Being well enough in old age

Abstract
This article offers a critique of the dominant ways in which well-being has been conceptualized and researched within social policy, focusing in particular on the significance of this for policy relating to older people. It conceptualises well-being as relational and generative rather than an individual outcome. We critically explore normative notions of independence, autonomy and consumerism at the heart of policy on well-being and ageing and suggest that indexes of older people’s happiness conceal more than they reveal. We illustrate this theoretical approach with empirical material from a participatory study in which older people were co-producers of knowledge about what well-being means and how it can be produced. Working with older people as co-researchers we found that keeping well in old age involves demanding emotional and organisational labour both for older people and for family and friends. We suggest the need for ethical and relational sensibilities at the heart of policy on well-being and ageing.

Key words
Ageing, care, dependence/independence, participative research, relationships, well-being

Introduction
The adoption of ‘well-being’ as a focus for health and social policy has generated a body of conceptual, theoretical and methodological work intended to ‘capture’ an elusive and promiscuous concept. This work extends beyond the social sciences to bio-medical studies which claim to demonstrate physiological changes consequent on shifts in subjective states of well-being (Clow et al., 2010). Within the social sciences, and geared to contributing evidence for the impact of policies, practices and interventions, various tools have been devised to measure well-being at an individual level (Dolan et al., 2011). Others have promoted sophisticated analyses of well-being as a counterbalance to an emphasis on economic utility (Jordan, 2008), and the
tendency within social policy to emphasize problems rather than to address positive outcomes (Dean, 2010).

A politics and economics of happiness has now become a central strand of debate about the aims of public policy. Once an add-on to health, well-being has become a value and an individual state to be examined, promoted and most crucially, measured by economists, experts in development studies and environmentalists, as well as by psychologists, sociologists and social and public policy experts.

In this article we offer a critique of the dominant ways in which well-being has been conceptualized and researched within social policy, focusing in particular on the significance of this for policy relating to older people. In place of a conception of well-being that can only be grasped as an individualized outcome measure, we utilize a conception of well-being drawing on Self-citation’s (2011) work that sees well-being as relational and generative. We illustrate this theoretical approach with empirical material from a participatory study in which older people were co-producers of knowledge about what well-being means and how it can be produced (Self citation, 2012).

A problem of measurement and definition?

The adoption of well-being as a policy objective has generated attempts to introduce indicators capable of measuring population well-being and allowing calculations of ‘national well-being’ and international comparison. As Beaumont (2011: 3) points out, “There is increasing interest in having measures that can be compared between member states of the European Union (EU) or the Organisation for Economic Co-operation and Development (OECD), in the way that Gross Domestic Product (GDP) and other national economic accounts measures are currently constructed to internationally agreed standards”. International interest in well-being as a measure of ‘social progress’ was boosted by the Commission on the Measurement of Economic Performance and Social Progress report to the French government (Stiglitz et
al., 2009), which recommended the measurement of well-being as an indicator of societal progress. The European Union’s statistical service Eurostat has also carried out a feasibility study on well-being indicators which shows that data at European Union (EU) level are available for most of what they refer to as the “drivers” of well-being. There is, thus, a growing international consensus on the need to focus on statistically comparable measures of well-being and, in some cases, to understand the ‘drivers’ or causes of subjective well-being outcomes.

In the UK, the Coalition Government invested £2million in a National Well-being Project for the Office of National Statistics to compile a ‘happiness index’ (Evans, 2011). In 2011 ONS included four questions in the Integrated Household Survey (IHS):

- Overall, how satisfied are you with your life nowadays?
- Overall, how happy did you feel yesterday?
- Overall, how anxious did you feel yesterday?
- Overall, to what extent do you feel the things you do in your life are worthwhile?

