antonovsky (1987) identified what he referred to as the bounded spheres of life. These spheres hold subjective importance for the individual, and they determined the strength of the SOC. He claimed that whatever went on outside of these spheres did not have any real implication for the SOC. This was because the SOC itself is a global orientation, the way a person views the world and their place in it. There is a considerable element of choice here. That is not however to deny the role of broader structures, or the social determinants, in exerting their influence on the individual's life. The individual is after all immersed in a wider social, economic, political and cultural context, and these broader structures reach inside these spheres and become part of the lived experience within this bounded world. The resilience element here is how people *react* to this external world - can they cope when faced with adversity, can they find meaning in their lives despite adversity, can they make sense of their place in the world even when confronted with chaos? The role of agency thus operates within the boundaries of these spheres. Put simply, regardless of what is happening around us we have to go about our daily lives; wider structural forces do not paralyse us. Our SOC will determine how we approach the activities of daily life, and determine whether this approach will positively contribute to health and wellbeing or pose a threat. The SOC perspective gives new meaning to the health promotion policy slogan 'making the healthier choice the easier choice' (Department of Health, 1995), or the *Ottawa Charter's* (WHO, 1986) priority to give people control over their health. Social conditions must enhance the SOC, or at the very least support the development of a strong SOC, and perhaps through this the healthier choice becomes the easiest choice.

Importantly, Antonovsky (1987) choose to study the 'deviant' and he based his theory on the exceptional individual. Thus the epistemological, ontological and methodological choices that Antonovsky (1987) made has resulted in an analytical construct that can determine what makes an individual exceptional in terms of their outlook. In its methodological design this thesis sought the 'deviant', the active and independent oldest old person, to firstly verify Antonovsky's description of the SOC qualitatively and locate it within the lifeworld, and secondly to consider the SOC as an indicator of resilient ageing. One of the main criticisms of the SOC as a theoretical basis for health promotion that

emerges from this thesis is Antonovsky's (1987) ultimate separation of the human psyche from their environment. It is through this separation that resilience results as a transcendence of the conditions one finds oneself in. The 'deviant' represents the individual that transcends their circumstance to live a productive and meaningful life, and it is only a very distinctive type of person that can transcend an adverse objective state or situated context.

The SOC components when applied qualitatively, as in this research, identify the cognitive processes that lend themselves to such transcendence. Identifying life's crucial spheres around which boundaries are constructed, moulded and remoulded, that is 'one's inner feelings, one's immediate interpersonal relations, one's major activity, and existential issues' (Antonovsky, 1987:23) across the participants provided a focus for examining the SOC. What emerged from this was the intensely subjective nature of the SOC components, and crucially the complexity involved in determining what is located inside and what is located outside the crucial spheres of life. Gerontology's continuity theory (Atchley, 1999) provided insight on older people's activities and was applied to make sense of how the boundaries around the crucial spheres of life are drawn and re-drawn in later life. This emerged from the life review data as the continuation of family roles and identities, meaningful activities, sense of belonging, friendships, and spiritual life. Perspectives from relational geography also contributed to the analysis of the crucial spheres of life, in particular the importance of personal biographies and the biographies of place, in supporting the older person's SOC, and in providing them with meaning and comprehension as they age-in-place.

One of the difficulties in solving the context versus composition debate is the role of the non-shared environment. Health outcomes are often the result of an accumulation of events and experiences throughout the life course, and across space and time. Therefore, in an increasingly mobile world it will become more difficult to pin down health outcomes in later life to a particular geography. This poses a significant problem for the geographer. To make things more complicated Antonovsky (1987) claimed that one's SOC is established, and somewhat stable, by young adulthood, thus suggesting that after a certain point in time, context becomes irrelevant. The stability of the SOC is questionable and to verify its stability a series of longitudinal studies on the SOC would be required. The stability or changeability of the SOC poses the greatest difficulty in merging the SOC construct with relational perspectives in geography. Nevertheless, by bringing salutogenic ideas to

geography this thesis has established a starting point for plenty of fruitful analysis on relational geographies of health and ageing.

There is considerable scope for the SOC to move relational geography forward theoretically, although admittedly there are a number of issues to be addressed, namely transcendence. The relational approach is about bridging the gap between the structure and agency dualism (Pile and Thrift, 1995). This thesis has taken a humanistic focus, paying close attention to the individual as agent in determining their experiences, and in meaning making, which is 'derived from the internal self in the context of life course experience' (Pile and Thrift, 1995:3). The structural approach, as the other half of the structure and agency dualism, is about the pressure external structures exert on individuals thereby determining their experiences. According to Pile and Thrift (1995) this dualism cannot fully appreciate the everyday experience located at the intersection of the individual and the structure. In bridging the gap between structure and agency using the relational approach it is possible to consider the individual as acting in time and space and this includes their interpretation, their feelings, their activities and other processes of being in the world intersected by structural influences. The analytical focus of the SOC on the individual provides insight on the subjective experience of the potentialities and opportunities of relational spaces because it asks how people feel in these spaces, thus opening up the real meaning of context and structure in shaping individual's agency, and importantly in determining their resilience, health and wellbeing. The application of the SOC to relational geography provides a lens through which data can be gathered on experiences of being in the world in terms of finding meaning and understanding, and in accessing the necessary resources internally and externally to rise to the challenges presented at the relational intersection between individual and structure. Relational geography's understanding of people and places as having a mutually reinforcing and reciprocal relationship (Cummins *et al.*, 2007) is reflected in salutogenic thinking and the SOC, but the degree, or extent, of this reinforcement and reciprocity is uncertain in terms of the development and maintenance of the SOC. More work thus needs to be done to unpack relational thinking on space and place, and the lived experience, and the SOC certainly provides a construct through which this can be achieved. If space and place is experienced through boundaries that are negotiated and manifested cognitively, and subsequently projected onto the world, the relevance of context is reduced, in favour of composition. Yet it is equally likely that the SOC is the product of the context, and that a strong SOC is the product of an egalitarian society, where people are

supported to live fulfilling lives, are provided with the opportunities to participate in all aspects of society, and have access to the necessary resources to live a long, healthy and happy life.

Not everyone it seems has the capacity to be resilient, so why do some people end up in the choppy waters of the River of Life while others remain on the banks? The unshared environment may explain this. The environmental and social forces that strengthen one's resilience are not equally distributed across a population, while individuals themselves differ in terms of their inner strengths, which can be understood as deriving from a complex interaction between their external environment, across time and space. The ability of a family or community to respond to an individual's vulnerability and promote their resilience can also differ greatly. Therefore contextual factors will require careful and further consideration in studying resilience among older people, as well as consideration for the sources of their inner strength, the sustainability of this inner strength, their personality and the potential for increasing an individual's SOC.

Because of their diverse biographies each of the participants had varying degrees of access to resources in their social and interpersonal worlds. While Terry for instance lacked secure kith/kin relations, he did demonstrate considerable agency and positive emotion despite the pressure of caring for his wife. He was driven by love. Likewise Kathleen rarely relied on others to support her while she cared for her mother. Doug was an exceptional case demonstrating immense individual resilience even with the limitations of his blindness. In addition to this inner strength, Doug also received very good support from his family, who provided him with resources and opportunities to pursue his interests, encouraging him to stay active and engaged in the activities of his earlier life. He reacted by embracing the opportunities for engagement afforded to him, but this continued engagement was underpinned by the meaning he found in these activities and in providing him with a continued sense of self. Similarly, Mag was determined to keep out and keep going, and to getting involved in everything she could. Mag was supported in doing so by a wider intergenerational network in which she decided to immerse herself.