Results from this have been published that draw conclusions about the distribution of well-being according to geography, social group and age (ONS, 2012)

But both the concept and practices associated with delivering and measuring well-being have been subject to serious critique. Within positivist paradigms problems arising from the diversity of meanings attached to the concept have been identified. For example, a meta-analysis of studies of the relationship between filial care-giving and well-being of parents and adult child carers found that the precise conceptualization had a significant impact on study findings. Thus ‘studies using mere positive conceptualizations found significantly stronger effect size than studies including negative well-being measures’ (Merz et al., 2010: 1545). The Centre for Health and Well-being at
the University of Sheffield (www.shef.ac.uk/cwipp) identifies the following measures of well-being: life satisfaction; subjective happiness; authentic happiness; positive mental health; positive and negative affect; needs satisfaction; quality of life; health states; health utilities, each of which may be measured using different scales encompassing a further range of indicators. It is hardly surprising that meta-analyses identify difficulties in comparing results when both concept and measurement may be so diverse and this casts serious doubt on the confidence policy makers apparently place in measurement as a basis on which to make policy.

‘Quality of life’ (QoL) often appears to be synonymous with well-being. The dimensions of quality of life identified as important in a study of people aged 65 or over by Bowling and Gabriel (2007) reflect many of the issues, such as feeling secure, access to companionship and feelings about home, that were discussed by older people in the study discussed in this article which was framed by reference to well-being. In Bowling and Stenner (2011) well-being is identified as one dimension of quality of life. The authors’ sophisticated measure incorporates criteria defined by older people and offers a much more sensitive means of measuring QoL than the ONS questions can generate. However, the conceptual difficulty in distinguishing well-being from other ways of characterizing older people’s assessments of their lives remains, as does the issue of resolving different outcomes when using different measurement tools. There are also well known methodological limitations to seeking to capture well-being as a psychological outcome through self-reported rating scales. As Cromby (2011, p 840) points out, “Happiness questionnaires are troubled by problems of definition, introspection, memory and insight; their population-level summation is grossly inaccurate as a representation of everyday emotional experience; and both their reliability and their validity might be better accounted for as products of their ability to model, rather than to measure, psychological processes”.

The seductive simplicity of subjective well-being measurements cannot sustain the claims made for them and it is not just conceptual diversity and associated measurement challenges that prompt caution about well-being as
a notion around which to design policy. Well-being embodies how people feel about themselves in relation to their personal, social and material worlds and thus requires an engagement with objective realities as well as emotional states and the values people attach to things (Sayer, 2011). In this sense, it cannot be grasped outside of the material circumstances within which relationships are formed and which embody the consequences of both socio-economic and cultural or symbolic injustices (Fraser, 1997).

According to one group of writers, a focus on promoting well-being may be a way of thinking about a more “fully rounded humanity” (Gough et al., 2007: 3). But within this collection, Ryan and Sapp (2007:71) locate responsibility for being well solely within the individual:

“well-being concerns a person’s capacity for optimal functioning and encompasses not only the issue of physical health, but also a sense of interest in one’s surroundings, a confidence in being able to formulate and act to fulfill goals and the motivation and energy to persist in the face of obstacles. A well being is able to maintain its vitality and to thrive within its everyday ecological environment.”

Although they are attempting to set out a universal account of well-being, this approach implies, nevertheless, a set of capabilities grounded in a particular view of the individual as a rational cognitive actor in possession of a clear set of goals and the capabilities to achieve them. It is a perspective that appears to value positive action and to downgrade the complexity of human social relationships that generate positive and negative feelings in necessary relation, and the diverse strategies individuals adopt to achieve personal well-being at different stages in the life-course when both material circumstances and subjective factors might threaten this.

Nevertheless, it is hard to argue against an objective of enabling and supporting people to ‘be well’ in the world, or to reject the notion that a key responsibility of states is to create the circumstances in which well-being can be achieved. Politically, it is unlikely that well-being will be abandoned as a concept for social policy in the near future. Thus there is value in both
empirical and theoretical work to develop our understanding of what this means and how it might be achieved. Rather than placing emphasis on measurement, we suggest research needs to explore both how people in different circumstances construct and interpret what well-being means to them, and how they seek to ‘be well’, especially in their relations with others, drawing on diverse resources that are impacted by cultural and socio-economic inequalities.

Self citation (2011) has argued that a relational concept of well-being means we need to understand this as a ‘generative’ concept, in that material and cultural circumstances and social relations generate the conditions within which individuals can exercise agency for well-being. This implies that issues of inequality, diversity and power relations will be implicated in both the possibilities available to individuals seeking to maximize well-being, and in the meaning and significance of the everyday interactions through which well-being is produced. He also (2011:780) suggests that well-being may be generated in both (emotionally) ‘close’ and (socially) ‘distant’ relationships, reinforcing the need to understand the way in which diverse relationships are constructed and what might be their significance for individuals in very different circumstances.