In many ways however having a wider network of social support does not guarantee meaningful relationships that make sense on an emotional level. Two identifiable social spheres formed by negotiable boundaries are identifiable – the participative sphere and the emotional sphere. Close personal relationships, as a bounded sphere of life, is constructed around those we let into the intimacy of our inner emotional world, and those we keep at a

distance. Kay for example had good relationships with her extended family, yet she missed the intimacy of friendship she had shared with her close friends after they passed away. While Matt had access to his wife's friendships they were not meaningful to him. Julia maintained close relationships within the family and her social life centred on the home, even though she had plenty of opportunities to socialise in the wider community she chose not to. Helen also described having a close bond with her grandchildren, especially her teenage granddaughters, who spoke to her with the openness and honesty of a close friend, although at times this did make Helen squirm because she felt it was too much. Martha's neighbours did not meet her expectations of what neighbourhood life should be like, because of a perceived social and emotional distance. Each of the participants have thus constructed boundaries within their social worlds, in accordance with what was meaningful to them, and what made sense to them, in the context of their biographies and daily life. What emerged quite strongly are the roles of attitude, preference and subjective feelings in influencing how these boundaries are constructed. Operating at the intersection between the person and the external world are feelings about other people, ideas about their purpose in life, and even wider existential issues such as their spirituality and belief system.

The boundaries constructed around the crucial spheres of life have implications for policy. In accepting that people want different things for their lives, and if these desires are based on several decades of life experience, profound challenges are posed for ageing policy. The particularity of the individual and the significance of subjectivity is however explicitly recognised in Ireland's most recent ageing policy *The National Positive Ageing Strategy* (2013). This marks a significant progression in the philosophical framing of policies on health and wellbeing in later life. Like health promotion, it suggests health is a resource for living, and in terms of the future or possible self it is embodied and contextualised. The relational and possible self is located in a space where self-actualisation occurs, and the goal of *The National Positive Ageing Strategy* (2013) is to provide opportunities to achieve a self-defined possible self by providing the basic needs for survival but also the conditions to flourish.

The policy implications of subjectivity: Writing a prescription for a good life

The theoretical, empirical and analytical discussion presented in this thesis is set against a progressive ageing policy discourse. In the past ageing policies in Ireland have concentrated

on the health and social care issues of older people (*The Years Ahead Report*, 1988) but the recent document, *The National Positive Ageing Strategy* (2013), looks beyond the pathogenic focus of physical and cognitive decline, to consider the experiential, the subjective and what it means to live a good life in old age. This marks a very important paradigmatic shift in Irish health policy more generally, where people and communities are increasingly recognised as agents in promoting their health rather than passive recipients of care. *The National Positive Ageing Strategy* (2013) uses the conceptual idea of 'positive ageing', because its thinking is associated with 'affirmative concepts of ageing that have been developed internationally i.e. healthy, active, positive, productive, and successful ageing' (National Positive Ageing Strategy, 2013:8). They seemingly didn't want to leave anything out. Positive ageing as it has been applied in the strategy is thus an amalgamation of all the positive characteristics that could be hoped for in later life. The strategy also presents insight on how wellbeing has been both understood and applied in its vision for older people:

> *'Wellbeing is a positive physical, social and mental state. It requires that basic needs are met, that individuals have a sense of purpose and feel able to achieve goals that are important to them and that they can participate in society and live lives they value'* (The National Positive Ageing Strategy, 2013: 8).

When older people's wellbeing is recognised as the result of living lives they value, having a purpose and achieving meaningful goals, there is a need to open up empirical research to explore the lived life of the older person. Importantly, such studies should not take for granted the activities of the older person's daily life, or relational encounters with their social world. As was apparent in the empirical data presented, it is in this relational space that the fabric of life is created and conditioned, and where a continued sense of self is located and maintained. The subjective processes involved in promoting wellbeing are located upstream on the River of Life. These processes are situated alongside the prerequisites for health, which are the fundamental conditions and resources for health, such as peace, shelter, education, food, social justice and equity (*Ottawa Charter*, 1986: 1).

The commitment to promoting wellbeing as a holistic endeavour set out in the strategy marks a substantial shift from the dependency and needs-based priorities set out in *The Years Ahead Report* (1988), which focused on supporting frail older people to live at home in dignity, to recognising them as active in pursuing meaningful goals and future-

orientated in their outlook. Whereas *The Years Ahead Report's* future orientation was based on dependence and sickness. The idea of the possible self (Markus and Nurius, 1986) emerges from *The National Positive Ageing Strategy* (2013). The intention of the strategy is to facilitate and support the older person through the processes of preservation, growth, change and adaptation associated with ageing, and leading to the achievement of the possible self as imagined and hoped for by the older person. The possible self refers to a positive image of the self in the future (Markus and Nurius, 1986). Policies that set out to support the possible self require sensitivity towards experiences of continuity and change, and their meaning. Future orientation is indeed one aspect of resilience in later life (Frazier *et al.*, 2000). The idea of 'possible selves' closely resembles aspects of the SOC such as predictability and having a positive outlook for the future. Antonovsky's (1987) boundary making can also be identified in future orientated thinking, where imagining and striving for the possible self requires addressing what is meaningful and re-drawing boundaries to encapsulate what is deemed worthwhile.

Resilience can be understood as the continuous and purposeful pursuance of meaningful goals in synergy with the environment (Gillespie *et al.*, 2007). It is about having a future orientated outlook, and the striving for goals that require perseverance. These goals might be to accomplish something considered worthwhile by the individual, group or community. Such goals are considered to be for betterment, or at least a return to neutrality. Alf and Doug would are good examples of older people pursuing purposeful goals despite considerable limitation and many set backs. Resilience is about 'sustaining pursuits of the positive', and such pursuits of the positive were evident across the participants. They pushed their boundaries, and drew on many of their resources, whether they found them through family or community life, or looked inwards to their own strengths and resources, or outwards to spiritual sources. When the 'pursuit of the positive' is placed into the framework of the SOC it is the individual with the strong SOC that acts with perseverance. But how can policy support a sustained pursuit of the positive? Perhaps through sustainable efforts to ensure the conditions are provided that can preserve the older person's engagement in subjectively valuable and meaningful activities across the life course. For those ageing-in-place a community that can provide the very basic needs for survival is paramount, but outside of the basic needs are the resources for inner strength and determination. Resilient places or communities offer their older people opportunities for social generation, psychological growth and fulfilment. The relational space between the

older person and a resilient community is a future-orientated imaginative one, where the older person can place themselves in the community's future as having an on-going identity that is immersed in all aspects of family and community life. The ability of an older individual to relate to the present or future of family or community life, to predict their on-going role in the collective, (remember predictability is an indicator of one's SOC), and to maintain a sense of relational identity might determine the older person's sense of self in the relational world, and also their self-esteem, self-worth, agency, control and purposefulness, all of which are indicators of wellbeing.

Active ageing policies are also located in wider discussions on 'Big Society', encouraging people to continue to participate and actively contribute to society in a productive way (Ziegler, 2012). Given this discursive context there is a need to examine older people's motivation and engagement in socially productive activities, and determine the meaningfulness of 'contributing'. Such motivations can be understood using the SOC by asking if for example the socially productive activity of volunteering as an example makes sense to the older person, and subsequently do they regard such activities as worthwhile. Do healthy older people ask themselves how can they be more worthwhile to society? Disengagement theory (Cumming and Henry, 1961) fell out of favour among gerontologists, because it relied on a narrow understanding of activities in later life (Lemon *et al.,* 1972), but the notion of disengagement does hold some merit in discussing the central objective of active ageing policies. It was noted by one community development worker consulted during this research that there is a marked difference in older people's engagement in wider community life once they reach about 75 years old. This of course might be related to health issues, however among the older participants in this research there was a definite boundary drawn in terms of how their energy was spent. Often their activities were limited to family life, spirituality and meaningful personal goals often imbued by a desire for a continued of a sense of self and identity. If these activities are considered in relation to their SOC they are drawing considerably on and demonstrating their inner freedom, by investing in meaningful activities and relationships that made sense emotionally to them and provided them with a comprehensible relationality.