Birditt (2007: 604) also suggests that, to understand the quality of well-being “a new approach to social relations research is necessary—one that recognizes the importance of understanding individuals' multidimensional social worlds.” She notes how different ‘social worlds’ lead to differences in the quality of relationship profiles by gender, race, and age. In the particular context that is the focus of this article: well-being in older age, McIlvane et al., (2007) suggest we should consider well-being not only in terms of which relationships contribute to older people’s well-being, but also how older people might be a resource for the well-being of younger people. That is, we need to consider the reciprocal nature of processes though which well-being may be generated. This reciprocity within ‘close’ or ‘distant’ social relations emphasizes the interactional nature of well-being within a broader social and
cultural context. Such contexts may be more or less supportive of both individual and collective well-being (Jordan, 2008).

Alongside an understanding of the relational contexts within which well-being is generated (or not), is the need to critically examine the normative assumptions on which definitions of well-being are constructed. Drawing on feminist care ethics we argue the need to accept ‘interdependence’ rather than ‘independence’ as an ineluctable component of human experience, and thus the impossibility of constructing a notion of ‘being well’ around an assumption of disconnected individuals (Tronto, 1993). An analysis that recognizes the fundamental relational ontology of humanity also requires recognition of inequalities based both in material circumstances and deriving from disability, ageing and the impact of illness. For Kittay ‘the conception of society as an association of equals masks the inevitable dependencies that form part of the human condition – those of children, the aging and the ailing – dependencies that often mark the closest human ties’ (1999, p.14)

Individualised discourses of active agency for positive well-being and self-fulfillment may have an exclusionary effect. For example, work by Fisher (2008) explored well-being and its relationship to recognition amongst parents of disabled babies. In this context the disjuncture between the narratives constructed by mothers of their lives and relationships with their babies, and the way in which they are measured against normative frameworks defined by ‘experts’, generated ‘misrecognition’ with consequences both for well-being and empowerment. Fisher (2008: 584) notes “the importance of according recognition to the diverse ways people seek to construct authentic routes towards well-being and empowerment.” And as Edwards and Imrie (2008: 333) point out, “such an analysis may … ignore the significant societal barriers that particular individuals, such as disabled people, experience in participating in a society as self-determining citizens and, through a reductive analysis of emotions, further stigmatise those that do not meet the well-being ideal.” This ‘ideal’ may also be difficult to reach for older people facing personal loss and an ageist society.
Our initial discomfort about conceptualising well-being as an individual quality rather than something produced through diverse relationships that need to be understood in both personal and social contexts, was reinforced in dialogue with the older people with whom we carried out the research that forms the empirical content of this article. Older co-researchers rejected the use of a measurement tool to explore well-being, in part because they felt it did not encompass a sufficiently relational understanding of this. Thus we developed an approach that would enable us to research well-being in old age from a basis of the need to understand this as both generative and relational.

The research sought to understand what can generate the conditions for being well at a time of life when both personal and social relationships may undergo significant change. If well-being is to be a useful concept for policy relating to older people, we need to understand what it means for those whose horizons are becoming more limited, whose timescales are shorter than other adults and who may see little point in ‘looking forward’ (Clarke and Warren, 2007), or who are experiencing illnesses associated with growing older and thus need to find ways of being well when they are unwell (Sanders et al., 2002). This is not to argue an inevitable association between older age, poor health and reduced circumstances, but to highlight particular features of ageing that challenge normative constructions, which assume a particular type of person. Hence our adoption of the notion of ‘being well enough’: “a sense of integrity, respect and recognition but not necessarily one in which individuals are judged against a benchmark of ‘perfection’ or, in this case, a model of perfection which consists of the ability to act rationally in pursuit of complete self-fulfillment.” (Self-citation, 2011:787)

Before describing how we went about the research, we consider how well-being has been applied in policy relating specifically to older people, drawing on the critique developed above.