The idea of predictability associated with the SOC, the future orientated outlook, and goal driven aspects of resilience theory are challenging ideas for qualitative research on older people to address. Future orientated thinking in later life can be complicated because

commitment to goals is difficult when the future is in many ways uncertain (Aspinwall, 2005). While many of the research participants had goals they hoped to achieve, they also had a guarded optimism about the future because they recognised that they had limited control over the normal physical and cognitive declines associated with advancing age. Many of them appreciated how well they were in the present, particularly having witnessed the decline of their peers, although this in itself posed an emotional challenge, and also having experienced serious illness in the past. The finite nature of life is very present in the daily lives of older people. Whether this manifests as the death of loved ones, as was the case with many of the participants, or as the observation of gradual yet subtle declines in physical health and cognition. The sphere of existential life thus takes on considerable significance in later life, and it is within this sphere that people draw on their spirituality as a resource for coping by locating their current life in a much larger framework of existential meaning.

Spirituality is a form of future-orientated thinking linking one's present situation to possible future outcomes, especially the belief of living a moral life now and receiving the reward of eternal rest. Spirituality, as it was described in the life review accounts, provided detail on its role in coping with the unknown, or in making sense of adversity. As already mentioned Antonovsky (1987) talked about the role of predictability in putting order on chaos, and removing fear and worry about future negative outcomes. According to Aspinwall (2005) when things are not predictable people might choose to turn to interpretive forms of coping, for example believing things happen for a reason. If these thoughts are mediated through a belief in a higher power, or a divine plan, outcomes are ordered relative to a greater whole or oneness. As described in Chapter nine, having a belief system is strongly correlated with wellbeing, but how can a belief system be accounted for the health policies of secular countries?

Future directions in SOC research: Setting a new agenda for health geographers
Possibly the best positive ageing strategy any country can implement is one that starts very early in life and concentrates on promoting positive mental health, and this includes tending to the broader structural forces impacting on daily life. Positive affect can increase longevity by up to 7.5 years (Levy *et al*., 2002), by improving overall health (Benyamini *et al*., 2000), and increasing survival chances (Ostir *et al*., 2000; 2001). The true extent of mental health's impact on physical health may be underestimated, but it is found that poor mental health

poses more risk in developing cardiovascular disease than smoking (Keyes, 2004). Other psychosocial factors such as mood, social support and isolation have the equivalent effect on heart health outcomes as smoking, high blood pressure and raised cholesterol (Bunker *et al.*, 2003; Kubzensky and Kawachi, 2000). Among those living in poverty there is the biggest concentration of obesity, excessive consumption of alcohol, depression and anxiety, as well as poorer mental health status (Freidli, 2009). While there are number of issues merging to influence health here, certainly one of the most important influencing factors on physical health is mental health and so promoting mental health is worth investing in (WHO, 2003). The salutogenic orientation and the SOC when considered qualitatively can provide a reasonable indication of areas where investment should be directed. Going back to the notion of the non-shared environment, it seems that health and wellbeing outcomes are the result of accumulating stresses through psychobiological mechanisms operating over time and space. Interventions that address the SOC components by enhancing the conditions that strengthen the SOC components are one way forward. While this research has considered what the components look like in the reality of the older person's life, the methodological, and in particular, analytical frameworks employed here would be suited, with perhaps some tweaks, to examine other stages in the life course. This would involve exploring the lived and ordinary daily expressions of the SOC qualitatively to identify the sources of psychological strengths such as finding meaning, motivation and comprehension, and accessing and utilising the resources required to improve manageability used to negotiate the world. Because the SOC components develop in synergy with multiple environments across space and time, pinning them down, and isolating the direct relationship between the cognitive processes used in evaluating the world, and ill health causation, is very difficult.