**Well-being and older people in policy**
Well-being has been mobilized within English policies focused on ageing and older people as a response to ageing demographics and increased longevity, and the consequent increased demands on health, care and pension resources. As a result well-being has become discursively linked to policy objectives related to individual responsibility and self-governance through the ‘active ageing’ agenda; and to independence, choice and consumerism through the ‘personalisation’ agenda and transformations in the organisation of social care.

Early mentions of well-being appear in *The National Framework for Older People* (Department of Health, 2001). It advocates health promotion initiatives to encourage active ageing. The framework set out standards that service providers should aim to meet including:

“Standard 8: The promotion of health and active life in older age. The health and well-being of older people is promoted through a coordinated programme of action led by the NHS with support from councils” (Department of Health, 2001:14)

This is in line with wider responses to ageing demographics (for example World Health Organization 2002), where the concept of ‘active ageing’ has become the principle way in which governments are seeking to mitigate the economic ‘burden’ of ageing populations. Active ageing draws substantially from ‘activity theory’ and the purported association between being ‘active’ and personal well-being in later life (Adams et al 2011; Litwin and Shiovitz-Ezra 2006). Yet as a policy goal active ageing has been criticized for its lack of coherence (Walker 2006) and has predominantly been mobilized to increase the paid and unpaid economic contribution of older people to society via the labour market and / or voluntary activities (Clarke and Warren 2007).

Subsequent New Labour policy drew associations between individual well-being with ‘independence’ and linked this to public sector reforms. For example, in *Opportunity Age* (Department of Work and Pensions, 2005) promoting independence and well-being becomes the rationale through which arguments for the modernisation of public services are made via the
introduction of personalisation, thus mobilizing discourses of autonomy and a consumer model of choice:

“In developing modern public services for older people, our overarching objective is to promote well-being and independence. We want to achieve a society where older people are active consumers of public services, exercising control and choice, not passive recipients.” (Department of Work and Pensions, 2005: 44)

The association between well-being and independence was reinforced in *Independence Well-Being and Choice: Our vision for the future of adult social care in England* (Department of Health, 2005). This explicitly linked social care provision to wider well-being and public health initiatives aiming to prevent dependence and more costly intensive services:

“We want to link social care more strongly to the wider well-being agenda of local authorities, build on the well-being focus promoted by *Choosing Health* and offer services and support which prevent individuals becoming dependent and needing more specialised social care interventions” (Department of Health, 2005: 37)

This policy framework established by New Labour governments (Department of Health, 2006, 2009; Department of Work and Pensions, 2009a; HM Government 2009) has been continued through the Coalition Government approach to social care provision, demonstrating continuity in the emphasis on choice, control and independence:

“Care must again be about reinforcing personal and community resilience, reciprocity and responsibility, to prevent and postpone dependency and promote greater independence and choice” (Department of Health, 2010a:5).

Thus the Coalition Government also mobilises these concepts to support a wider agenda on public sector reform. This includes the extension of personalisation (including Direct Payments as the preferred method), and shifting provision of services to non-statutory providers.

Personalisation embodies a particular conception of ‘the person’ as having:
“…a high level of self knowledge and reflexivity; substantial predictability in relation to needs and the circumstances in which they may be met, and a willingness to take on responsibility of constantly reviewing whether the support and help being given is enabling the achievement of objectives” (Self-citation, 2008:156-7).

The appropriateness of the particular models of personalisation being promoted to the circumstances of older people who use social care services has been questioned because of this, and because of the low resource base of services for older people (Lloyd, 2010; Lymbey, 2010).

In relation to public health the Coalition approach also echoes earlier policy frameworks that encourage individual responsibility for ‘healthy’ behaviour across the life course and makes specific reference to ageing and later life (Department of Health 2010b).

Thus, from an English government policy perspective, well-being in old age is understood to be generated through independence, choice and active ageing. It is a position that is reflected internationally in ‘active ageing’ policies, and policies for social care delivery (e.g. Anttonen and Haikio, 2011). Rather than offering any explanation or understanding of what well-being might entail in the lived experience of older people, these policies make use of the term as a discursive tool by building particular associations between well-being and individualized norms of independence and ‘healthy’ lifestyles. As Martin (2012) notes in relation to visual images which promote ‘active ageing’ discourses, this conceals the embodied lived experiences of ageing and may compel older people ‘to negotiate their social identities in an era when images of dependency, ill-health and decline in ageing bodies have become increasingly hidden’ (Martin 2012:53-4). This evidences the ambiguous benefits of activation policies as applied to older people and emphasizes the importance of exploring the actual perspectives of older people on the assumed link between activity and well-being (McKee, 2009) and which, as other studies have observed (Clarke and Warren 2007; Howarth 1998; Stenner et al 2010), are at odds with those of policy makers and researchers.
Researching well-being with older people

The study we draw on here was developed to explore the meaning and sources of well-being from older people’s perspectives. It adopted a participatory research approach embodying principles from critical gerontology and reflecting wider acceptance of the value of involving older people in research (Bernard and Scharf, 2007; Futurage, 2011). The research involved collaboration between academic researchers, a voluntary sector organisation and older people, in a city in the southeast of England. We recruited a team of older co-researchers who were actively involved in designing and conducting the research. They carried out interviews and focus groups with older people, and took part in analysis and dissemination. The approach thus involved older people both as active subjects and co-researchers (Self-citation, 2007). We describe the participatory research as a relational methodology through which understandings were generated not only through interview and focus group data, but also through dialogue within the research team.

The co-researchers were recruited through the voluntary organisation’s established volunteering process. This produced a team of twelve people, with an age range of 60 – 87, three men and nine women, all white, most of whom had experience of working with older people through their current volunteering work, and two of whom were active in the city’s Older People’s Council. In addition to their professional backgrounds (including two who had worked in adult social care) they also brought a shared interest in, and knowledge of, issues that people face in later life. The older co-researchers were given training in data collection and analysis.

As part of the research design process we reviewed CASP -19, a quality of life tool designed specifically to be used with older people which has been used by the UK government in generating ‘Opportunity Age’ indicators (DWP, 2009b). CASP stands for Control, Autonomy, Self-realisation and Pleasure –
the key concepts considered to constitute well-being from the perspective of those designing the tool (Hyde et al., 2003). The team of co-researchers tried using this tool. They completed it themselves in order to consider its value for our purpose. Their responses were informative. They were concerned that completing the tool would be potentially upsetting, for example, for people answering ‘never’ to the question of how often ‘I feel the future looks good for me’. They were clear that how they responded to the Likert scale measurements would be dependent on emotional states that might vary from day to day (if not hour to hour) and this made it hard to answer as the changing contexts of their lives could not be reflected in tick box responses. Bowling and Stenner (2011) also note the impact of ‘life events’ on older people’s assessment of their quality of life. Co-researchers observed that the measures focused on the individual and did not allow a consideration of the ways in which relationships with others – family, friends, carers – might be important for their well-being. Hence we developed a different approach that would enable older people (both our ‘respondents’ and the co-researchers) to engage in reflection and dialogue about what well-being means to them and what contributes to and detracts from well-being in later life.

Based on discussions within the research team we designed a topic guide to use in semi-structured interviews and focus groups. Participants were first invited to talk openly about circumstances that contribute to their well-being, and then asked to respond to prompts addressing issues identified within the research team discussion. These included, for example, questions about the importance of place, different types of relationships, money, and experiences of using health and other services.

Using the topic guide the co-researchers conducted one-to-one interviews with 30 older people and ran 7 focus groups involving another 59. Interviews were recorded and transcribed. Focus group discussions were recorded but not transcribed. These recordings were reviewed to consider if the discussions identified any themes not identified through interviews. Participants were identified through local voluntary services, and then via snowballing designed to ensure a diverse group of participants living in their
own homes and in sheltered housing. There was considerable discussion within the team about the age range to include. Sixty five was agreed as the minimum and interviewees’ ages spanned more than 30 years. Half were aged 85 or older and 5 were in their 90s. Twenty were women and ten were men. One particular perspective that this study offers is thus an understanding of what well-being can mean in old, old age and how this may change in the course of ageing. Much of the current ‘active ageing’ agenda assumes the ‘third’ rather than ‘fourth’ age and focuses on activity understood in terms of participation in physical, social and economic spheres intended to maintain health, reduce social exclusion and prevent dependence on services (Walker, 2009). This may have limited relevance for many of those in their late 80s and 90s for whom the challenge is often to find new ways of being well enough when they are unwell and when their horizons are reduced.