For the health geographer who takes on the task of exploring the SOC qualitatively they have access to a whole range of methodological tools that would be suitable. One of the limitations of this research methodologically was the capacity of old-old people to engage with diverse methods. Because one of the principles of qualitative research is to use methods familiar to the participants one that is based on dialogue was the obvious choice, especially when the value of dialogue is emphasised in health promotion. However, in applying the SOC as an analytical framework to other, younger, age groups there are many more opportunities to employ diverse tools in generating meaningful narratives such as photovoice, diaries, and other tools of ethnographic or participative observation. There is

ample opportunity for not only the health geographer, but also human geographers working in other areas of the discipline, to engage with the SOC in expanding how people's relationship with place is formed and reformed.

Final remarks

It is difficult to make resilience a goal of policy (Zautra, Hall and Murray, 2010). One of the most significant issues of applying the concept of resilience in policy, it seems, is its individualistic and subjective nature. The results of this research reinforce the view that resilience is primarily a characteristic of the individual, developed over time in synergy with their socio-structural environment (Gillespie *et al*., 2007). It is worth highlighting that this conclusion is strongly influenced by the research design, in particular the individualist focus of the SOC, applied as the main theoretical and analytical framework, and explored using the life review method within the hermeneutic phenomenological tradition. Therefore an exploratory and tentative conclusion is presented here rather than a definitive one. Despite the individualist focus, there is evidence that the strength of the individual's SOC can be improved by the activities of the collective, and also through investing in broader structures that provide individuals and communities with opportunities to live worthwhile and fulfilling lives, across the life course. Policies that strive to promote wellbeing do not require a prescriptive route to achieving subjective feelings of meaning, purpose, or motivation. Wellbeing, it seems, belongs to the philosophical realm, and the SOC components of meaningfulness, manageability and comprehensibility provide a valuable framework from which an understanding of health as physical, mental, social and spiritual wellbeing can be found.

The view that health is very much part of the philosophical realm as suggested in this thesis aligns itself naturally with prompts in health geography to consider health as more-than-absence of disease and to look further into the domain of wellbeing (Andrews *et al*., 2014). This requires the geographer 'to understand the well of being, that depth of knowing what it is to be human' (Kearns, 2014: 147). The SOC provides an analytical framing to not only explore what it means to be human, but also to consider what it means to be human in context. By looking at what it is to be human from the vantage point of the oldest old person a sense of more than knowing emerges, a sort of wisdom, or truth, located within the boundaries of the crucial spheres of life. And these crucial spheres of life are grounded in the context of the very ordinary, and very mundane, realities of daily life, its

spaces and places. But it is within the ordinary spaces of our kitchens, bedrooms, and gardens, our neighbourhoods, and our workplaces that wellbeing is located. This is where life happens. Being human is Doug in his plastic house, Alf in his driveway, Ann in her garden, Kay in her kitchen, Matt at a hurling match, Mag in her car. The SOC provides the health geographer with a tool to firmly grasp the many layers of meaning these places hold, and the significance of the ordinary in locating ourselves in the world.

Can Antonovsky's (1996) salutogenic theory inform the theoretical basis on health promotion and healthy ageing? Not entirely, because the role of context versus composition in determining outcomes is unclear, but it can certainly provide an analytical lens to understand the individual's experience at that relational space between them, their family, their community, and wider society.

By expanding and explicating the SOC components using the life review, as has been done in this research, deeper understanding is gained on how the salutogenic orientation relates to wider goals of promoting health, in particular the implication of the SOC components. The processes of mental, social and spiritual wellbeing upstream on the River of Life means that it is difficult to develop a policy intervention that is not too prescriptive or coercive, because much of what is happening here is influenced by human nature, and philosophical and individual ideas about what makes a good life. What can be done however is to create an egalitarian society that provides every individual with equal opportunity to become the person that they potentially can be, at any age. Having a purpose, a sense of self, continuity of the self, meaningful friendships, and living a life of subjective value cannot be prescribed for at the national scale, but it can be planned for.