We deliberately sought to include people whose financial circumstances varied by recruiting participants from different areas of the city. Interviewees were sought through contact with a Black and Minority Ethnic (BME) community partnership, but although this led to a focus group only one black person took part in an individual interview. Two gay men were interviewed – identified through personal contacts and targeting a community group in an area with a large gay population.

Team members discussed both the content and experience of interviewing and an initial coding framework was developed from these discussions. Coding was carried out by co-researchers and the research fellow to ensure consistency in application of codes. The coding involved closely reading interview transcripts and organising sections of the transcripts under descriptive categories to identify themes and patterns. The coded data was organised into thematic sections and brought to team discussions for reflection and interpretation. For example, at one meeting all the data relating to the significance of care giving and receiving to well-being was discussed. Co-researchers reflected on the data from their own lived experience and this enabled a richer understanding of the meaning and significance of interviewees’ responses to emerge.
Thus the study created a dialogic process in which older people interviewed other older people and talked with them in groups, then reflected on what they had said in team discussions, contributing responses and thoughts from their own lives. This offers deep insight into the processes involved in producing well-being and the resources older people identify and use in sustaining their well-being as they age. We illustrate this below with findings from the study.

**Older people constructing well-being in old age**

In this section we consider what this research suggests about the usefulness of a relational concept of ‘being well enough’ in relation to well-being in old age. The invitation to reflect on what well-being meant and to offer examples of circumstances in which they experienced well-being, led interviewees to reflect on current and former lives, on major changes and how these had affected them. People spoke of losses: of friends, loved ones, roles or capacities and of how they dealt with these; they spoke of the impact of giving and receiving care as they became frailer or as a partner suffered illness; they spoke of the need to adapt their way of living as their mobility became problematic or as activities they used to enjoy became closed to them for different reasons. They spoke of changes in the world around them – in the behaviour and attitudes of others, and of how their own attitudes had changed. Thus through the interviews they were both constructing what well-being meant to them, and demonstrating the processes through which they sought to maintain and develop their own well-being and contribute to that of others, in changing and often difficult circumstances.

Our analysis identified a number of resources older people draw on in generating well-being. Such resources are personal, interpersonal and material. Personal resources include people’s capacity to develop greater tolerance of difference and thus to adapt to the changes taking place around them, and to draw on a lifetime of experience to develop an acceptance of the present:
“I have learned to accept myself as I am and not to be so critical, self-critical….there is nothing you can do about the past, why are you beating yourself up now?”

But interviewees’ narratives also highlighted loss of personal resources, including confidence, which impacted on their capacity to take advantage of opportunities to do things that could generate well-being. For example, one woman spoke of her fear after a fall when crossing the road following a stroke and thus a reluctance to go out.

Loss also featured substantially in relation to interpersonal resources: “We’re reaching the stage where we’re running out of friends and relations…they’re just dying off.” One couple, both in their 90s, highlighted the importance of, and suggested an acceptance of, inevitable closing down of such relational resources:

“We lived for 23 years in [town] where we had many friends, acquaintances and we had a nice house and, you know, there are things going on and people you talk to and people come to see us and there’s always…the whole thing was happy. That’s gone but we realise this happens with older people and you tend to be withdrawn, but our daily lives fill everything in”.

The significance of material resources arose in different contexts. For some who described their economic circumstances as comfortable, having enough to pursue leisure activities contributed to their sense of well-being and enjoyment of life. But for many, uncertainty about financial security constrained both present and future well-being. This was not just a matter of living on limited income, although descriptions of careful planning and money management indicated this was an accepted aspect of post-retirement life. Anxiety about having enough money for the future impacted on decisions about how to live in the present. Interviewees expressed concerns about the uncertainty of future costs, whether for care or maintenance charges for housing which might rise unexpectedly. The response of this 96 year old
woman to the question of the importance of money to well-being illustrates this balancing of present and future needs:

“Well I suppose it is but on the other hand I manage. But then because I don’t do anything, as I say I mean I don’t buy clothes, I don’t want them, so really what I use it on is my maintenance [for her flat], I know I’ve got to keep six thousand or just under in the bank … when your maintenance comes in it’s very high … I don’t have anything to play with but I’m not hard up, I mean I, if I wanted a pair of shoes I expect I could get them but I don’t want them you see”.

The analysis of resources and how they impact on well-being highlights the importance of understanding how older people develop strategies to be well enough in the context of changing circumstances throughout old age. We suggest this can be conceptualized as ‘learning to be well enough in old age’ and is a process that requires substantial emotional and organizational labour (Self citation, 2012). Such emotional labour includes reflections on what is important in terms of values, relationships and priorities and dealing with a sense of declining visibility and lack of recognition of one’s strengths. It also includes learning how to receive care and how to respond to changes in the nature and balance of close relationships.

The relational characteristics of well-being were very evident in interviews with older people in our study. Such relationships included both the close and distant relationships distinguished by Self-citation (2011). Caring relationships occupied a significant place in the narratives of many interviewees. Some identified themselves as carers and their narratives were constructed around the centrality of this role. Others talked of their need for care and of both positive and negative experiences of the way this was offered. One example illustrates how the presence or absence of care within a ‘helping’ relationship can make a substantial difference to well-being. A 97 year old woman living alone and with very limited mobility needed to be taken by car to do her shopping. She contrasted the way this help was provided by her son – who offered a functional service with no sense of going beyond ensuring food was available for her, with her experience of being taken shopping by a friend:
“… he treats me. I just feel like the queen! You know, he says ‘don’t you dare open the car, I’ll do all that’ Opens the car, gets the… I say ‘darling I can put my seatbelt on, I’m not helpless’ and he says ‘you’ll do as you’re told when you’re out with me.’ And he treats… it’s just wonderful, he’s such a darling”.

Some would suggest the way this man treats her denies her autonomy, leaves her out of control. Elsewhere in her interview she demonstrated a fierce independence. But in this context, where going shopping is about the only time she gets out of her flat, her friend’s treatment transforms a functional activity into an experience of being cared for and made to feel special. We suggest that this may be an example of the ‘positive dependency’ that Self-citation, 2011) suggests may contribute to rather than detract from well-being.

Care is characterized by complexity and ambivalence in older people’s stories. On the one hand skilled, sensitive care is fundamental to well-being, as is the confidence that good care will be available when it is needed and that people can easily find out where they can get help. On the other hand older people have been well schooled into thinking that to seek help involves becoming a burden. The concern that they may be seen as ‘burdens’ itself detracts from well-being. We can see here the material effect of discursive constructions that link well-being with independence. The woman quoted above lived alone without assistance and spoke of her independence: ‘I don’t ask anybody for anything. I’d sooner crawl round the floor than ask’.

For some the identity of care giver is central to their sense of self and was the focus of their narrative around well-being. One man had been involved in caring for his wife for much of their married life following her experience of post-natal depression. Whilst objectively his situation appeared highly constrained he expressed satisfaction with being able to secure good care for his wife (cf Nolan et al., 1996) and this contributes to being at one with himself. Notions of control or autonomy cannot encompass the complex relational characteristics of care giving and receiving, and their significance for well-being. Highlighting the individualised assumptions that equate
independence with well-being both ignores and devalues the significance of relationships that go beyond offering functional support.

But in addition to the close and often intimate relationships that characterise care giving and receiving, older people’s accounts of factors impacting on well-being also identified relationships within families, with friends and neighbours, as well as casual interactions with people in everyday encounters (which we have called ‘stranger relationships’ – see Self Citation, 2012) as important. These different types of relationships highlighted not only the importance of social contact of some kind in most people’s lives, but how the nature and quality of the interactions they had with those around them impacts on well-being. Thus, for example, both absent and poor relationships with adult children can detract from well-being, as can a sense that there is no one locally who could help out in an emergency:

“...if I’m sick here now I haven’t got anyone anywhere that I can phone to say, ‘come over and spend a weekend with me because I have a stroke and I’m unable to help myself’, there isn’t anyone. My relatives I have in London, they have the children and they can only maybe spend a day…”

Making new friendships in old age can be hard because they lack the shared history that often gives friendship its quality. This woman suggests that exhortations to get involved and be active may not work as means of developing new friendships:

“But I do desperately need, and there’s no point in saying, oh, join an evening class or join this and that because people are not, I don’t actually think they’re actually joining things with the objective of making any sort of firm friendships. I mean, I get this at the poetry group, you go in and the recitals are over and everybody is up and away, you know, quickly, they don’t hang around to pass the time of day or anything else”.