Within the European context, Ireland is ranked in third place of the EU27 in terms of the opportunities provided for older people to age actively, to remain living independently in their communities, and for their continued engagement and participation in all areas of social life. Significantly, Ireland was ranked number one for older people's participation in economic, social and political life, which incorporates the variables relating to unpaid work and volunteering, having an active role in the functioning of family life, in creating supportive environments, in contributing to community life, and also participation in political life (Zaidi *et al*., 2013). Because Ireland has one of the youngest demographic structures in the developed world the country is in a very good position to plan and prepare for the years ahead, to ensure that older people can age actively and remain on the banks of the River of Life. With effective planning, by drawing on the research evidence and newly

emerging and well-informed theoretical perspectives such as the salutogenic orientation, there is plenty of scope for Ireland to become exemplary leaders in planning for the health and wellbeing of older people as they age-in-place.

Thesis highlights

This thesis has tested the applicability of the SOC, devised by Antonovsky (1987), as an analytical construct for investigating the person-place-health triangulation. This was done using an empirical study of older Irish people as they age-in-place. It has stretched the application base for empirical work on the SOC, by shifting from the more traditional quantitative approach, to a qualitative one, thereby opening up the theory of salutogenesis for further development. This qualitative approach provided scope to incorporate context and place as central positions of analysis absent from the original theory of salutogenesis, and thus established the relevance of salutogenic theory to geography, and the relevance of geography to salutogenic theory. By focusing on the socio-spatial contexts in which the empirical material was gathered, previously under-considered dimensions of the SOC were uncovered. The importance of identity, role and activity continuity, intergenerational relationships, friendships, loving relationships, and spirituality emerged as important aspects of the crucial spheres of life influencing the SOC. This thesis argues that salutogenic theory has some real value, but can be deepened within a relational geographical framework, and by using methodological approaches that can consider more fully the life course narrative. The potential result of doing so is a more fully developed and rounded theory of salutogenesis than its original form, Salutogenesis 2.0.

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Information sheet and consent form

You are invited to take part in a research project on health promotion and ageing in the community. The following details will explain what the research is about and what your role in the research process will be. Please read the details carefully before giving your consent to participate.

Who is the researcher?
My name is Sandra Walsh and I am a doctoral student based in the Department of Geography, National University of Ireland, Maynooth, Co. Kildare.

What is this research about?
This research is about health promotion and ageing. The research focuses on two key themes: The first theme explores older people's experiences of community life; The second theme explores the formal and informal support structures that exist within the community that promotes the health and wellbeing of its older members. The data gathered in this project will be analysed and interpreted to construct a picture of the experiences of ageing in both rural and urban communities.

Who participates?
Older people living independently in their communities, and people involved in developing both formal and informal support structures for older people are asked to participate.

Why participate?
Those who will participate in this research project are contributing towards a better understanding of the experiences of ageing, health and wellbeing, which will inform the planning and development of age friendly communities.

What are participants asked to do?
Participants will be asked to take part in interviews. These interviews will take place in a mutually agreed location. During these discussions participants will be asked to reflect on their lives, and their experiences of their community with relation to their health and wellbeing. These interviews may take up to one and a half hours, although the actual length of time and number of interviews is at the discretion of the participant. With the participants consent these interviews will be audio-recorded, and the session will be later transcribed.

Important to note
All material gathered during this research will be treated as confidential and securely stored in a locked cabinet at NUI Maynooth. Identifying information about you will **not** be used in any reports of the research or in any publications that draw on the research.

Your participation is voluntary. You are free to refuse to take part, and you may refuse to answer any questions during the interview or request to stop at anytime. You may also withdraw from the research up until the work is completed.

Should you have any questions about the research, you may contact myself, Sandra Walsh, Department of Geography, National University of Ireland, Maynooth on (01) 7086837 (office) or 085 1669279 (mobile). I can also be contacted by email at sandra.walsh@nuim.ie

'If during your participation in this study you feel that the information and guidelines that you were given have been neglected or disregarded in any way, or if you are unhappy about the process please contact the Secretary of the National University of Ireland Maynooth Ethics Committee at research.ethics@nuim.ie or telephone 01 708 6018. Please be assured that your concerns will be dealt with in a sensitive manner.'

Signature of participant _____   Date