In contrast, comparatively low key contacts with others can be important both to know that others are concerned about you, and to relieve what can be the tedium of hours spent alone:
“So, if somebody breaks up the day, that’s good, or [name] next door when she is always out each day, she might call through the window, alright [name], you alright? Want to come in for a cup of tea? If I’m not doing anything I say yes and quickly go in or if she is on her balcony, she loves the sun, we talk to each other…”

Some people talked about deliberately starting conversations with strangers at the bus stop, and of having conversations with those working on checkout counters in supermarkets as important in sustaining a sense of connection with others and promoting recognition of themselves. They also spoke of the impact of the way in which they were treated by, for example, receptionists when they visited the GP. Thus, interviewees confirmed Self-citation’s identification of ‘distant’ as well as close relationships as important in relation to well-being.

**Conclusion**

In this article we have illustrated from empirical research the value of a generative and relational concept of well-being. The first ONS report based on the four questions set out in the introduction has suggested that those in their 60s and 70s rate their well-being higher than younger people, but that this drops off after age 80. But how confident can we be about such findings and what do they really tell us about what produces and detracts well-being in older age? Our findings suggest that subjective experiences of well-being in old age cannot be understood in isolation from social and cultural processes associated with growing older. These include the way in which older people are de-valued and may become ‘invisible’; the way the promotion of independence in contemporary political discourse undermines the significance of caring relationships and contributes to a reluctance to seek help; and the relational and material resources affecting people’s capacity to adapt to changes in their social environment as well as personal life changes. We suggest that being well enough in old age requires learning about how to live as an older person, particularly in the face of change and loss of different types: of friends and family, of health and physical capacity, of roles and
sometimes identity. Developing strategies to keep well in old age can involve both emotional and organizational labour and can be hard work - being well enough is often an appropriate ambition. But the learning required to create a supportive culture in which older people can be well also needs to take place amongst those who are involved in different types of relationship with older people. This includes those in close and distant relationships. Thus family members need to learn to recognise and respond to the impact of changes in roles and power relationships, and friends need to learn how to relate to people who have changed as a result of illness or impairment. ‘Strangers’ - whether GP receptionists, workers on supermarket checkouts or bank staff need to be aware of the significance of apparently trivial encounters for older people for whom a shopping trip may be the only time they leave their home.

Conceptually these findings reinforce the need to understand well-being as produced through relationships and interactions, rather than as an individual state. This has important implications for policy and the way in which well-being is researched. Our concerns are not just that an index of older people’s happiness conceals more than it reveals about what living into old age is like. Attempts to define well-being and determine indicators of this embody normative values that may not only be irrelevant, but sometimes positively detrimental to older people’s well-being. Not only do older people themselves resist help because they have learnt that it is bad to be dependent, policies and practices that devalue care and fail to recognize an absence of care as unethical create the conditions within which abuses can flourish (Ash, 2010, Parliamentary and Health Service Ombudsman, 2011). There are practical dangers in equating well-being with autonomy, independence and choice. Not only does the Ombudsman’s report graphically illustrate a complete absence of concern for the well-being of the older people whose experiences of being in hospital are recounted here, it reinforces the anxiety felt by older people who may need to use services of what this will be like. An absence of confidence that good care will be available in future undermines current well-being.
From the perspective of our analysis here, the absence of relational and ethical sensibilities evident in this report and in Ash’s (2010) research in residential care homes emphasises the importance of countering the dominance of rational actor strategies to promoting well-being in old age. There is an obvious relationship between the way in which well-being is constructed in policy and practice discourse and the way in which it is researched. Thus we suggest there is an onus on social scientists and social policy researchers to offer different ways of both understanding and promoting well-being and to acknowledge the limitations of standardised outcome measures produced primarily for the purpose of international comparison.

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To be added

References


